MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Complaints and PALS – Annual Board Report 2017

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

Maidstone and Tunbridge Wells NHS Trust

Complaints and PALS – Annual Board Report 2017

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 2016-17. • A review of performance in responding to complaints in 2016-17. • A summary of the learning and action taken in response to complaints received 2016-17.
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
5.0	Fifth annual Board report	May 2017

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

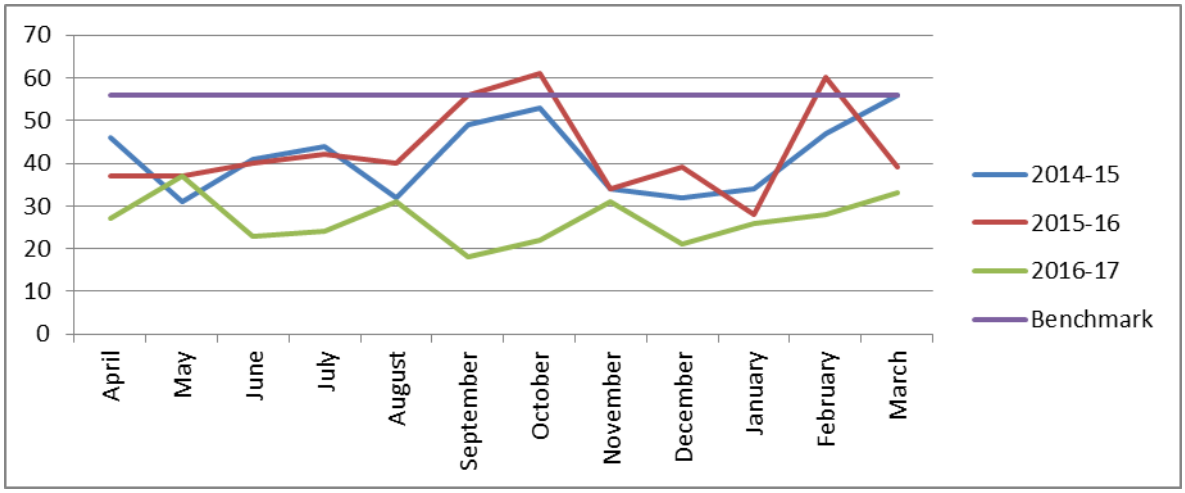
The year 2016-17 has been a challenging one in terms of staffing. Whilst the Patient Advice and Liaison Service (PALS) has remained fairly stable, in the first half of the year, both substantive Complaints Lead posts became vacant. Compliance with performance in responding to complaints remained the priority for the service, but the staff vacancies did impact on this.

3. Complaints received

For the year 2016-17, the Trust received 321 formal complaints, a significant decrease of 192 complaints from the previous year (513 complaints received 2015-16). This has been carefully reviewed and monitored during the year and there has been a small rise seen in the number of contacts being made with PALS during this same period. Healthwatch reviewed complaints services across the health care sector in Kent in June 2016 and their report published in November 2016 raised no concerns about the accessibility of the Trust's complaints process or service. This would suggest that service users are appropriately accessing support via PALS, thereby reducing the need to raise complaints formally.

The graph below (3a) compares the number of complaints received in 2016-17 against the number of complaints received in 2015-16, 2014-15 and the current benchmark of approximately 56 complaints per month. The benchmark is based on the national mean of between 1.318 and 3.93 complaints per 1000 inpatient episodes (excluding day cases). This shows that the rate of complaints received by the Trust remains significantly below the national mean.

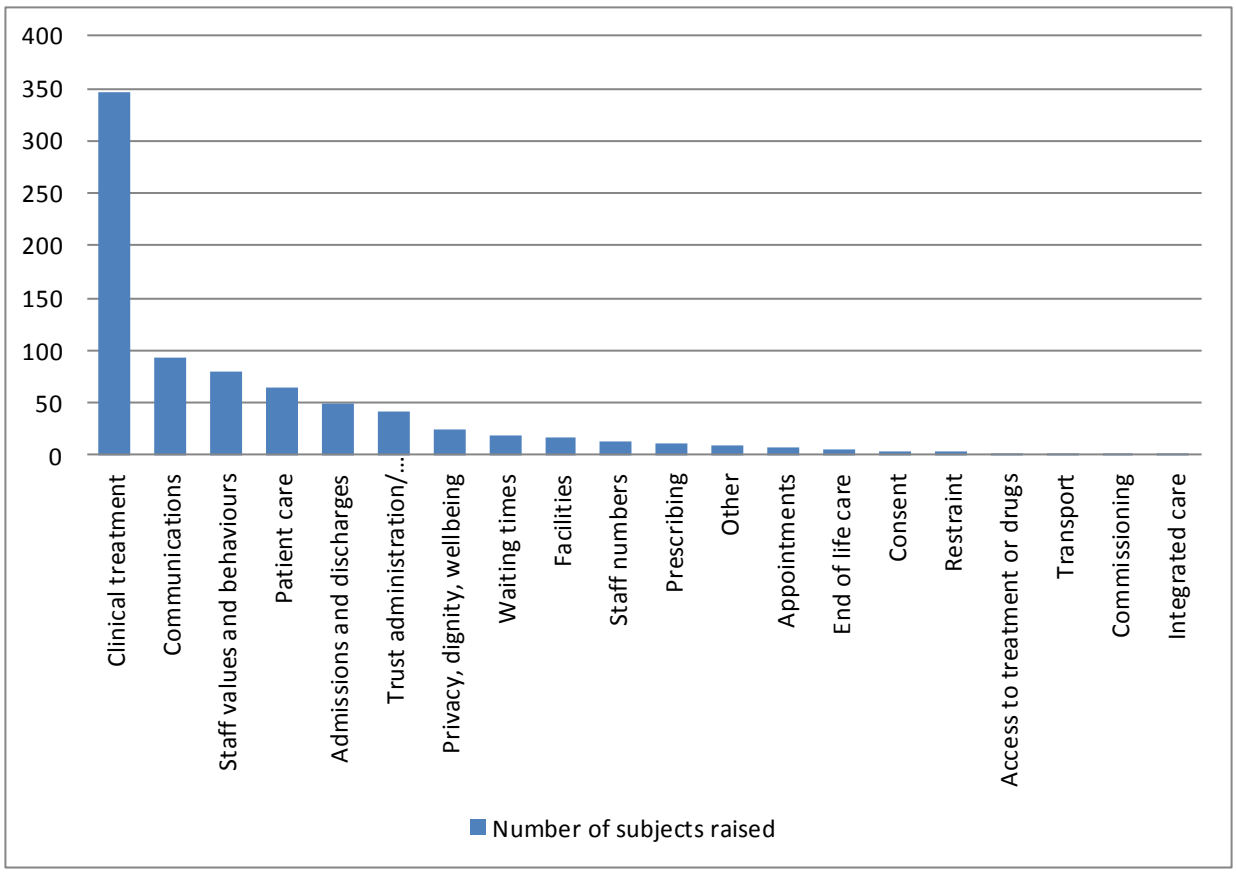
a) Number of whole complaints received



4. Subject of complaints

The subjects used to record the substance of the complaints received by the Trust are determined by NHS Digital. Under the current national 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 2016-17, 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 346. This far outweighs the other subjects. However, other issues commonly raised relate to: communications, staff values and behaviours and patient care.

Extract from a complaint:

'The doctor informed me he would….telephone my brother between 11-11.30 am the following day. My brother sat by the telephone all day waiting for a phone call, nothing came. I think I need to remind you that a patient in pain and worried will hang on every word of his care team and trust them to do this'

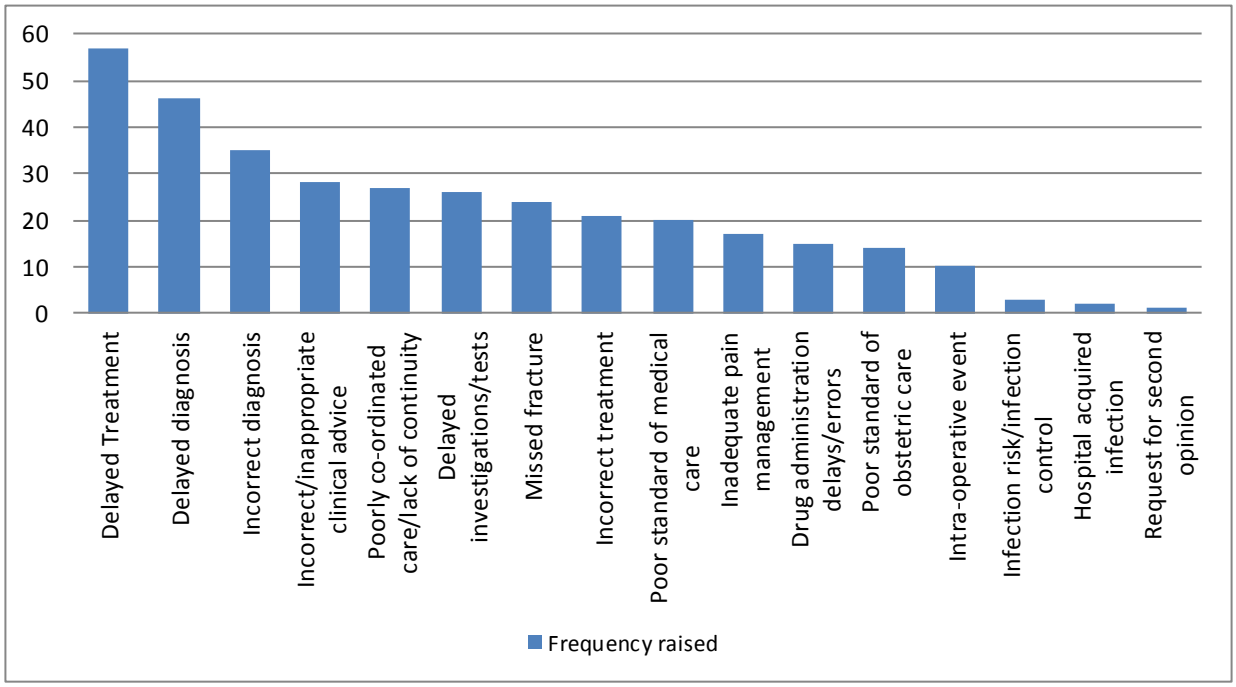
Due to the significant difference in overall numbers of complaints between 2016-17 and 2015-16, these have been converted to indicate a percentage of all subjects raised. Of note, comparing these percentages, there has been virtually no change in the proportions of subjects raised, as shown in the table below:

Subject	% of subjects raised 2016-17*	% of subjects raised 2015-16*
Clinical treatment	↓43	44
Communications	↓12	14
Staff values and behaviours	↑10	8
Patient care	8	8
Admissions and discharges	6	6
Trust administration/policies/procedures	5	5
Privacy, dignity, wellbeing	3	3
Waiting times	↓2	3
Facilities	↑2	1
Staff numbers	↑2	1
Prescribing	↓2	3
Other	↑1	0
Appointments	1	1
End of life care	1	1
Consent	1	1
Restraint	↑1	0
Access to treatment or drugs	↓0	1
Transport	0	0
Commissioning	0	0
Integrated care	0	0

*rounded to the nearest whole percent

Each subject code as defined by NHS Digital can be broken down to offer a higher level of detail, by analysing the locally determined sub-subject codes. Graph 4b) shows detail of the sub-subjects raised under clinical care.

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 and incorrect diagnosis.

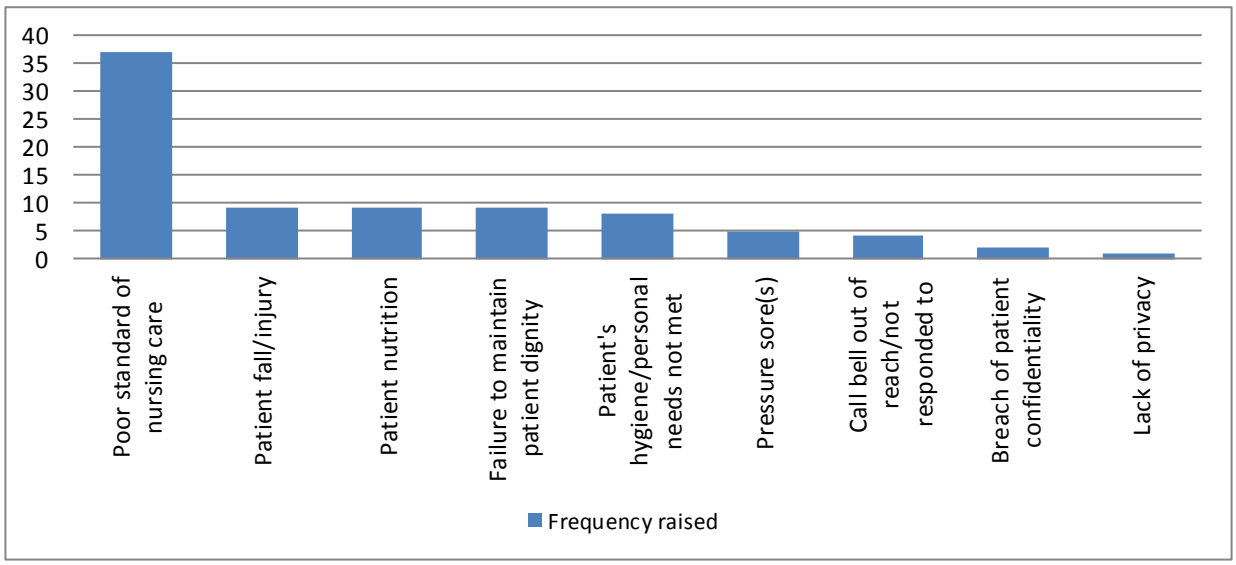
Patient story

A patient presented to the ED having fallen from a ladder. He was found to have a number of injuries, but was stable and was transferred to a ward overnight for observation. Whilst the patient and his wife were waiting for him to be moved to the ward, his wife asked staff on a number of occasions if they would clean and dress the wound on the patient's leg. Staff acknowledged the requests but they were never followed up. The patient was discharged home the following day, but was readmitted six days later with an abscess at the site of the leg wound. This required intravenous antibiotics and surgery. The complainant believed that this could have been avoided if the wound had been cleaned and dressed earlier.

This complaint was investigated by an ED Matron. The patient had presented as a trauma call and once the primary survey had been completed, the wounds should have been attended to. However, it was not possible to state with certainty that the delay in cleaning and dressing the wound had resulted in the abscess developing. The matron issued a reminder to the ED nursing staff around the need to attend to wounds in a timely fashion.

The clinical care subject focuses on the diagnostic and treatment aspects of care, however, the compassionate side of care is better encompassed within the other subjects of patient care and privacy, dignity and wellbeing. Looking at the complaints raised around these issues, graph 4c) shows the most frequently raised issues.

c) Complaints about patient care, privacy, dignity and wellbeing.

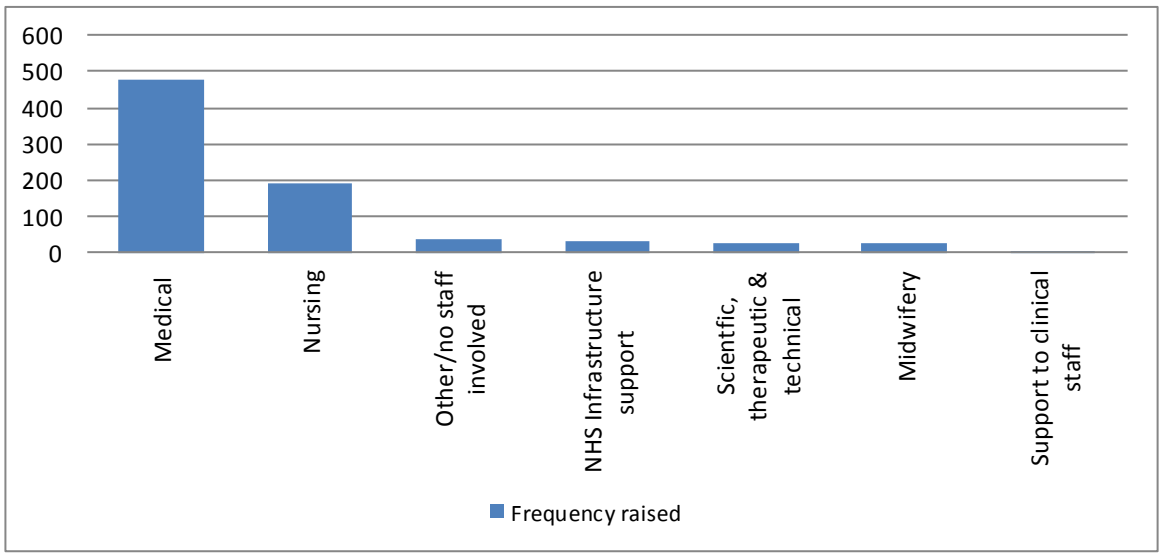


As can be seen, the most frequently raised issue is poor standard of nursing care, with patient fall/injury, patient nutrition and failure to maintain patient dignity all raised nine times each.

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, data is now reported per subject, rather than as whole complaints. Chart 5d shows the number of subjects raised in complaints, by staff groups.

d) Complaints by staff group



This clearly illustrates that the majority of complaints received 2016-17 related to medical professionals (doctors of all grades and specialties).

Again, due to the significant difference in overall numbers of complaints between 2016-17 and 2015-16, these have been converted to indicate a percentage of all subjects raised. Of note, comparing these percentages to the previous year, changes in the proportions of complaints about individual staff groups have been minimal, as shown in the table below:

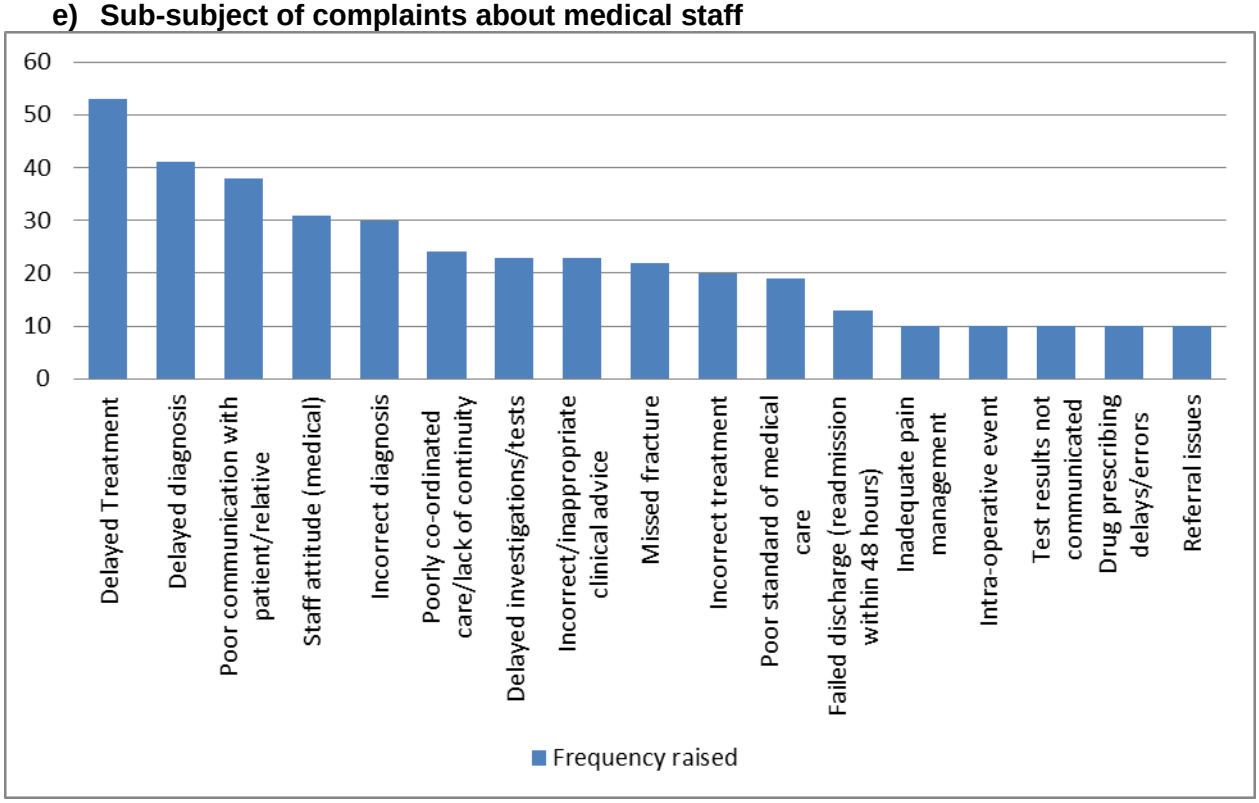
Staff group	% of all subjects raised 2016-17*	% of all subjects raised 2015-16*
Medical	↓60	64
Nursing	↑24	21
Other/no staff involved	↑ 5	2
NHS Infrastructure support	↓ 4	6
Scientific, therapeutic & technical	↑ 4	3
Midwifery	3	3
Support to clinical staff	0	0
Ambulance	0	0

*rounded to the nearest whole percent

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.

As shown above, 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 (5e).

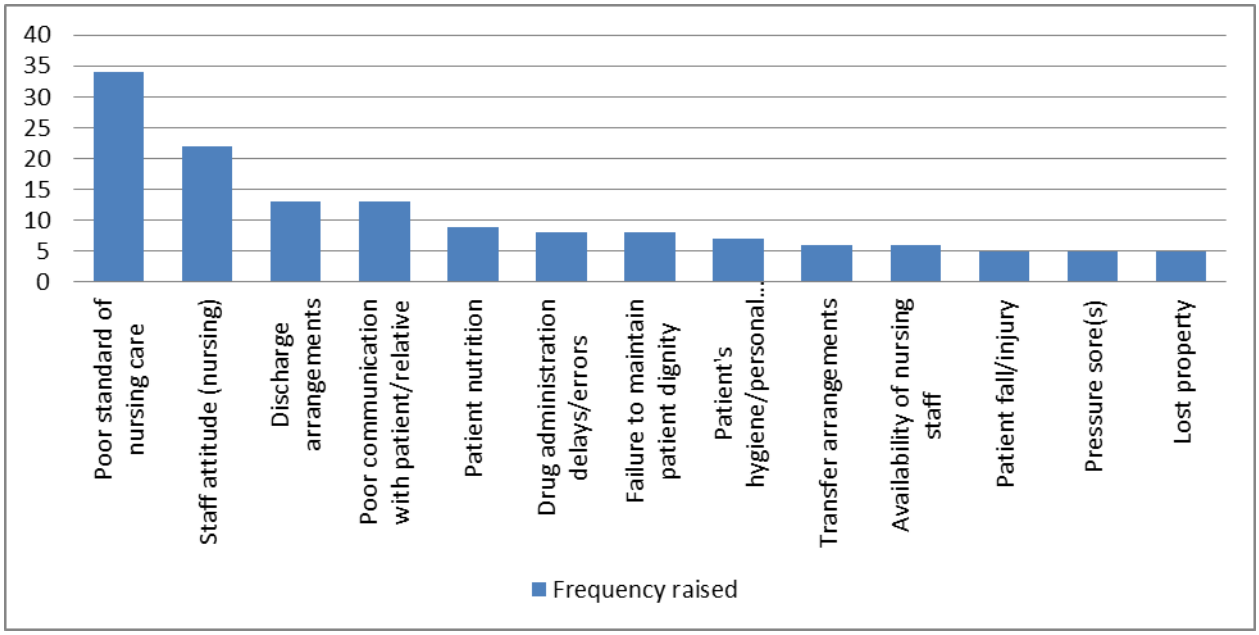
e) Sub-subject of complaints about medical staff



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.

Although the number of complaints relating to nursing staff is significantly lower, consideration should be given to these. Graph 5f offers more detail around this and contentrates on sub-subjects with over 5 incidences recorded.

f) Sub-subject of complaints about nursing staff



As can be seen, the majority of complaints relating to nursing staff are around poor standards of nurisng care.

Extract from a complaint:

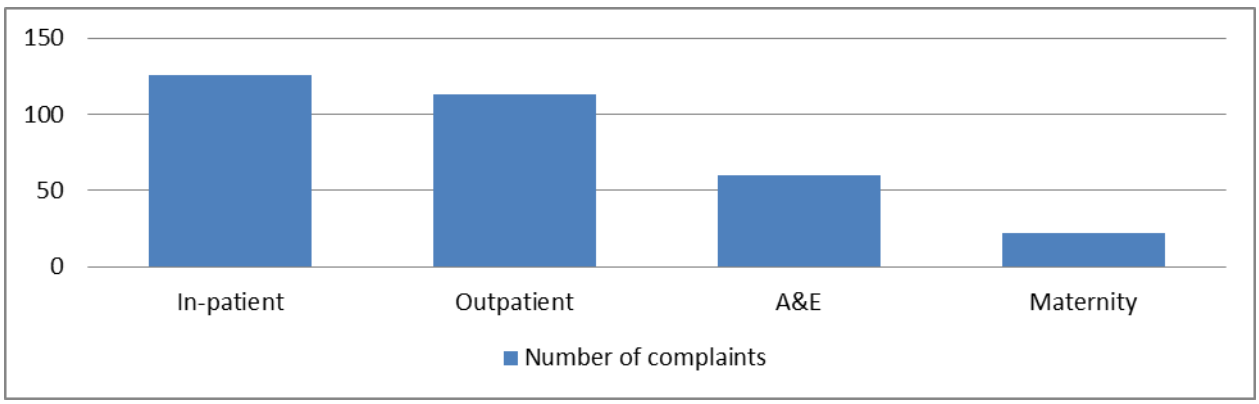
'There were only 4 nurses and 1 sister who I can honestly say were very good but sadly all of the others were sub-standard to the extent that some days and nights I would be frightened to leave my dad in their nursing care, it was this bad. This is awful for any relative to have to witness and need to complain about, and for the patients too especially when they are very vulnerable.'

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

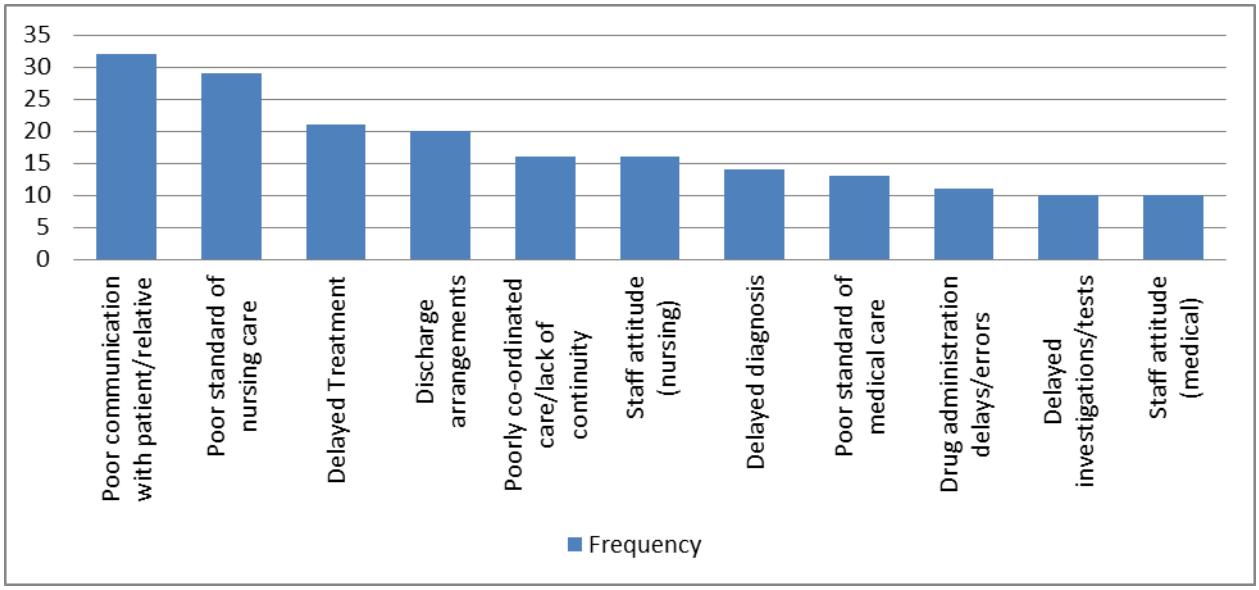
The distribution of complaints in relation to the service area involved is shown in graph 6g.

g) 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 103,969 admissions and 488,219 outpatient episodes in 2016-17, reflecting a higher proportion of complaints arising from inpatient services.

h) Subjects raised in inpatient complaints



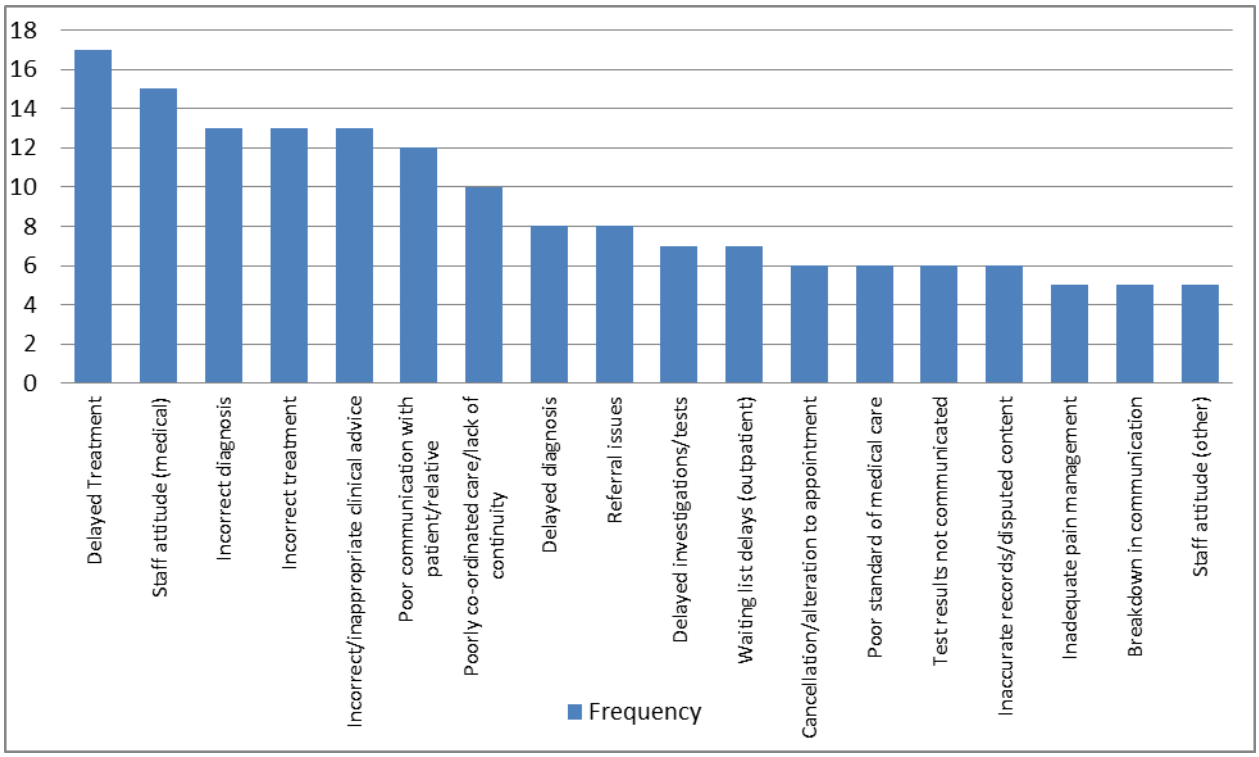
The graph above (5h) identifies those issues with 10 or more incidences reported during 2016-17. This highlights that poor communication was the most frequently raised issue in complaints about inpatient care.

Patient story

A patient had been admitted to hospital and a diagnosis of terminal cancer had been made. The doctor came to see the patient on the ward. The patient's daughter was present and indicated to the doctor that the family preferred that the patient was not informed of his terminal diagnosis. The doctor was reported to reply, "We normally like patient's to know what's going on." The patient's daughter reiterated the family's request. The doctor then bent down to the patient (who was hearing impaired) and asked him if he wanted 'to know what's going on'. The patient co-operatively said he did and the doctor informed him that there was no treatment and he would now receive palliative care. The family were upset that their wishes had not been respected and believed that the patient had been given information he had not requested.

The complaint was investigated by the Clinical Director. Unfortunately, the doctor involved had since left the Trust. Apologies were offered to the family for the distress this experience caused. It was explained that best practice requires staff to keep patients informed regarding their diagnosis and prognosis, but given the family's request, the doctor should have removed to a private area to discuss this with the family further, to better understand their concerns and explain and agree a communication plan.

i) Primary sub-subjects raised in outpatient complaints



This graph highlights those issues with 5 or more incidences reported during 2016-17. Of note is the number of outpatient complaints about delayed treatment and the attitude of medical staff.

Patient story

A patient arrived for a 13.40 appointment. The consultant arrived 15 minutes later, but did not apologise for his late arrival. During the consultation, the doctor checked two messages received on his mobile phone. The consultant appeared to have no prior knowledge of the patient and was unaware of the reason for the patient's referral to the clinic. The patient is hearing impaired and when she said 'pardon' on a couple of occasions, the doctor was described to repeat comments louder and with an 'exasperated attitude'. The patient's relative (who was present during the consultation) described the consultant as unprofessional and rude. However, the consultant then noticed that the relative was wearing a name badge, identifying her as a member of Trust staff. The relative reported a change in the consultant's behaviour, being more polite and providing a clear explanation and management plan. The consultant then asked the relative questions regarding the scheduling of appointments.

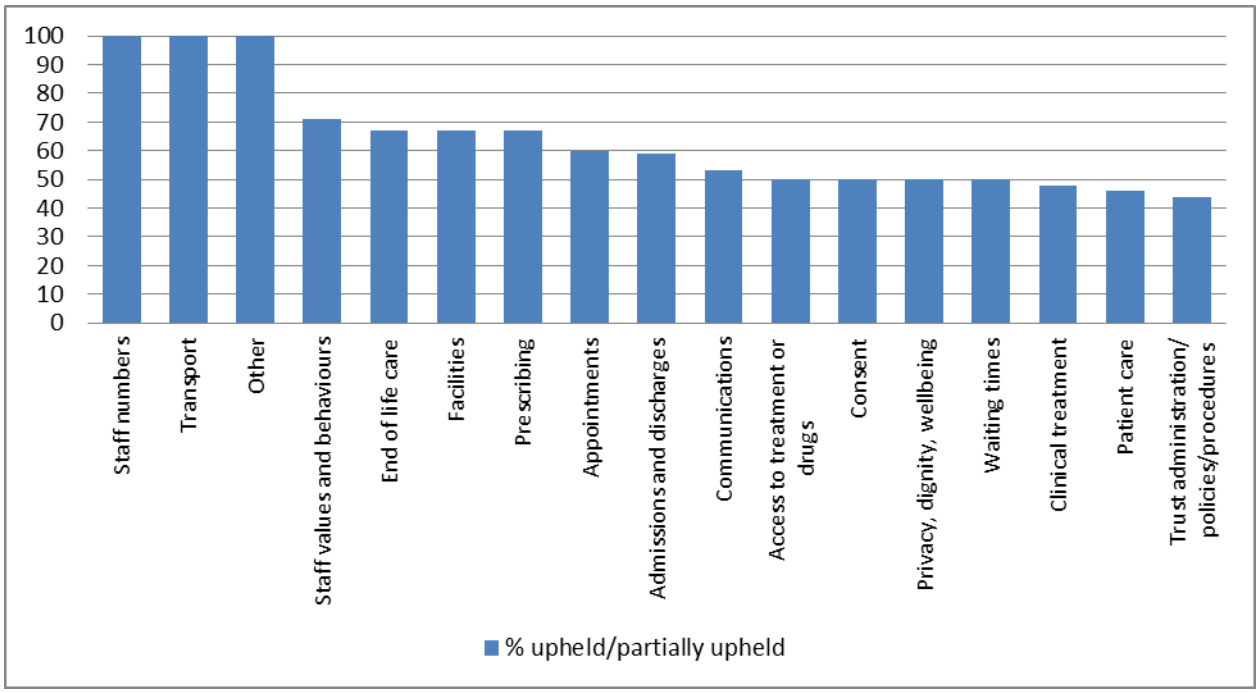
The complaint was investigated by the Assistant General Manager. The consultant was reminded of his obligations to be present from the start of clinic. The consultant expected that the patient would be undergoing observations ahead of seeing him and therefore did not appreciate that an apology was warranted. The consultant is available to the junior team for advice during clinics by phone and offered assurance that apologies would normally be offered at the time for any interruptions of this nature. This was the first appointment with this consultant and it was acknowledged that he was not fully apprised of her history. The consultant recognised that the discussion about scheduling appointments was inappropriate. Apologies were offered for the overall poor experience. The Clinical Lead met with the consultant to discuss the complaint and reinforce the expected standards.

7. 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 Trust Clinical Governance Committee.

The Trust is asked to report on the overall outcome of complaints as part of the data return to NHS Digital. 148 complaints were reported as upheld or partially upheld, a decrease from 2015-16 (270).

j) Percentage of complaints upheld by subject



Of note, only 1 complaint was received which was primarily categorised as transport and 2 complaints each for 'other' and staff numbers. The transport complaint related to the incorrect type of vehicle being requested for an intrahospital transfer. With regards to staff numbers, assurance was offered that despite shortages of substantive nursing staff, cover was being provided via bank and agency and that the Trust was engaged in a long term recrutiment and retention strategy. The 'other' complaints related to lost property (spectacles and hearing aids) for which financial remedy was offered.

A total of 22 complaints were received where staff values and behaviours were cited as the primary issue of the complaint. Of these, 3 related to the unprofessional conduct of a locum consultant. The agency were notified of the complaints and the decision was taken that this individual would not be booked to work for the Trust again. In 1 case, disciplinary action was taken against a substantive member of staff. In the majoroty of the remaining upheld/partially upheld complaints in this group, it was determined that the underlying issue was in fact poor or inadequate communication, rather than poor conduct. Articles based on complaints relating to communicaiton have been highlighted in the Governance Gazette and via the Chief Executive's newsletter to raise awareness.

A total of 4 complaints were received where end of life care was the primary issue. Of these, 3 had been responded to at the time of writing, 2 of which had been partially upheld. 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. Learning from these complaints has included:

- All clinicians from adult wards are to undertake end of life care mandatory training
- All end of life care complaints are now reviewed by the Lead Palliative Care Clinical Nurse Specialist to identify themes to inform training
- Each adult ward now has an identified Palliative Care Clinical Nurse Specialist who will be providing ward specific palliative care and end of life care training

The lower proportion of upheld or partially upheld complaints about clinical treatment is influenced by the large number of complaints received. The Trust recorded 181 complaints about clinical treatment, of which 76 were upheld or partially upheld.

8. 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.

The identified learning from upheld/partly upheld formal complaints closed in 2016-17 can be found at Appendix A.

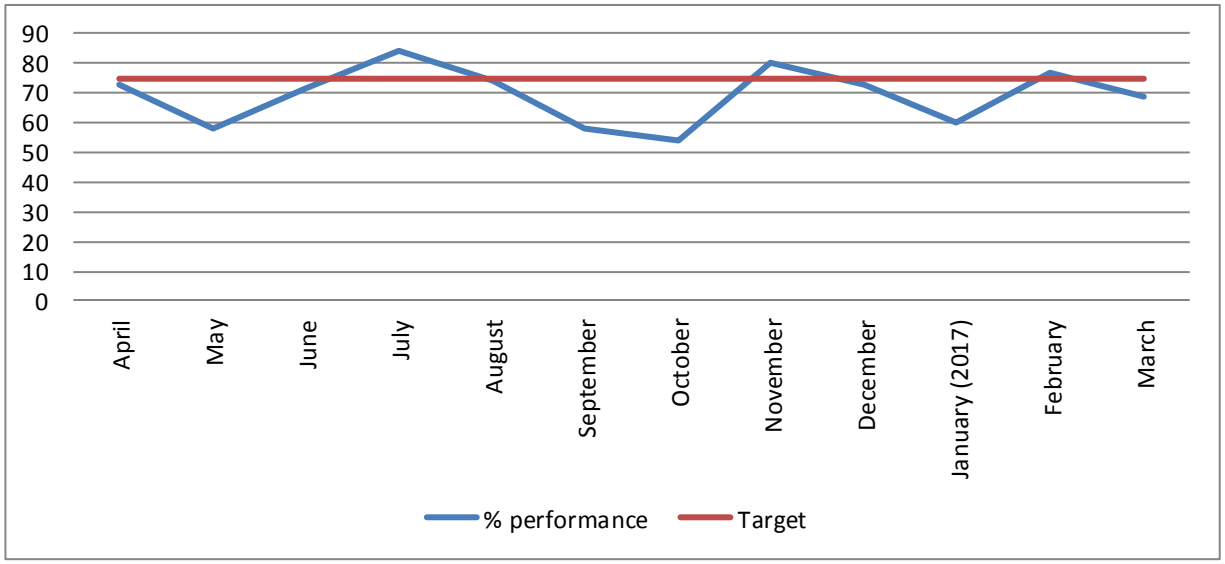
Some highlights include:

- Offering to share the Trust's End of Life care strategy with a relative for her consideration/feedback
- Identifying the need to develop local guidelines on the monitoring of women in hospital in the latent phase of labour
- WHO checklist introduced into cardiac catheter lab
- All trainee doctors starting work in the ED will attend a national radiology interpretation course
- Local guidelines to be developed on the management of neonatal jaundice
- New policy regarding blood tests prior to venesection being developed

9. 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 69% compliance for the year (74.3% 2015-16). Monthly compliance is shown in graph 10k.

k) Performance compliance 2016-17



As the above shows, compliance at points during the year was challenging, with three significant dips in performance. In May, there was poor compliance with response times from a number of directorates, specifically Cancer and Haematology, Women's and Children's and Acute and Emergency Medicine. Some of these were related to operational pressures (AEM) and all areas of concern were escalated to the Chief Nurse and recovery plans were requested from the directorates concerned. By September, both Complaints Lead posts were vacant which significantly impacted on the performance in September and October. A secondment post was filled in October, which supported performance the following month. Unfortutnately, the service experienced an unprecedented level of unplanned sickness absence in early January which significantly affected performance that month. The table below breaks down percentage performance by directorate, by month.

Directorate	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Acute Medicine	85.7	47.1	71.4	66.7	60	75	66.7	100	100	100	77.8	77.8
Specialist Medicine (incl. Therapies as of June)	88.9	100	40 †	80	80	0	50	100	100	100	90	66.7
Cancer & Haematology	33.3	0	71.4	100	100	N/A	100	100	66.7	50	0	100
Corporate Services	100	100	50	N/A	100	N/A	N/A	100	50	N/A	N/A	N/A
Critical Care	N/A	N/A	N/A	N/A	N/A	75	N/A	100	N/A	N/A	N/A	0
Diagnostics, Therapies (until June) **& Pharmacy**	N/A	N/A	100 † †	100	N/A	100	N/A	N/A	N/A	50	100	100
Paediatrics	50	0	66.7	N/A	N/A	100	100	N/A	N/A	N/A	0	100
Surgery (incl. Head & Neck until June)	87.5	100	100	100	80	100	45.5	N/A	100	50	33.3	50
Trauma & Orthopaedics	50	N/A	100	100	100	0	20	100	100	25	100	75
Womens' & Sexual Health (until June)	33.3	50	75	50	66.7	0	100	20	33.3	50	100	33.3
Head & Neck (reported seperately as of June)			100	100	50	50	100	100	100	100	100	N/A
Sexual Health (reported seperately as of June)			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Trust overall	**73**	**58.1**	**73.7**	**84**	**73.9**	**57.7**	**53.8**	**80**	**72.7**	**60**	**76.7**	**68.8**
Private Patients	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	100	N/A	N/A

† (includes Therapies) † † (excludes Therapies)

10. Satisfaction survey

Extract from a complainant's email:

'As you will note from the opening and closing paragraphs of my original complaint, all that was sought was an acceptance by the Trust that certain care fell below an appropriate standard; an apology; and some reassurance that the Trust would perhaps learn from the experience. I believe that as a result of your efforts and Mr Lusby's response, all three of these objectives have been achieved.'

Every complainant is offered the opportunity to provide the Trust with feedback on their experience of making a complaint by way of a satisfaction survey, which is provided with the response to their complaint.

34 completed surveys were received between April 2016 and March 2017, an approximate response rate of 9%, an improvement on the previous year. Key feedback from the survey is as follows:

- 79% of respondents found it easy or quite easy to make their complaint. Comments offered by the other 21% of respondents indicated that they were given incorrect contact details for PALS by other health agencies and they were unsure where to make their complaint about continuing healthcare funding to. One respondent queried why a complaints form was not available. Other comments did not relate directly to actual difficulties in making a complaint.
- The main sources of information on how to complain were the Trust website (29%) and PALS (19%). Two respondents had indicated that they could not find any informaton on how to complain
- 51% of respondents felt that they were kept adequately informed of the progress of the investigation
- 68% of respondents **had not** been contacted by anyone investigating their complaint
- 82% 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 addressed or that the they disagreed with the response.
- 65% of respondents **did not** feel that the response to their complaint had addressed all their concerns.
- 19% of respondents felt that their complaint had been resolved. 42% of respondents did not feel that their complaint had been resolved and were planning to contact the Trust again. 11% of respondents did not feel that their complaint had been resolved and were planning to contact the Parliamentary and Health Service Ombudsman.
- 48% of respondents felt that their complaint had made a difference. Negative comments suggested that respondents felt that the response to their complaint had been untruthful and/or defensive.
- 31% of respondents scored the Trust 4 or 5 (5=excellent) for their overall experience of the Trust's handling of their complaint. 36% of respondents scored the Trust 1 (poor). Comments suggested a need for greater honesty; that the Trust should listen to patients more rather than try to excuse experiences; the need for improved communication and updates during the investigation period; and quicker response times.

Considering the feedback provided, a complaints form is now available on the internet which complainants can complete and send in either by post or email. Correct contact details for PALS and complaints are available on the Trust's website. Staffing challenges in the complaints team have impacted on our ability to keep patients as updated as we would wish, due to competing priorities. The value of speaking with a complainant following receipt of a complaint is key in establishing an effective relationship, clarifying the precise nature of the concerns, obtaining further information (if required), identifying desired outcomes and managing expectations. Unfortunately, where a complaint is made by a third party, the complaints staff are not always provided with a telephone number and this prevents this conversation from being initiated. The

offer to discuss the complaint by telephone is always included in the acknowlegdement letter, but is infrequently taken up.

11. Cases referred to the Parliamentary and Health Service Ombudsman (PHSO)

During 2016-17, 7 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	Declined for investigation
Number of cases	0	3	1	2	1

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.

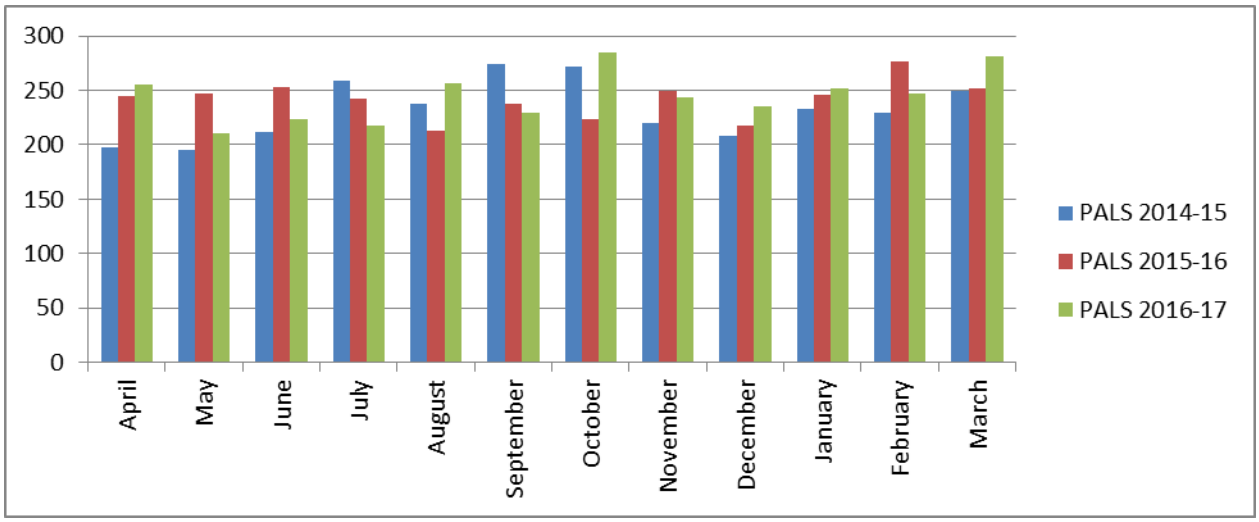
12. PALS contacts

Extract from a patient letter to PALS:

'A note of thanks to you for your help……I had been unable to contact staff at the hospital and was concerned about my treatment. You were able to make contact with a nurse and resolve my worries for me. Cancer can be very distressing and its times like this I need all the support I can get.'

For the year 2016-17, the Trust received 5258 PALS contacts an increase of 37 on the previous year (5221 received 2015-16). The PALS receives different types of contacts for different purposes including: general enquiries, concerns, compliments (including NHS Choices feedback) and sign language interpreting (until July 2016). Focusing on the concerns raised, the activity levels can be seen in chart 13l.

l) PALS concerns received by month



Analysis of the data above shows an increasing trend in the number of concerns being raised with PALS. This will go some way to account for the decrease in the number of formal complaints being received. Data on emerging themes and trends captured by PALS is reported to the Trust's

Clinical Governance Committee and reviewed in the Complaints, Litigation, Incidents, PALS and Audit (CLIPA) group.

It is relevant to note that because the contacts received by PALS vary in nature, in order 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.

13. Subject of PALS concerns

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 co-ordinated reporting on themes and trends across both services.

m) Subjects raised in PALS contacts

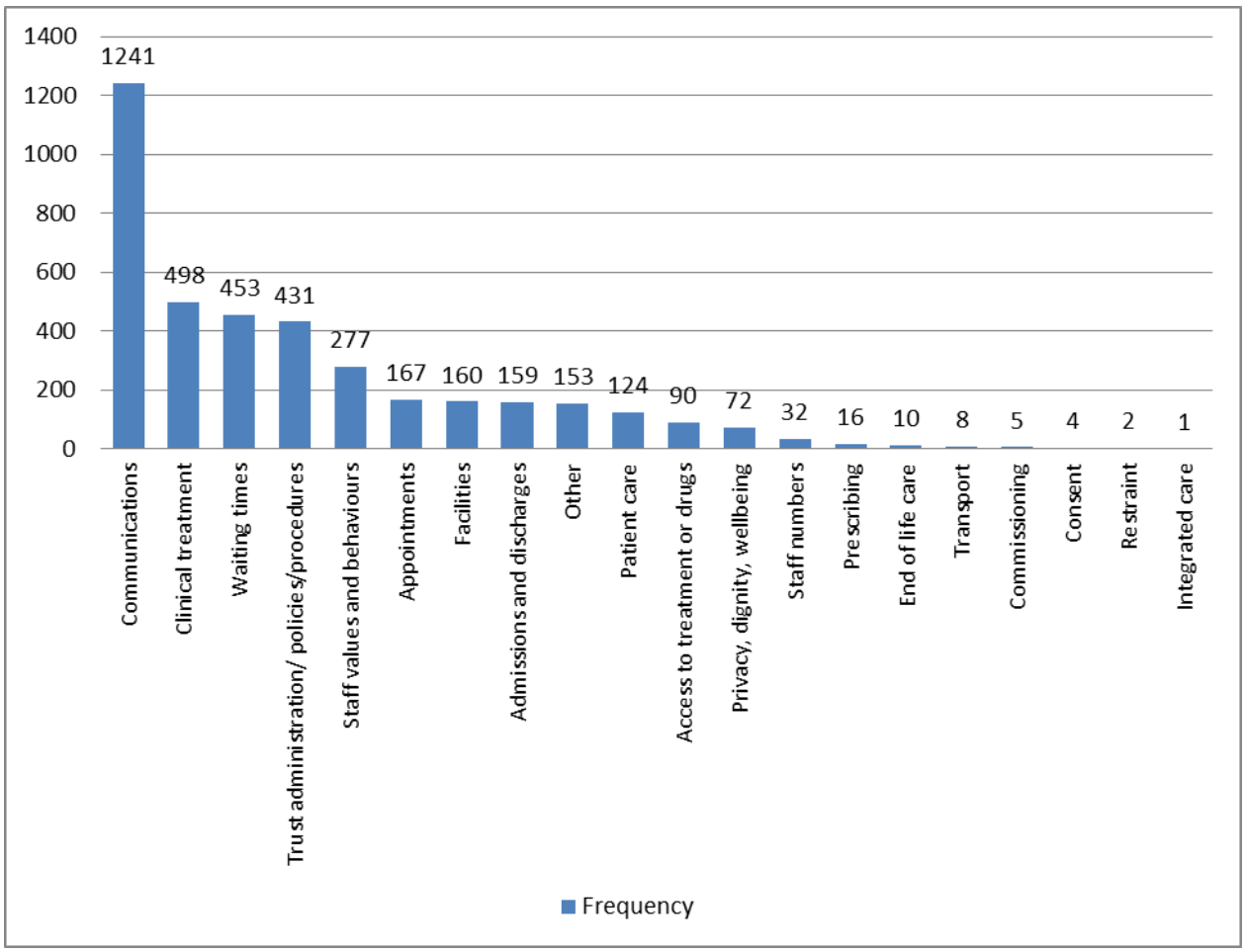
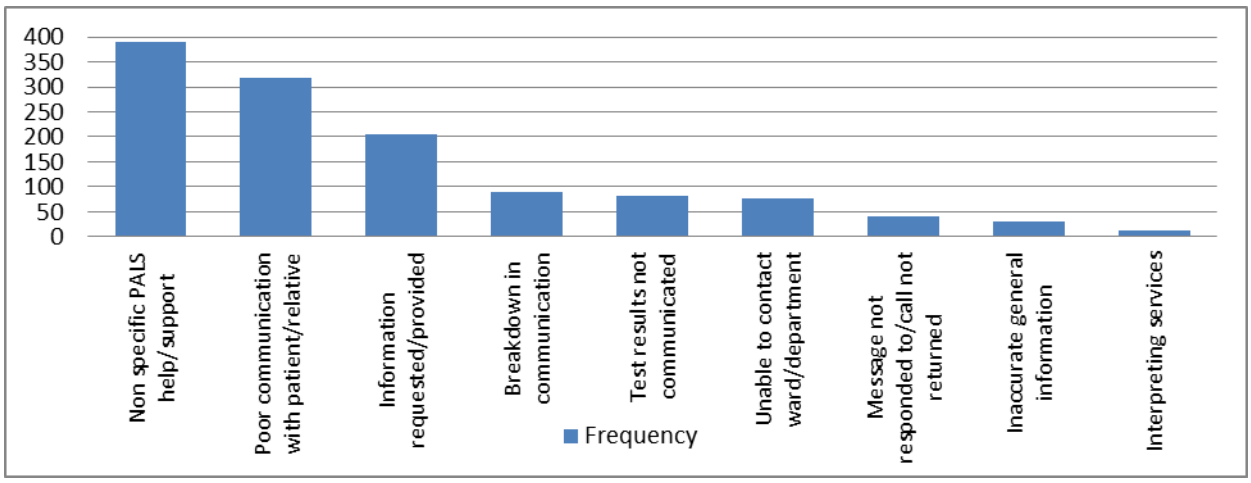


Chart 14m shows the frequency of PALS concerns by subject. This clearly illustrates that the main subject raised with PALS relates to communications. This is followed by clinical treatment and waiting times.

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 14nl.

n) Contacts relating to communication

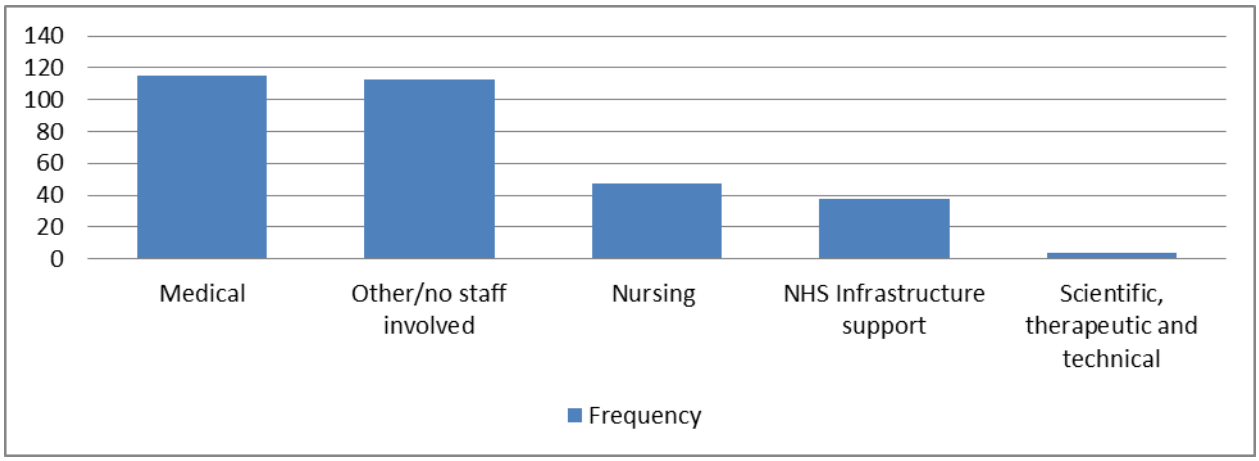


As outlined earlier, this shows that the highest use of PALS in relation to communication (390 contacts) is where there has been a direct request for help or support from PALS, which the PALS team would be able to respond to independently. However, it is significant that they have recorded 317 concerns about poor communication from staff with patients and/or relatives (a significant increase from 180 in 2015-16).

Extract from a patient letter to PALS:

'I had the CT scan on 14th Nov 2016. I was told that if there was a problem I would hear very quickly. I heard nothing so assumed everything was ok. Then out of the blue I get a phone call from gynae on Dec 6th, to say I need a gynae ultrasound. I assumed they had the wrong person, they went through my details and it was me who needed the ultrasound. I asked them why and they said they would get a dr to speak to me. They couldn't get hold of one but said someone in the dept had said to tell me 'the scan had shown something that needed further investigation and hoped that would reassure me'. It didn't …….On Dec 12th I saw a dr in …[the surgical] clinic. I asked why the small hiatus hernia had been mentioned in a letter I received. He said 'some would say you have a small hiatus hernia, some wouldn't.' So that was that! I told him what happened with the scan result. There was nothing said except 'these things can happen.' He then gave me a copy of the scan result. When I got home I noticed that the scan had been reported at 17.16 on the day of the scan. The person who had reported on it…..flagged up a suspicious abnormality and that I should enter the urgent 2 week cancer pathway and to contact the gynae [multi] disciplinary team. So why did…. [the surgeon's] team not contact me as a matter of urgency?'

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



Examining the 370 concerns received about poor communication, we can see that the majority relate to communication from doctors (115), followed closely by 'other' staff (113). This is illustrated in graph 14o.

14. Innovations

Unfortunately, due to the staffing challenges during the bulk of the year, progress with innovations has been limited. In line with the planned timetable, the Policy and Procedure for Managing Concerns and Complaints was reviewed and updated. An easy read leaflet on making a complaint was drafted and is currently undergoing external consultation with learning disability groups in the local area.

In April 2016, the facility for staff across the Trust to record compliments on Datixweb (in a similar way to reporting incidents) was launched. This has seen a marked increase in the recording of this feedback and PALS can provide reports on this data on request.

The PALS team identifed and agreed a set of questions on which to seek feedback on the service. A regular programme of collecting feedback via an online survey will be rolled out in the coming year (2017-18).

Work continues on developing a sustainable and effective tool for electronically recording all actions arising from complaints to offer the faciltity to track outstanding actions.

Work also continues 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 system is also being designed to improve the management of incoming telephone calls made to the PALS offices. This involves a new 'advisory' menu system, designed to encourage 'self-help' without limiting the access to the service. Callers will also be able to transfer their call to switchboard if they are simply calling to contact a ward or department.

15. Summary and conclusions

Overall, the year has been a challenging one. Despite the reduced number of formal complaints, the Trust struggled to achieve the performance target due to vacancies in the complaints team and operational pressures.

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.

16. 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	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	Performance reported monthly.	Complaints & PALS Manager	Associate Director for Quality	Progress will be monitored monthly as part	Trust target is to respond to 75% of all

Objective	Timescale & Targets	Lead	Supported by	Monitoring	KPI's
response times Trustwide			Governance; Directorate Leads	of the Trust's Quality and Governance Dashboard	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; 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.
Achieve at least amber on PALS and complaints KPIs by the end of the year.	By March 2018. Reported to management meeting monthly	Complaints & PALS Manager	Associate Director for Quality Governance	Progress will be monitored via monthly management meeting	As defined.

APPENDIX A

Learning from upheld/partly upheld complaints closed 2016-17

ID	Grade	Specialty	Closed	Description	Outcome
18770	HIGH	SPECME	30/03/2017	A number of concerns raised with standard and continuity of care, poor communication, nursing attitude, communication with DNAR decision, waiting times and cleaning standards in the ED, help with mealtimes and missed medication doses.	Meeting held with complainant and detailed written response provided. Apologies offered for poor standards of nursing care - use of strategies to support individualised care outlined. Work ongoing around recruitment of nursing staff to provide continuity of care and standards - establishments on wards identified have improved. Apologies offered for lack of clarity from doctor when discussing DNACPR decision. Apologies for poor conditions in ED - domestic staff are on duty 24/7. Apologies that patient was not offered analgesia in the ED - PDN leading a project on pain assessment and management in ED. Explanations provided around steps taken to improve patient flow to facilitate earlier discharge freeing up beds for admissions. Complaint discussed with relevant teams to highlight areas for learning.
18815	HIGH	ONC	24/03/2017	Delay in MRI results being reviewed, despite requests to consultant. Resulted in delay in diagnosing recurrence of cancer.	Apologies that despite chasing, MRI results were not reviewed by the consultant. Actions identified including: new SOP setting out roles and responsibilities around managing emails; setting up a new generic email address for the team; setting up dedicated waiting list for outstanding diagnostics; developing a crib sheet for haematology staff setting out expected turnaround times for radiology.
18822	HIGH	SPECME	14/03/2017	Concerns raised that patient was misdiagnosed with constipation and inappropriately discharged home. Pt readmitted later that day, GI bleed diagnosed and patient died.	Decision to discharge was inappropriate and resulted in missed opportunity to provide support and symptom control - apologies offered. However, even if correct diagnosis made on first attendance, unlikely patient would have been suitable candidate for surgery due to frailty. Case discussed with individual doctors involved in first attendance. Case to be presented at ED clinical governance session.
18810	HIGH	GYNAEC	15/02/2017	Concerns raised that experience whilst awaiting surgery on SSSU was not to the standard expected, no water offered, nobody on the unit to speak with, long wait for the door to be answered, no communication about how long the wait will be.	Apology given for the lack of care and attention provided during wait for surgery. Instructions given to staff re offering fluids and keeping patients informed as to any delays were not adhered to by staff. Staff reminded of need to provide regular updates and follow clinical instructions.
18692	HIGH	SPECME	07/02/2017	Pt raising concerns about decision to perform cardiac drainage. Pt experienced injury to his heart during procedure and required emergency transfer to London for surgical repair.	Assurance offered that drainage procedure was clinically required - apologies for poor communication with patient to explain decision making at the time. Discussed with all doctors involved. Apologies offered that patient was not consented prior to intervention taking place. WHO checklist introduced to prevent repeat. Case to be presented at Clinical Governance.
18561	HIGH	OBSMID	07/12/2016	Concerns raised that delays in recognising that the umbilical cord had prolapsed caused serious harm to baby.	Breech presentation was identified on scan at 34 weeks. However, at subsequent appointments, abdomen was palpated and midwife concluded baby was cephalic (head down). However, fundal height measurement at 38 weeks should have prompted another scan. Guidelines have been re-enforced with the community midwife teams.

ID	Grade	Specialty	Closed	Description	Outcome
18753	HIGH	AE	28/11/2016	Missed fracture in A&E. Pt attended following a fall. Left wrist fracture identified following x-ray but right wrist fracture not identified. At fracture clinic patient asked for right wrist to be checked and advised it was soft tissue damage. At follow up fracture clinic appointment the fracture was identified.	Right fracture was missed, likely due to doctor being more focused on left fracture. Discussed with doctor concerned and reported to educational supervisor. Reports of ongoing symptoms in right wrist should have prompted review of the x-rays and full discussion. Complaint to be discussed at ED and Trauma & Orthopaedic clinical governance meetings.
18722	HIGH	THEA	22/11/2016	Patient's mother would like to make a complaint about the anaesthetist attitude and language he used whilst treating the patient. Allegation that doctor swore, chastised the patient for crying and that patient's arms were marked.	Dr acknowledges his conduct was poor. Apologies offered. Managed under Trust disciplinary policy. No evidence to support that patient's arms were marked, although due to nature of procedure and fragility of skin, it is recognised that this can occur.
18501	HIGH	OBSMID	10/11/2016	Patient believes that she received a poor standard of obstetric care. She states that intervention and examinations were undertaken without her consent and she felt bullied.	Explanation provided around care and communication during labour. Service are reviewing process for obtaining consent to episiotomy as part of an assisted delivery, they are reviewing practice of delivering placenta by controlled cord traction following instrumental delivery and are working with local patient group to look at how we can improve communication with women in labour.
18465	HIGH	GYNAEC	10/10/2016	Patient's diagnosis and treatment was delayed despite presenting with significant symptoms associated with ectopic pregnancy. Patient's condition declined whilst in hospital however, there appeared to be no sense of urgency even after the patient suffered a witnessed collapse. Why are scans not available out of hours?	Apologies offered for delay in diagnosis. Trust policy was not followed effectively. Discussed with staff involved. All staff joining gynae receive an update on the ectopic and pregnancy of unknown location policy and procedure.
18641	HIGH	SPECME	07/10/2016	Concerns raised regarding a mental health patient who had previously attempted to take his life was able to access medication on the ward, subsequently he made a further attempt to end his life. Family also concerned that he was not appropriately discharged	Ward had not carried out risk assessment around possibility of patient self-harming - all wards now to use risk assessment tool as used by ED. Staff nurse was distracted by a query from patient when administering meds and left the drug locker unlocked. Individual nurse has reflected and learning shared with ward team. Apologies offered by KMPT around post-discharge support.
18464	HIGH	AE	27/09/2016	Concerns raised regarding a misdiagnosis and delayed treatment for a serious heart condition.	Diagnosis given on first presentation was incorrect. ECG provided evidence of MI. Case to be presented at directorate clinical governance meeting.
18652	HIGH	PAEDS	16/09/2016	Concerns raised by pt's mother about inappropriate conduct of doctor during an examination.	Dr should have been clearer in his communication prior to undertaking examination. Personal reflection undertaken. Recommendations to refresh principles of chaperoning and to develop information specifically for parents.
18385	HIGH	AE	11/08/2016	Pt unhappy with report following Serious Incident investigation. Specific questions raised.	Specific questions answered. Apology offered that report incorrectly referred to patient having sepsis. This was not the case.
18602	HIGH	SPECME	02/08/2016	Concerns raised regarding the delay in providing tests and treatment, the patient subsequently attended another hospital where he underwent surgery for a subtotal colectomy.	Recognised that there was a delay in the flexisigmoidoscopy being completed, which took longer than intended. Learning identified - all patients in this group must be given the contact details for the IBD helpline; patients should meet the IBD nurse specialists; faecal calprotectin should be considered to monitor disease activity and distinguish between functional symptoms and those caused by disease. The availability of urgent or immediate mesosigmoids slots will be discussed in the endoscopy users group.

ID	Grade	Specialty	Closed	Description	Outcome
18474	HIGH	AE	27/07/2016	Delayed diagnosis of cancer despite multiple presentations at A&E and GP. Poor communication between hospital and GP. Poorly coordinated care. Delayed investigations and treatment. Manner and attitude of staff. Staffing levels. Poor standard of nursing care.	Investigation has identified some areas of learning, the case will be the subject of a dedicated presentation at the medical clinical governance meeting to focus on the lessons learned. This will include: Ensuring that our GP colleagues are aware of the correct emergency referral pathway and how to escalate if they are unable to contact the medical registrar by telephone. Early referral to a senior member of ED staff where there is confusion or uncertainty about a GP referral having been made or received. The importance of compassionate communication at all times. Reinforcing that if there has been a breakdown in relationships such that a patient or relative is becoming extremely distressed or agitated, support should be sought from a senior nurse, consultant or site practitioner (out of hours) to help defuse and resolve the situation. The need to clearly document the rationale for ordering investigations and if they are not completed, the reasons why. In the event that a consultant makes the decision to bring a patient in from home for admission, clear information must be provided around transport arrangements.
18612	HIGH	AE	11/07/2016	Concerns raised regarding misdiagnosis, patient attended ED and had had x-ray he was advised that he had badly bruised his left leg. Patient then attended for physiotherapy six days later and they advised patient should re-attend ED. Following further x-ray, MRI scan and PET scan it was found that he had 3 fractures and a torn ligament.	One fracture on initial x-ray was visible and not identified. Apologies offered for resulting delay in treatment. Further injuries were revealed by subsequent imaging. Consultant to complete radiology course. All formal radiology reports will be sent to the ED consultants for review of every fracture for training and monitoring purposes.
18563	HIGH	SPECME	08/07/2016	Concerns raised regarding misdiagnosis following an incorrect MRI request, patient subsequently passed away.	A whole spine MRI was requested but only part of the spine was imaged. Consultant was falsely reassured that MRI was normal, without appreciating the whole spine had not been imaged. This resulted in a delay in diagnosing cancer. Changes made to the ordering of spine MRIs to prevent this happening again. Radiology will annotate reports if different imaging to that requested has been performed. Consultant staff reminded of responsibility to review imaging themselves. Accuracy of imaging request information to be included in junior doctor induction. Changes made to the way death notifications are generated to ensure accuracy.
18572	HIGH	HEADN	23/06/2016	Delay in communicating test results and delayed investigations. Delay in diagnosis of cancer.	Apology offered for obvious and understandable distress caused. Explanation that there was no clinical indication to pursue invasive treatment sooner and in fact, the patient's condition was noted to have improved by scan 3. However, with the benefit of hindsight, lump should have been removed. New FNA protocol for paediatric patients being developed. Review of test tracking is underway within Head & Neck Service.
18323	HIGH	HEADN	21/06/2016	Incorrect diagnosis of eye condition. Complainant feels that surgery was incorrectly performed which has caused the problems.	Apology offered that patient experienced incarceration as a result of surgery and that this was not discussed with her at the time. Unfortunately, this was not clear in the records and it was only on review of the information from the Moorfields that the patients outcome was confirmed. Case to be discussed at clinical governance meeting

ID	Grade	Specialty	Closed	Description	Outcome
18502	HIGH	AE	23/05/2016	Concerns raised regarding the x-ray interpretation and subsequent discharge from A&E. Patient was readmitted two days later and died 12 days later.	Review of case concludes that x-ray was misinterpreted by doctor and misreported by radiology. If fractures had been identified, patient would have been admitted for further management. Apologies offered. Actions identified: all trainee doctors starting work in the ED will attend a national radiology interpretation course, in order to ensure they have safe skills in interpreting chest x-rays in this situation. A teaching module on thoracic trauma is being introduced for the trainee doctors during their induction. This will specifically include the management of potential rib fractures in elderly patients. Consultant is in discussion with the radiology department regarding consideration of routine chest CT scans for chest injuries in elderly patients with abnormal observations on admission. Doctors in the ED have been reminded of the importance of gaining advice from a senior doctor at the time of any uncertainty in interpretation of investigations.
18908	MOD	AE	29/03/2017	Pt was having a stroke and staff thought he was drunk. His diagnosis/treatment was delayed as a consequence.	Dr completed an informal FAST assessment which was negative. However, he didn't complete a neurological assessment. Apologies offered as this may have identified possibility of stroke earlier. Dr involved has undertaken reflection.
18891	MOD	SPECME	23/03/2017	Concerns raised about loss of patient's belongings during ward transfer, that drug cupboard keys were lost and as a result, medication was not available for patient. Staff persisted in trying to take a bp reading from patient's injured arm.	Apologies offered for poor nursing care re taking blood pressure readings from the injured arm, the fact that the patient's belongings were mislaid and the drug locker key went missing. Loss of locker key was correctly managed at the time. Complaint has been discussed with ward team for learning.
18903	MOD	AE	21/03/2017	Concerns raised that wound to leg not cleaned and therefore developed into an abscess which required surgical removal.	Apologies for delay in cleaning and dressing wounds - ED nursing team reminded of need to do this in a timely fashion. Not possible to state that abscess was definitely the result of the delay but the delay may have increased the risk of infection.
18839	MOD	AE	15/03/2017	Concerns that shoulder fracture missed in A&E.	Fracture was missed by ED dr and radiology department. On review, fracture is very subtle and difficult to interpret.
18702	MOD	OBSMID	15/03/2017	Patient believes that she received a poor standard of obstetric care which resulted in her son being oxygen deprived during delivery. She believes that she was left in labour for too long and states her request for a c-section was refused. Lack of support from midwife. Difficulty inserting epidural.	Long latent phase of labour, explanation offered as to why a c.section could not be performed and why pethidine was only pain medication available. Apology offered that unable to control pain effectively due to not being able to site the epidural. Apology offered for the lack of support from the midwife.
18242	MOD	AE	14/03/2017	Concerns raised regarding delayed diagnosis and communication	Treatment pathway explained and apologies given for lack of communication. Review shows there were missed opportunities to prompt earlier review/investigation of patient. Apologies that this contributed to the length of time take to make the diagnosis.
18837	MOD	OBSMID	09/03/2017	Concerns raised that not listened to during labour which resulted in prolonged labour and resulted in forceps delivery as baby identified as being back to back. Baby born with floppy arm and delay with paediatrician reviewing baby. Asked for a debrief but nothing arranged.	Meeting held with complainant. Apologies offered for inadequate communication with mum and dad during labour. Staff should have explained the action they were taking in response to concerns expressed at the time. Matron will discuss with midwives and reinforce need to document discussions in the records. Feedback on messaging being provided by birth centre staff will be reviewed to make sure all prospective parents are receiving consistent information. Apologies that despite rationale for transfer to TWH being for paint relief, no pain relief was provided. Issue to be discussed at clinical governance. Lack of communication around arm palsy discussed with post-natal team.

ID	Grade	Specialty	Closed	Description	Outcome
18503	MOD	SPECME	07/03/2017	Concerns raised that during a cardiac procedure a vein was pierced, patient also required a drain inserted into his lung and was transferred to Guy's for further surgery.	No evidence that treatment was inappropriate, procedure was consented for and patient aware of risk. However, patient was discharged direct from tertiary centre and this did affect continuity of follow -up. Team will look at how to mitigate this in future.
18880	MOD	OBSMID	03/03/2017	Concerns raised with the manner and attitude of the triage midwife on two occasions. concern raised that advised to go home after waters had broken without examination and despite required antibiotics for Group B strep.	Apology offered about perceived poor attitude of midwifery staff. Investigation revealed that there was not a disagreement around the antibiotics but poor communication. Manager asked to reiterate importance of effective, timely communication to midwifery staff. Decision to send home after waters broken was appropriate, no examination was required.
18878	MOD	RADIO	01/03/2017	Patient underwent procedure to veins in leg. Attended ED some weeks following procedure with pain in leg. Scanned and ED doctor advised DVT present and prescribed heparin to be self-administered. GP also prescribed warfarin. Abnormality seen on scan was part of the mechanism of healing for the procedure she underwent, therefore both heparin and warfarin unnecessary.	Investigation revealed that radiology report stated no DVT present however ED doctor advised DVT present and anticoagulants prescribed. Apology offered and to be raised as an incident.
18738	MOD	ONC	28/02/2017	11 questions raised. Seeking clarification of imaging reports, terminology used, whether colonoscopy was correct, how imaging results are communicated, timing of follow up appointments.	Review of imaging confirms there was either a typographical or voice recognition error which confused 'ascending' with 'descending' - reassurance offered that this did not impact on onward management. Apologies offered that consultant was not informed when PET scan results were available - change since made to practice and all results now emailed to consultant.
18868	MOD	AE	27/02/2017	Concerns raised regarding a missed L1 fracture. Patient attended ED, was x-rayed and discharged with soft tissue injury. Patient saw GP in the interim and was given reassurance. 12 days later, patient was recalled to hospital as fracture had been seen on the x-ray.	Review of imaging shows fracture was evident on initial x-ray. However, clinical examination had been reassuring. Apologies for delay in recalling patient to ED. Had fracture been identified, management of injury would have been the same. ED looking at options for reporting scans while patients are in the department.
18871	MOD	SPECME	27/02/2017	Concerns raised that this was a failed discharge as patient re-admitted 10 hours following discharge. Family unclear as to diagnosis. Concerns raised that telephones on both the ED and Ward 21 were not answered. Concern re patients swallow.	Review of initial attendance shows patient did not have signs of infection - decision to discharge was correct. Apologies for difficulty in contacting wards - staff will prioritise patient care. Patient was assessed by SLT and appropriate recommendations made.
18411	MOD	ONC	22/02/2017	Concerns raised regarding incorrect/delayed diagnosis.	Scan from 2012 has been reviewed and evidence of PVT has been found. Although this should have been identified at the time, it is difficult to see. Case discussed in radiology meeting.
18844	MOD	RADIO	22/02/2017	Concerns raised that fracture missed on 1st attendance, fracture to left ankle recognised on 2nd attendance. On 3rd attendance, fractures to both ankles identified.	Initial imaging did not show fracture and clinical examination was reassuring. Fracture only became visible when the ankle was reimaged.
18637	MOD	AE	13/02/2017	Concerns raised regarding the end of life care provided and standard of nursing care.	Apologies offered for poor attitude described from members of nursing staff. Use of smartphones on ward areas currently under review. apologies for delays in administering medication due to the need for 2 staff to prepare them. Acknowledgment given that opportunities were missed to administer other meds. case to be reviewed by end of life committee. Actions agreed: Family provided with copy of individualised care plan document. All clinicians from adult wards are to undertake end of life care mandatory training. All end of life care complaints are now reviewed by the Lead Palliative Care Clinical Nurse Specialist to identify themes to inform training. Each adult ward now has an identified Palliative Care Clinical Nurse Specialist who will be providing ward specific palliative care and end of life care training

ID	Grade	Specialty	Closed	Description	Outcome
18855	MOD	TANDO	13/02/2017	Patient reports that dislocation of little finger was not diagnosed and this has resulted in him requiring multiple operations to correct this.	Apology offered as dislocation missed on attendance to ED. Assurance offered that management of these injuries are discussed in teaching sessions.
18819	MOD	TANDO	10/02/2017	Concerns raised that staffing levels on Ward 10 and Ward 31 inadequate to undertake patient care properly. No property disclaimer completed and dentures went missing. Issues with food being inappropriate, long waits for assistance from nursing staff. Nobody contacted family to advise patient had had a fall. Discharge notification incorrect.	Staffing levels were adequate at the time of the admission. Apology offered that dentures went missing and that weight was not recorded. Explanation offered regarding dietary intake (of which there was no cause for concerns) and around pureed meals. Apology offered re long wait for assistance from nursing staff and that no contact was made with the family following the fall.
18830	MOD	AE	08/02/2017	Concerns raised that hand fracture was missed in ED due to insufficient imaging.	Appropriate imaging was ordered in the ED and the doctor did not see any radiological evidence of fracture. Clinical picture also supported that this was not a fracture. When the x-ray was reported by the radiologist, a fracture was seen and patient was recalled. Apologies fracture was missed on initial attendance, assurance offered that this did not impact on management of injury or recovery.
18802	MOD	OBSMID	02/02/2017	Concerns raised with delivery of baby by forceps and the damage caused to the mother and baby. Also the delay in seeing a doctor during labour and the confusion around the delivery method to be used. Attitude of nursery nurse was dismissive.	Explanation and assurance given around delivery by forceps and that ongoing health concerns could have been caused by a number of other factors. Investigation revealed there was no delays in being reviewed by the doctor. Communication with mother could have been improved - discussed with the staff. Apology offered for manner of nursery nurse. Apologies given that frequency of monitoring was not what we would have expected in early labour. Review with staff how they prioritising conflicting duties.
18859	MOD	AE	02/02/2017	Concerns raised around discharge - family not notified of patient's discharge, patient sent home without her dossette box, increased care needs were only picked up by carers when they visited her post-discharge.	Apology offered that NOK were not notified of discharge and insufficient consideration was given to patient's circumstances at home that evening. SN involved has been reminded of responsibilities and is currently overseeing all patient discharges to support personal development. Safe discharges discussed with ward team. No indication that patient's level of function had changed at the point of discharge.
18826	MOD	GYNAEC	31/01/2017	Concerns raised with attitude of staff on SSSU. Long wait for operation and poor communication between patient and nursing staff.	Apology offered for attitude of agency nurse and advised that concerns will be discussed with the agency involved. Explanation given for long wait and comments provided advise that patient was kept updated of progress.
18834	MOD	AE	30/01/2017	Concerns raised around inappropriate decision to discharge pt from ED - patient readmitted within 24 hours and stayed for 2 weeks. Concerns raised around poor quality of care on ward, particularly around feeding. Confusion around discharge planning and patient sent home with no supplies. Poor communication from member of pharmacy staff.	Explanation offered around initial decision to discharge - no clinical indication to admit and when pt was offered admission for social reasons, he declined. When patient re-presented, his blood tests indicated that admission for IV antibiotics was required. Patient was prescribed additional nutritional supplement during admission which needed to be ordered in. Apologies the supply ran out and took 2 days to rectify - staff reminded of need to consider alternatives if prescribed supplements not available. Patient's NBM status was indicated on the ward board but high number of agency staff on duty may not have been aware of this. Staff reminded to record information on nervecentre to support handover of care. Apologies offered for poor communication - complaint shared with ward team. Discharge plan was explained to patient. Patient declined to wait on the ward for the supplement to arrive and agreed to have it collected the following day. However, a relative could have picked it up on his behalf - apologies this wasn't made clear. Apologies offered for poor response to enquiries when patient and relative arrived on the ward to collect the supplements.

ID	Grade	Specialty	Closed	Description	Outcome
18797	MOD	SPECME	30/01/2017	Concerns relating to leg injury sustained during SECAMB transfer. Family feel they were not adequately informed around the purpose of best interest meeting and were therefore unprepared. They felt pressurised to accept a nursing home and believe the handover between hospital and nursing home was poor, resulting in poor care to patient following discharge.	SECAMB have partly upheld complaint relating to leg injury. Apologies family felt inadequately informed with regards to discharge planning meeting. There was no fixed timeframe for making a discharge destination decision, but it is in patient's best interest to be discharged as soon as possible once medically fit. Unfortunately, MTW cannot evidence what information was handed over to the care home - need for clear documentation of handover shared with the ward team.
18741	MOD	AE	27/01/2017	Formal concerns: was the patient correctly triaged? length of wait in the ED, felt staff were not trying to reach their own diagnosis, patient was discharged unable to stand, test results were not communicated to patient. Complainant would also like an informal meeting to discuss communication from oncologist, delay in palliative care being involved, delay in PAT testing a fan, poor general condition of the site and facilities.	No clinical indication of neurological pathology on first presentation but decision to discharge was incorrect, Overall outcome would not have been different. Management of case discussed with individual drs and reminders issued to wider team around need to exclude less likely diagnoses and only to discharge when patient able to manage symptoms. Apols offered for wait in ED. Staff now considering time since arrival when determining order of patients being seen.
18809	MOD	ESTFAC	25/01/2017	Concerns raised that patient was struck by a kitchen trolley being pushed by a member of staff. Increased parking costs incurred.	Apology offered. Trolley should have been pulled and not pushed. Ex gratia payment and parking costs offered.
18742	MOD	SURG	24/01/2017	Concerns raised around attitude of consultant. Concerns that patient's clinical markers of dehydration were not monitored during admission and no instruction was given to monitor them post-discharge. Non-availability of food. Poor communication with patient/relative over eye drops - resulted in patient receiving incorrect medication.	Explanations given. Apology offered regarding attitude of consultant and nursing staff. Explanation given regarding availability of food. Apology offered for poor communication. Pharmacy reviewing practices with regard to medication history.
18613	MOD	ONC	12/01/2017	Concerns raised regarding incorrect diagnosis of the extent of the primary cancer.	Review of CT head and MRI head show that metastatic disease was present on MRI. Apologies offered. Reported as an error and will be discussed at radiology clinical governance meeting.
18808	MOD	SPECME	10/01/2017	Concerns raised around communication with family - patient had a DOLS applied but family were not informed. Concerns about confusion with discharge planning which resulted in the discharge being delayed by 3 days but then actually taking place within 24 hrs. Meds were not sent home with the patient. Inaccurate EDN.	DOLS was completed and NOK should have been informed - apologies this wasn't done. Plan to discharge was discussed with relatives who raised concerns; decision taken to allow time for further support to be considered for family the following morning, however, patient then became abusive and wanted to go home, so discharge was expedited. Apologies NOMAD box was not sent home with patient - nurse did not check bedside locker. Apologies for error with EDN - doctor selected wrong item in drop down menu. dr reminded of need for care. Discharge process reviewed with ward team
18820	MOD	AE	05/01/2017	Concerns raised as to why patient did not have any imaging of his brain performed while he was in the ED - a week later patient was diagnosed with a brain tumour. Concerns also raised that ED did not identify a malfunctioning VP shunt when patient reattended following neurosurgery.	On first occasion, there was clinical indication to carry out urgent neuro investigations - apologies offered that this was not done and dr's agency informed of case. On second occasion, patient presented with intermittent symptoms, not usually an indicator of a malfunctioning shunt. Management on this occasion was reasonable.
18816	MOD	SURG	05/01/2017	Concerns raised that on the day of surgery, MRI results had not been reported and therefore surgery cancelled.	Surgeon had booked procedure before MRI scan results were available, in the belief that they would be available in time. No indication on MRI request that results were required by a specific date. Due to specialist nature of scan, it couldn't be reported on the day. Reminder issued to surgical team to ensure all relevant results are available ahead of treatment.

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18803	MOD	SURG	22/12/2016	Patient attended for endoscopy, change in appointment time had not been passed onto unit staff, which caused a delay. Concerns raised that procedure undertaken whilst patient uncomfortable and in pain and also that patient sustained bruising during the procedure. No pain relief offered. Comments from surgeon inappropriate.	Apologies offered for confusion on the part of staff when patient booked in - highlighted with reception team. Patient has a twisty colon which is known to be a more complex procedure. Apologies offered for the discomfort patient experienced during colonoscopy and for the subsequent bruising. Patient was offered the opportunity to stop but elected to complete the investigation. Apologies offered for inappropriate comments - surgeon has reflected on this and will be more mindful of his language in future. Apologies for error on the colonoscopy report - surgeon will correct these.
18666	MOD	NURSIN	21/12/2016	Concerns regarding the nursing care and communication on ward. Delay in providing medication as instructed by palliative care team. Lack of supportive intervention from nursing staff, especially night staff. Query regarding patient fall.	Issues regarding communication to be discussed with ward team and at clinical governance. Case discussed with palliative care to gain full understanding around end of life management. Trust developing education programme for staff around delivering end of life care. Offer made to complainant to share draft end of life care strategy for consideration/feedback.
18805	MOD	HEADN	21/12/2016	Concerns raised that eye block used when, during pre-assessment, patient asked for general anaesthetic. Possible consent issue.	Request for general anaesthetic was noted, but patient required an eye block first. Apologies that this was not made clear - highlighted with staff who will in future seek specific confirmation from patients that they have understood the anaesthetic process in advance.
18271	MOD	SURGAI	21/12/2016	Patient received incorrect treatment owing to orthotic equipment being unfit for purpose. Communication with managing director of AC Tonks.	Apology offered for distress caused and acknowledgement of difficulties experienced.
18783	MOD	PAEDS	13/12/2016	Concerns raised following birth of baby. Baby jaundiced, 6 hour blood tests advised but significantly delayed. Baby had high bilirubin levels. Delayed referral to senior Doctor which resulted in 2 day delay in baby being identified for triple phototherapy and then blood transfusion, transferred to SCBU. Family concerned there maybe lasting damage to babies hearing due to high bilirubin levels.	Apology given for lack of 6 hourly blood tests - due to poor communication between paediatric team and midwifes. Apology given for lack of escalation of babies condition to senior team. Explanation given that on neonatal unit treatment was appropriate and swift. A local guideline to be developed for the management of neonatal jaundice
18800	MOD	OBSMID	12/12/2016	Manner and attitude of staff when attending ante natal triage.	Apology given for attitude of staff member. Apology and explanation given for the alarm caused during the telephone conversation with the antenatal triage unit staff. Staff did explain to patient the delay in being seen by the obstetric team.
18754	MOD	OBSMID	12/12/2016	Concerns raised with the induction process. Patient feels was not listened to regarding pain and feels was left for too long between checks. Asked if the ribbon was left in for too long.	Investigation complete, apology offered that additional pain relief could have been offered sooner. Explained that midwives undertake various observations. Frequency of observations was explained. Confirmed ribbon was not left in for too long.
18806	MOD	SPECME	12/12/2016	Pt was rebooked to have heart scan with surgical access to veins. However, no anaesthetist was available on the day. Patient spent 4 hours with a number of staff unsuccessfully attempting to gain venous access. Pt could not have scan completed.	Dr ordering scan was unaware of difficulties with cannulation as patient didn't mention them. However, there was previous documentation in the records to reflect the problems. Apologies for distress patient experienced. Alert added to radiology system, request made to have alert added to patient administration system and letter provided to patient for use in future.
18730	MOD	SURG	07/12/2016	Concerns raised that despite repeated attendances, there was a delay in correct diagnosis being made. Staff repeatedly sought to send patient home with pain. Upon refusing to leave, pt was admitted and investigations revealed tumour for which the patient had surgery.	Review of case shows that patient should have been admitted for further investigation (CT scan) when she first attended the ED. Management of case discussed with surgeon for re-education and discussed at clinical governance meeting to share learning. Subsequent CT scan has been re-reviewed and shows no evidence of bowel blockage. Improving pain and the CT scan result was falsely reassuring. Apologies for delay in diagnosis - not clear that this impacted on overall recovery.

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18643	MOD	AE	02/12/2016	Concerns raised regarding a missed fracture and the impact delays in diagnosis had on the patients recovery.	Fractures were missed on x-ray. Formal reports picked them up and attempt was made to contact patient to advise (safety net). Management of fractures would have been the same regardless. Reassurance offered with regards to radiation exposure from multiple x-rays.
18774	MOD	THEA	28/11/2016	Patient attended pre-assessment and cleared for surgery. On day of surgery Anaesthetist advised surgery not going ahead - conflicting information given for cancellation of surgery.	Apologies offered, breakdown in communication. Process for pre-assessment is currently under review in the anaesthetic department.
18673	MOD	TANDO	28/11/2016	Concerns raised regarding transport, appropriateness of ambulance booked and if the crew should have refused to transport the patient. Patient was caused pain and distress as his knee was pressed against a trolley during journey. Manner of security / parking staff	Appropriate to transfer the patient however the request for type of transfer was not optimal. Work underway to improve handover of transport requirements as part of inter-ward handovers of care. Apologies offered re manner of security staff - discussed with team. New cash machine installed and work ongoing to take card payments for parking.
18728	MOD	GYNAEC	25/11/2016	Pt raising concerns re medical management and multiple cancellations. Concerns raised that initial symptoms were not adequately investigated/responded to by GPs. Concerns that initial surgery in 2014 was carried out without an MRI being performed. Subsequent MRI showed other problems that hadn't been addressed by prior surgery. Concerns regarding repeated cancelled admissions.	Explanation offered for surgery undertaken and findings. Consultant believed pain was related to adhesions following c-section - MRI is not used to diagnose these. Apologies offered for repeated cancellations.
18693	MOD	HEADN	25/11/2016	Patient concerned over the lack of continuity of her care between ENT and Respiratory. Alleged poor standard of nursing care. Alleged medication error. Concerns regarding discharge from hospital	Pathway of care explained with acknowledgement that communication and continuity between respiratory and ENT can be improved - new locum respiratory consultant in post and ward manager meeting with ENT consultant to look at communication pathways. Apols offered for shortfalls in nursing care. Patient should have been offered washing supplies, apologies for delays in administering pain relief on the ward and in the discharge lounge. Explanation offered for choice of antibiotics - stopped when patient had a reaction.
18764	MOD	TANDO	17/11/2016	Concerns raised by patient's mother relating to processes for 17yr old undergoing surgery. Informed would be able to accompany son to be sedated but this was not the case. Was not informed when patient was moved to another area. Patients clothes went missing and was discharged without EDN or anticoagulation medication.	Apologies mother was not allowed to support patient - discussed with ward team to raise awareness of considering individual needs. Pt had to be moved to a different location post-operatively due to bed availability. Apologies offered that clothing was misplaced - was located. Apologies offered that EDN was not provided on discharge and medication was omitted. Nursing staff to undertake additional checks to make sure patient leaves with all required medication.
18766	MOD	CORP	16/11/2016	REDACTED at complainant's request.	REDACTED at complainant's request.
18703	MOD	SPECME	15/11/2016	Concerns raised over number of nursing staff available. Patient transferred out of hours	Rationale for timing of patient transfer explained. Due to late hour, family were not contacted. Breakdown in communication meant that need to contact family was not effectively handed over to receiving ward. Changes made to roles and responsibilities of ward clerks to support this. Out of hours transfers also added to site reports so that Matrons can check that relatives have been notified. Reassurance offered around staffing establishments.

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18763	MOD	AE	14/11/2016	Concerns raised that fracture to arm was missed in ED. Patient had been discharged with crutches (due to fractured ankle). Pt was admitted for ankle surgery but no beds available. Confusion over who was overseeing patient's treatment and one doctor thought pt had had her surgery when she was still waiting. Pt in significant pain post-operatively and delay in this being addressed.	No record of patient reporting any shoulder symptoms on initial presentation to ED so shoulder was never examined. Apologies that the shoulder fracture was missed. Apologies for miscommunication from doctor on the ward - explanation offered. Pt received what would be considered adequate pain relief to manage post-op pain - the level of pain experienced could not have been predicted and could only be relieved by removing the cast.
18747	MOD	AE	09/11/2016	Concerns raised around inaccuracies in the EDN relating to patient's diagnosis, medical history, drug regime and level of function. CXR taken during admission was referred to on EDN as 'abnormal' - GP reviewed and diagnosed pneumonia.	Explanation offered around diagnosis of pneumonia - radiology suggested this was possible, but clinically, this diagnosis was not supported. Apologies for errors with EDN - consultant will remind his team of the need for accuracy and reminder to be issued to all staff via chief executive's newsletter.
18691	MOD	TANDO	08/11/2016	Pt unhappy with standard of care and treatment provided following transfer to ED at TWH. Promised an MRI scan but discharged without one being carried out. Delay in providing pain relief. Felt nursing staff treated him as a burden.	Explanation of care pathway provided. Apologies offered for delay in providing pain relief following transfer to TWH. Apologies that care plan was not made explicitly clear to patient. Need for effective communication regularly discussed at clinical governance meetings. Nurse should not have completed an MRI questionnaire at 2.30am - this was not appropriate.
18720	MOD	OBSMID	02/11/2016	Poor standard of obstetric care. Lack of recognition of patient's condition. Lack of examination despite requests. Poor communication with patient and colleagues.	Apologies offered. Patient was being treated for possible pre-eclampsia and was transferred to maternity HDU in view of this. Breakdown in communication meant the fact that patient was in labour was not handed over to the receiving team. Midwife is undergoing update training.
18674	MOD	AE	25/10/2016	Patient believes that there has been a delay in diagnosing her cancer as nodules on her lungs have been present for several years but not acted on. She would also like to know why she was told her CXR was clear in A&E only then to be called by her doctor to advise of the nodule.	Review of all imaging. X-ray in Sept 2014 shows very subtle nodule which was unchanged by May 2015. Dr wrote to GP to recommend onward referral for further investigation - not clear what GP did. On attendances in October and December 2015, nodule had progressed and ED doctor should have sought senior advice on both occasions. At 2nd attendance in March 2016, abnormal x-rays were interpreted as being normal. Apologies offered. Case to be discussed at Clinical Governance, consultant has requested chest x-ray refresher training is introduced into the induction teaching package.
18669	MOD	TANDO	21/10/2016	Delayed referral to King's college hospital following fall and back injury. Poor pain relief in A&E. Was the admission to hospital over a weekend necessary?	Assurance offered that it was necessary for patient to remain in hospital while MTW awaited advice from the neurosurgery service at a tertiary centre. Tertiary centre have apologised for the delay in providing advice. Apols offered for delays in ED and the lack of pain relief provided - addressed with staff. There was some confusion around the referral for follow-up care - spinal service for south of England is under review and this should reinforce referral protocols.
18734	MOD	OBSMID	17/10/2016	Specific questions raised around antenatal care. Concerns that diagnosis of TTTS was missed until too late. Patient went into labour but staff did not explain this to patient. Resulted in loss of twins at 22 weeks - babies delivered in outpatient clinic following transfer to tertiary centre.	Review of antenatal care shows that all appropriate guidance was followed and there was no earlier opportunity to diagnose TTTS. Apologies offered that initial scan was not offered within the required timeframe - booking team asked to ensure that all scans are booked at the appropriate time. Apologies offered that patient's pain was not recognised by staff and therefore the possibility of the patient being in labour was not considered prior to undertaking transfer to tertiary centre. Matron will reinforce need for staff to document pain, offer analgesia and provide clear explanation about possible causes of pain.

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18638	MOD	AE	13/10/2016	Concerns raised regarding incorrect , delayed diagnosis and treatment and the attitude of the doctor. Patient was admitted and subsequently died a short while after.	Assurance provided that medical/surgical management was correct on each attendance and nothing could have been done to prevent the patient's death. Apologies offered for poor manner of surgeon - addressed with him and reminder issued to wider team.
18735	MOD	AE	12/10/2016	Pt's parents raised concerns that pt's fracture (leg) was missed, when he attended A&E on 5/7/16. Pt was discharged home, having been advised the x-ray was clear. Parents took pt back to GP as he was still in pain and GP advised parents to take pt back to A&E. The original x-ray was checked and shown to parents, where a clear fracture could be seen. Pt was in plaster for 6 weeks.	Clinical examination gave suspicion of fracture so x-ray ordered. On review, very subtle non-displaced fracture is visible - apologies this was not identified on the day. Fracture became more obvious as it began to heal. Assurance offered that delay has not had an adverse impact on healing. Case discussed with ED dr for learning.
18584	MOD	OBSMID	11/10/2016	inaccurate information shared with patient regarding formula milk. Loss of drug chart resulted in medication not being administered. Delay in fragmin being prescribed. Incorrect information noted on discharge paperwork. Scan not arranged.	Apologies offered for poor experience and delay in responding to complaint. Apols for concern caused by comment from bank member of staff about not normally working on the ward - only trained staff would take obs. Advice to dilute formula was wrong - apols offered, but nothing recorded in notes to identify who said this. Infant feeding midwives recently appointed to provide support and education. Pt missed 2 doses of pain relief - work ongoing with post-natal ward manager around care pathways. Apols pt not given lunch/dinner/refreshments on day of discharge. Apols for error on EDN. Reassurance offered that there was no need to further investigate hips by way of a scan.
18709	MOD	UROLOG	10/10/2016	Concerns raised regarding delay in diagnosing spread of cancer. Poor experience when under the care of urology team and in A&E. Patient left in corridor for extended period. Poor environment in A&E. Manner of doctors. Should the patient's oncologist and surgeon have been more involved?	Apologies offered for lack of compassion shown by dr in ED - nothing documented to indicate who this was. Patient did need an ultrasound scan but it was deemed clinically appropriate for him to have this completed as an outpatient. Following CT scan, pt needed to be seen by surgeons so had to be transferred to TWH. Apologies for long wait - referral pathway explained. ED staff expected to maintain patient comfort while waiting for specialist team and experience highlighted to senior staff. Apols offered for ED environment on that occasion. Consultant surgeon determined that patient did not require immediate admission for surgery and felt it was better for the patient to remain under his colorectal consultant for continuity. Oncologist has confirmed that pt's cancer initially responded well to treatment but then it progressed to the point it became untreatable. An earlier scan would not have altered this.
18732	MOD	SURG	10/10/2016	Unhappy with having been asked to arrive at 7.30am when op didn't take place until 2pm. Despite assurances, patient's husband was not updated when patient came out of theatre. Patient was discharged without receiving anti-coagulant injection. Pt not given post-op exercise information.	Apols for poor communication - due to competing demands on staff. Ward staffing levels are being reconfigured and this is being factored in. Patient should have been given anti-coag prior to discharge - omission due to human error. Correct advice given to pt to return to hospital. Incident discussed with nurse and shared with ward team.
18634	MOD	SPECME	10/10/2016	Manner and attitude of doctor, patient found him to be rude and dismissive. Query incorrect diagnosis. Was an orthopaedic referral indicated?	Summary of clinic discussion included in clinic letter as per normal practice. Dr felt that symptoms were not indicative of polymyalgia and more likely to be osteoarthritis. On review, medication prescribed was too strong as a first line treatment - discussed with consultant. Apols offered for difficulties with follow-up appt. Consultant apologised that patient found him to be rude and dismissive - this wasn't intended. Complaint to be discussed as part of annual appraisal. Request for reimbursement for private appointment rejected.

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18686	MOD	SPECME	10/10/2016	Patient's son has concerns over the time it took for his mother to be diagnosed. Patient ultimately ended up having a leg amputation.	Consultant did suspect ischaemia initially but other clinical indicators led him to investigate and exclude DVT. Apologies offered for this. Consultant has undertaken personal reflection on the case.
18707	MOD	SPECME	05/10/2016	Delay in neurology appointment and onward referrals. Inconsistent communication regarding availability of scan. Delay in pain clinic and lack of support with pain control.	Patient did have a long wait for appt but was seen within the 18 week limit. Apologies offered that patient was told scan was available but it couldn't be located at the appointment. Apologies offered by consultant that pt felt unsupported - explanation provided of care and treatment given. Pt referred to tertiary centre for further diagnostics.
18715	MOD	AE	28/09/2016	Concerns regarding medical treatment provided. Was the doctor competent to perform the procedure? Should the surgeon have attended to review the patient. Concerns regarding lack of chaperone.	Assurance offered that doctor was competent to perform procedure. Dr did not wait for a chaperone as the department was busy. Need to use a chaperone in future discussed with dr.
18625	MOD	AE	21/09/2016	Concerns raised regarding the technique in the removing of a cannula which caused harm to the patient and following a further admission he was treated roughly in the x-ray department causing pain.	Apologies that skin was damaged during cannula removal - however this was always a risk due to patient's fragile skin. Dressing subsequently used was not the most appropriate and staff nurse undergoing period of supervision re wound management. No evidence to support pt being treated roughly during x-ray. Medical team reminded of need for accuracy when completing EDNs.
18683	MOD	AE	19/09/2016	Lack of / delayed monitoring of patients condition. Lack of checks on patient injuries. Perceived lack of support during seizure. Manner of nursing staff.	Nurse was falsely reassured by CT report and therefore did not follow consultant's instruction to carry our neuro obs. Apologies offered. Discussed with individual and wider nursing team. Local nursing checklist updated to include prompt around neuro obs.
18704	MOD	HEADN	16/09/2016	Manner of doctor during clinic appointment.	Consultant offered apologies for patient's experience.
18697	MOD	AE	15/09/2016	Missed fractures in child's arm and therefore delayed treatment (immobilisation). Perceived reluctance to apply a cast.	Fracture was missed. ED working on pathway to get all x-rays reported on while patient is still in the department.
18705	MOD	RADIO	14/09/2016	Manner and attitude of staff in screening van. Lack of privacy and dignity	Apologies offered for poor experience. Expected standards of communication have been reiterated to staff involved. No patients are expected to leave the scanning room in a state of undress - apologies this was not made clear.
18559	MOD	AE	12/09/2016	The complainant feels that staff lack the knowledge to deal with his wife's condition and are reluctant to contact the endocrinology team when attending A&E.	EDN recommended f/up appt which was never made - apologies offered and highlighted to ward team. Assurance offered that ED staff are able to ask for input from other specialties. Apologies for miscommunication around this. ED consultant has advised ED dr that patient should have been referred to consultant for review in the ED.
18687	MOD	AE	06/09/2016	Patient attended A & E twice and told he has a water infection. On his 3 rd attendance he was admitted for emergency surgery as he had a ruptured appendix. Unhappy with management on first 2 attendances.	Patient presented with very subtle signs of an already subtle condition. Medical management on each occasion was appropriate but pt should have seen a more senior dr when he reattended the ED. Learning shared around senior review of all reattending patients and need for clear documentation of advice given on discharge.
18682	MOD	SPECME	30/08/2016	Complaint raised that patient has not been appointed in the timeframe suggested in previous clinic letter. Complainant does not understand why the Trust cannot put on more clinics	Delays with f/up due to capacity issues. Consultant is running additional clinics and additional staff recruited.

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18585	MOD	AE	24/08/2016	Concerns raised regarding a misdiagnosis of a fractured shoulder and dislocated ball joint.	Radiology alone not conclusive re fracture/dislocation. Undisplaced fracture visible on post-reduction x-rays. Onward management via referral to fracture clinic was correct. No evidence of displacement until imaging in fracture clinic. Apols for lack of information provided on discharge - ED looking at sending copy of GP letter home with patients who live in care homes. Apols not made clear that pt should seek support from GP/ED if needed while waiting for fracture clinic appt. Apols for wait for f/up appt - virtual clinics since introduced to reduce waiting times.
18676	MOD	TANDO	23/08/2016	Lack of coordination lead to incorrect leg marked for surgery in 2014. Poor communication in terms of wound and stitches. Why did consultant not come to see the patient after surgery. Why was a fixation not undertaken during most recent surgery	Apologies offered that leg incorrectly marked prior to surgery - this was rectified well in advance. Not clear who informed parent that stitches were removable - not indicated on EDN. Apologies offered for miscommunication around treatment plan - effective communication to be discussed at clinical governance meeting.
18420	MOD	TANDO	16/08/2016	Delayed orthopaedic surgery and the impact this has had. Manner of CAU staff.	Apology for delay in pathway and acknowledgement that some of the delays were avoidable. Apology for manner of CAU staff. This has been discussed with her
18642	MOD	SPECME	12/08/2016	Concerns raised regarding the care received by late father. Concerns are: lack of pain control, family were not informed regarding seriousness of their father's condition and standard of nursing care.	Apologies offered for shortfalls in nursing care and communication from the drs. Actions identified: reminder to nursing staff re prompt administration of pain relief, vigilance around patient property, pillow stock to be reviewed, action taken re agency nurse, case to be discussed at clinical governance meeting re communication with family and poor documentation.
18677	MOD	SPECME	09/08/2016	Loss of glasses	Reimbursement of cost of replacement glasses offered
18556	MOD	PAEDS	09/08/2016	Pre-operative MRSA screening test results not communicated to patient's mother. Poor communication on day of surgery. Parent believes that patient was discriminated against owing to infective status.	Apology offered for error made and distress this caused. Unfortunately, request for MRSA treatment was not actioned until after the patient's surgery date. This has been discussed with those concerned and staff have been reminded of the need to use urgent Dictaphone when urgent action is required. The case has also been discussed with nursing team to reiterate expected standards when caring for children
18658	MOD	AE	08/08/2016	Concerns raised regarding the communication and understanding of ED doctor. Patient has also asked if the plaster applied post blood test was appropriate as on removal it caused her an injury.	Apologies offered for poor experience. All drs are required to pass a communication assessment prior to appointment. Complaint will be considered as part of dr's appraisal and revalidation. Not clear what specific dressing was used - wound dressing to be discussed with staff by matron. Apols for errors in clinical documentation - to be discussed with ED team.
18620	MOD	ONC	08/08/2016	Concerns raised regarding the delay in commencement of radiotherapy due to communication about where treatment should be undertaken and incorrect information given with regards to stopping his anticoagulant medication.	Apology offered for confusion regarding appointment. Assurance that this issue was discussed with those concerned and the importance of ensuring clarity with regard to treatment dates has been reiterated.
18675	MOD	AE	03/08/2016	Missed fracture. Manner and attitude of doctor.	Minor fracture was missed on x-ray but Clinical Director has confirmed this was very subtle and unlikely to have been picked up by a non-radiologist. Explanation offered re failsafe processes. Dr has reflected on feedback with support of CD. CD has no concerns about dr's clinical management. Dr has apologised for irrelevant line of questioning.
18651	MOD	PHARM	27/07/2016	Concerns raised regarding incorrect dosage of medication being dispensed. The box stated 5mg however, inside the box were 25mg tablets. Pt noticed this and had not taking any of the medication.	Human error. Changes made to storage of the different strengths to make the difference more obvious to the pharmacy team. Nursing team have also changed their practice and will check the contents of the boxes with patients.

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18590	MOD	AE	27/07/2016	Concerns raised regarding an inaccurate diagnosis of a calf sprain. Patient was later diagnosed with an Achilles rupture. Concerns that position of crutches following surgery has caused shoulder pain.	Consultant discussed management of case with the doctor concerned. Doctor has undertaken reflection and further study on ankle injuries. Apologies offered if it wasn't made clear that crutches would need adjustment as patient recovered.
18680	MOD	GYNAEC	25/07/2016	Manner, attitude and comments made by locum consultant	Apologies offered. Locum consultant - concerns reported to agency, he will not be booked to work at MTW again.
18607	MOD	SPECME	21/07/2016	Concerns raised regarding the lack of escalation to the medical team, Lack of dementia awareness, communication and staff attitude.	Explanation provided regarding medical management and assurance offered around medical input following transfer to step down ward. Apologies offered re the flower symbol not being used and that the ward manager was unable to provide names of the dementia champions.
18569	MOD	UROLOG	20/07/2016	Delayed treatment for infection. Poor standard of care on Whatman ward. Medical notes unavailable. Patient ID band not provided.	Assurance offered that the possibility of infection was appropriately considered and no delay occurred. Apology that aspects of care on Whatman ward fell below expected standards. Assurance that issue re: ID bands will be kept under review by ward manager.
18635	MOD	THERAP	18/07/2016	Patient believes that physiotherapy was incorrectly prescribed against the orthopaedic advice. He subsequently developed an infection which has severely damaged his rotator cuff and he would like to know how this developed.	Explanation of care pathway provided - surgical intervention explained including risk of infection. Re physio, advice should have been given around the range of movement - exercise sheet will be reviewed/revised by ortho/physio MDT.
18440	MOD	SPECME	12/07/2016	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.
18624	MOD	SPECME	08/07/2016	Concerns raised regarding a failed/ inappropriate discharge, communication and a lack of understanding from nursing staff regarding patients' needs and disabilities.	Apologies that change in discharge plan was not communicated to family. Signs should have been displayed in patient's room to alert staff to her visual impairment. Referral should have been made earlier to dietician - issues to be addressed at ward meeting. Apologies that EDN was not updated when discharge plan changed - medical team reminded.
18627	MOD	SPECME	07/07/2016	Family raised concerns regarding the lack of communication around the placement of a DNAR, poor communication around discharge. Concerns also raised regarding patient's wishes not to be attended by male nursing staff and that patient's dietary needs were not correct which they believe contributed to a choking incident.	DNAR decision was discussed with family and their wishes were respected until patient was able to express her own preference. Request for patient to be attended to by female staff was noted and instruction given to team to try to meet this. On one occasion, pt activated her call bell and male staff attended as they didn't want to keep the patient waiting. Request for personal care to be delivered by female staff should have been documented on handover sheet. Dietary requirements were recorded in This is Me document - should have been used by staff. Addressed with ward team.
18639	MOD	TANDO	05/07/2016	Medication error in not recommencing loading dose of warfarin as required. Patient believes that this resulted in her suffering a TIA. Incorrect diagnosis of sinusitis in A&E.	Apology offered that information regarding loading dose of warfarin was not handed over. This issue will be discussed at clinical governance meeting. Assurance offered that care in A&E was appropriate, apology for worry caused.
18636	MOD	HEADN	05/07/2016	Delay in investigation results being communicated.	Apology offered for delay in providing test results and making onward referral. Management of test result tracking database has been built into PDP of secretary and will be monitored by management team
18621	MOD	SPECME	04/07/2016	Concerns raised regarding the conditions on ward, patient had a rolled up blanket for a pillow, urine bottles were left on bedside table and not emptied, when patient was discharged both he and his wife contracted Norovirus.	Apologies re pillow - ward checking stocks. Apologies re urine bottles - ward purchasing bottle holders to store them away from bedside tables. Staff reminded to use disinfectant wipes on bedside tables prior to meal service. No other patients on the ward at that time had diarrhoea.

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18597	MOD	CLINGO	30/06/2016	Concerns raised regarding breach of confidentiality	Apologies offered - human error. Reported on risk management system and affected party informed.
18544	MOD	HEADN	30/06/2016	Query regarding delayed diagnosis of cancer. Patients wife does not understand how diagnosis was not made sooner and wonders if this would have impacted on prognosis for patient	Confirmation provided that there was missed opportunities to highlight the need for further investigation which in turn, would most likely have diagnosed cancer. Apology offered for understandable distress caused. Case to be discussed at Clinical Governance meeting. Test tracking database to be monitored more closely and recruitment of specialist nurse. radiology to contact patient by telephone when DNA'ing investigation.
18521	MOD	ONC	30/06/2016	Complainant believes that there was a delay in diagnosing the patient's condition as requested tests in 2013 were not acted on.	Due to time elapsed, conclusion is that referral letter was sent in internal post but never received. Referrals from haematologists to other internal consultants are now emailed. Unlikely that this would have affected the outcome due to the nature of the disease.
18611	MOD	SPECME	27/06/2016	Concerns raised regarding lack of communication around end of life care and the lack of investigations and personal hygiene needs not met on initial admission.	Apologies offered that hygiene needs not always met - discussed with ward staff. Ward had been escalated and agency staff were in place. Changes since made to staffing of escalation areas, recruitment of substantive staff and opening of new ward. Apologies for lack of clarity when discussing discharge planning. Agreement was reached with family around provision of end of life care.
18617	MOD	ONC	21/06/2016	Concerns raised regarding chemotherapy treatment. Should the patients chemotherapy have been stopped sooner, was the chemotherapy only stopped when consultant saw patient in a wheelchair and what was the problem in transferring care from one clinician to another?	As soon as consultant was aware of the impact of the side effects on the patient, it was recommended to stop the chemo. With hindsight, consultant feels that if pt had been reviewed by dr earlier, decision may have been taken to stop chemo earlier. Consultant wrote to the surgeon to recommend further investigation and discharged patient to nurse-led clinic. GP and other specialists were also notified of management plan.
18489	MOD	AE	21/06/2016	Concerns raised regarding the nursing care provided whilst on ward which include delayed treatment, attitude, dignity and nutritional concerns. Concerns also raised around GP and district nursing input.	Apologies offered for poor environment - unit has now closed. Changes made to staffing of escalation areas in future to ensure presence of substantive staff. Explanation of medical management provided - care given on ward did not cause patient's death.
18622	MOD	TANDO	20/06/2016	Patients hearing aids were lost on ward 31 and ward 21. Request for reimbursement (greater than previously offered). Lack of response to emails.	Apology offered for loss of hearing aids and for lack of response to communication to matron. Financial redress provided for loss £1145.00.
18433	MOD	OBSMID	17/06/2016	Patient believes that she received a poor standard of obstetric care. Despite a complex obstetric history, she was refused admission to labour / delivery.	Apology offered that patient was not kept in when attending triage. Apology offered for distress. Assurance offered that case had been investigated at the time and learning had been widely shared. Consideration will be given to adding sticker to outside of notes highlighting those patients who labour quickly.
18640	MOD	OBSMID	16/06/2016	Complaint about the behaviour of the doctor who made some inappropriate and unprofessional remarks during the consultation	Apology offered for distress caused. Assurance that the doctor will not work with us again and concerns will be shared with his agency
18564	MOD	AE	16/06/2016	Concerns raised regarding misdiagnosis of hand fracture and why patient was not contacted.	Fracture was missed on initial presentation, however there is evidence that the failsafe worked in this case and the fracture was later identified. Therefore an apology has been given for this error but no action has been identified. There is also evidence that staff had tried on several occasions to contact the patient to advise of such.
18644	MOD	OBSMID	16/06/2016	Manner and attitude of consultant.	Apology offered for distress caused. Assurance that the doctor will not work with us again and concerns will be shared with agency

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18603	MOD	HEADN	13/06/2016	Delayed diagnosis and treatment for TB in patient eyes. Patient believes that if his condition had been comprehensively reviewed sooner, he would be in a better position.	Apology offered for delay in reaching diagnosis. Explanation provided detailing that although initial symptoms did not indicate TB, given the patients background a test was done however, the result was not accessed as promptly as expected. Case to be discussed at clinical governance meeting. Review of H&N test result tracking underway.
18600	MOD	PAEDS	13/06/2016	Test results not communicated to child's mother despite assurances. Telephone message not responded to.	Apology offered that test results were not communicated as they should have been. Issues highlighted to clinical director and risk lead for discussion with doctors and discussed with ward staff
18566	MOD	AE	27/05/2016	Concerns raised that delayed tests led to a delayed stroke diagnosis. Concerns also raised regarding conflicting information about discharging patient when condition had not changed.	Review of case shows that there were subtle signs of stroke which were overlooked by a number of doctors. Case discussed with all staff involved and additional education provided. Reassurance offered that delay did not significantly impact on the outcome for the patient. Apologies offered for communication around discharge - patient wasn't being discharged as further investigations had been ordered.
18482	MOD	SURG	24/05/2016	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 (£250) offered in recognition of continued pain.
18479	MOD	AE	23/05/2016	Concerns raised regarding the staff attitude and lack of response when patient required urgent attention as he was struggling to breath. When Dr attended the patient required an urgent lung drain.	The nurse involved accepted that her response to the patient's concerns was not appropriate and will complete a communication course. There will also be a review of mobile phone use policy.
18592	MOD	TANDO	23/05/2016	Manner and attitude of nursing staff. Delay in responding to call bell.	Apologies offered for patient's poor experience. Concerns to be discussed at ward meetings.
18458	MOD	ONC	23/05/2016	Concerns raised regarding conflicting information 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.	Investigation has concluded that there is a need for a clear policy regarding blood tests prior to venesection; a policy is under development.
18575	MOD	GYNAEC	17/05/2016	Patient believes she received poor advice of early pregnancy care. She believes that there was a reluctance to see her.	Apology offered that patient was upset at care received. Assurance offered that there was no reluctance to see her however, apology offered that medication was not ordered by EGAU as suggested. Discussed with EGAU team. Assurance offered that care provided in A&E was correct and appropriate.
18457	MOD	ONC	16/05/2016	Concerns raised regarding delays in treatment, follow-up appointments and receiving medication. Concerns also raised regarding communications of test results.	Instruction was given to administration team to book appointments - person involved has since left so it is not clear why the appointments were not made. Actions taken in response: 1. Local induction training for all new staff members to ensure they fully understand their roles. 2. Review the current roles and responsibilities of the team to ensure all actions are appropriately completed. 3. Regular reports have been created to ensure all patients receive follow up appointments. This is monitored by the Patient Services Manager on a monthly basis. Apologies offered for delays encountered. Apologies offered by East Kent for other aspects of service referred to in complaint.

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18565	MOD	AE	16/05/2016	Concerns raised regarding discharge from A&E without a confirmed diagnosis. Patient woke the following day with pains in chest and calf returned to the hospital, further tests revealed patient had 2 clots on her lung and a blood clot going from her calf to groin. Results of investigations communicated to husband, not patient.	Patient was managed correctly on first attendance - diagnosed with possible DVT and treated with anticoagulation and follow-up scan. Apologies that patient was misinformed that scan would be completed the following day. Apologies that consent was not gained to share the information with the patient's husband. Case discussed with doctor for learning.
18518	MOD	SPECME	13/05/2016	Patient wishes to make a complaint about unprofessional manner of a Dr also that the specified Dr entered the incorrect dosage when prescribing medication 1/10 of what it should have been.	Incorrect dosage of medication prescribed by consultant. Reported as a patient safety incident for further investigation.
18555	MOD	ONC	13/05/2016	Concerns raised regarding moving and handling of patients within the radiology department and the policy regarding lifting of patients. Patient was left feeling embarrassed and upset following her experience when having to be hoisted from the toilet.	Delays were unacceptable and staff should not be delivering conflicting information regarding health and safety regulations. Member of staff to be reminded of acceptable handling of such a situation.
18547	MOD	SURG	03/05/2016	Delayed investigation and treatment. Lack of continuity of care. Poor communication with service user.	Explanation provided that the patient had already undergone the procedure the month before and therefore it did not need to be repeated. This was due to an error when booking. Apology offered for upset caused.
18538	MOD	NURSIN	03/05/2016	Manner and attitude of staff nurse	Apologies offered. Issues raised being managed under HR policies and procedures.
18554	MOD	AE	29/04/2016	Patient has raised concerns that after being referred by her GP to the medical team via A&E she still waited over 7 hours to be seen by the medical team. She has also raised concerns regarding the communication and why blood test/scans were not performed during the wait.	Apologies for poor welcome by reception team - manager has discussed complaint with them. Apologies for the long wait in the department. Changes are being made to the staffing with more doctors being rostered on duty. Nurse in charge also reminded to escalate to site manager when waiting times reach 1 hour so that additional resources can be deployed. Delays in taken blood samples were due to activity levels. Matron is reviewing the systems are processes to try to improve this.
18549	MOD	SPECME	29/04/2016	Breach of confidentiality - multiple patients' letters sent to patient.	This was due to human error and the secretary has been spoken to and an incident form completed.
18545	MOD	AE	25/04/2016	Delay in administering medication. Lack of introduction to ward. Poor continuity and query regarding why reaction to medication was not documented.	Apologies offered for poor experience. An alert has been added to the Trusts electronic patient information system regarding patient's allergy.
18469	MOD	AE	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
18463	MOD	NURSIN	22/04/2016	Concerns raised about the discharge arrangements, specifically the information handed over to transport provider and difficulties and delays encountered.	Apology offered for errors made when booking transport. Offer of £25 financial redress made
18548	MOD	SURG	18/04/2016	Poor communication. Patient had been told that she could remain an inpatient over the weekend but was discharged despite this.	Apology offered that the patient was discharged when she did not feel ready. Doctor acknowledges that she had agreed that the patient could stay however, the nursing team misunderstood this as she was medically fit. Issue to be discussed with ward team to reiterate importance of effective communication
18553	MOD	PLAN	15/04/2016	Concerns raised regarding the delay in providing copy records and poor communication.	Apology offered for poor communication. Explanation provided that emails had been sent by access team however, we cannot account for why they were not received.
18446	MOD	AE	15/04/2016	REDACTED at complainant's request.	REDACTED at complainant's request.

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18530	MOD	AE	12/04/2016	Pt's wife has raised concerns regarding her husband's treatment in A&E and her experience within the discharge lounge when no offer of help was made when her husband became distressed.	Explanation provided around preparation of trolleys for waiting patients - apologies for delay in providing bed linen, reminder to be issued via departmental newsletter. Apologies offered for wait to be seen by a doctor on that occasion. Apologies offered for lack of assistance provided in discharge lounge - staff to complete further training around dementia care.
18515	MOD	SPECME	07/04/2016	Concerns raised regarding the falls whilst on Ward, alleged bullying by staff on another Ward and failed discharge.	Complainant had lengthy conversation with Lead Matron where concerns were discussed and resolved. No witness to conversation between nurse and patient which makes it difficult to draw robust conclusion. However, staff nurse accepts communication style can be a bit abrupt. The staff nurse will undertake further training in conflict resolution and communication.
18428	MOD	AE	05/04/2016	Concerns raised regarding why their one year old son had to wait 15 hours for appropriate treatment for a deep laceration to his head. Child was eventually taken to East Grinstead.	Temporary suturing of wound should have been considered when bleeding did not stop as expected. Staff to be made aware of how to seek further advice when treatment is unsuccessful. Staff reminded to consider need for early intravenous access in such cases. Closure of head wounds in children to be taught as part of ED doctors education programme. QVH also considering action they can take regarding communication.
18510	MOD	SURG	04/04/2016	Medication error - patient prescribed antibiotic medication despite known allergy.	Apology that patient was prescribed and administered medication that she was allergic to. Explanation that pharmacy had assessed that it was not an allergy, rather a known side effect and therefore medication could be given. Apology this information was not shared. To be discussed with pharmacy team
18426	MOD	AE	04/04/2016	REDACTED at complainant's request.	REDACTED at complainant's request.
18517	MOD	SPECME	04/04/2016	Concerns raised regarding the standard of nursing care and discharge process. Pt was discharged without care package in place, venflon in situ, incomplete TTO's and DNAR form not included.	Complaint is upheld, the appropriate discharge paperwork was not completed in a timely manner and communication with social services around care package recommencing did not happen. Actions identified; Additional training and support to be given to the staff nurse who was responsible for the discharge of your mother. All ward staff to be informed that the day before discharge checklist must be utilised for all patients discharged from the ward. All new starters and temporary staff, who are new to the ward, are to be given a full ward induction, including discharge planning
18746	MOD	UROLOG		Patient seeking apology from consultants for 'appalling care' and 'disgusting attitude'; wants explanation for why the sepsis was not acted on and why she was not told she had a UTI.	Consultant has apologised that patient was upset by comments he made when discussing risks and benefits of treatment. Patient was warned of risk of infection prior to procedure.
18858	MOD	SPECME		Concerns raised regarding poor nutrition - patient made NBM and received no nutrition until she was seen by SLT 8 days later and cleared to have thickened liquids. Ward staff did not seem to take note of the collateral history provided by the family around the patient's pre-admission status. Concerns that patient developed a pressure sore during admission.	Records shows that family's concerns about nutrition were identified on admission and input from speech and language therapy was promptly sought. Family's preference to feed patient orally was respected despite the risks. This was only stopped when there was concern that the patient had aspirated and was then restarted. Collateral history was documented - records show patient's level of function fluctuated. Pressure damage was investigated at the time and found to be unavoidable.

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18907	LOW	RADIO	16/03/2017	Patient arrived for scan on his lower leg as advised by A & E as he has possible DVT. He was advised that it is against hospital policy to scan his lower leg. Concerns raised about lack of compassion shown by staff involved. Also unhappy with how manager dealt with concerns.	Evidence suggests that staff conducted themselves politely and professionally. Patient was very angry when discussing his experience with the manager, hence the manager was reticent to provide the sonographer's name. Recognition that providing the name may have alleviated the tension. Apologies that patient was given a false expectation by other staff about the nature of the scan - clinical lead for ED asked to ensure that doctors are aware of relevant scanning protocol.
18850	LOW	SPECME	16/02/2017	Concerns raised about manner and attitude of consultant during consultation. Dr arrived late with no apology, checked messages on his phone during the consultation. Dr described as rude and abrupt until he noticed that the relative was wearing a Trust name badge. After this, dr's attitude improved. However, dr then started asking relative questions related to clinic scheduling. Patient wishes to change consultant.	Consultant apologised for overall poor experience. Consultant did not appreciate that pt expected an apology as he did not believe he had arrived late. Consultant would normally apologise if he received work related calls during a consultation - apologies if he didn't. Consultant recognises that his discussion about clinic scheduling was not appropriate. Content of complaint to be discussed with consultant by clinical lead.
18824	LOW	ONC	03/02/2017	Family unhappy that patient was informed he was terminally ill against their wishes. They feel this caused unnecessary distress.	Dr involved has since left Trust. Staff are expected to keep patients informed unless they specifically request not to be. Apologies for distress caused - would have expected dr to adjourn the discussion to somewhere private to explain to relative what she was going to say to patient and why.
18843	LOW	SPECME	24/01/2017	Concerns raised around poor administration following discharge. GP did not receive EDN for 4 days, no-one had requested the echo recommended on discharge until patient's wife chased the hospital. Patient then waited from 25/10 to 14/12 before receiving the results of the echo, which was needed to determine onward management plan.	Recognise there can be delays in producing GP letters following ED attendance - staff encouraged to update system promptly and we are working towards emailing letters direct to local GPs. Medical team did not book the echo or cardioversion - apologies offered and reminder issued to the doctors. Apologies for delay in producing clinic letter - new strategy developed to avoid such backlogs building up in future.
18739	LOW	TANDO	23/01/2017	Concerns raised that medication was not administered from dossette box - is this in line with Trust policy? Concerns that discharge was very protracted - patient very distressed when she arrived home.	Explanation offered and assurance that medication administered in line with policy (see ref 18713). Explanation around discharge provided, delayed transport and assurance that medication received whilst awaiting transport home. Apology offered that difficulties experienced contacting the ward
18835	LOW	HEADN	10/01/2017	Concerns raised that eye health records are incorrect as received appointment for incorrect clinic which was only picked up after patient attended the clinic. Second time this has happened as patient was referred for laser treatment when anti-VEGf injections would be more effective for condition. Asking for travel costs to be refunded.	Appt should have been cancelled as patient had attended previous appointment. However, the appointment was not made for the incorrect clinic. Travel costs refunded.
18789	LOW	ONC	28/11/2016	Appointment letter sent to an old address.	Address should have been updated on system. Reminder issued to administration team for need for accuracy.
18793	LOW	SPECME	10/11/2016	Pt unhappy with time taken for lung function tests to be sent to St Thomas'. Believes these were only sent after St Thomas' chased, despite the patient highlighting it to the doctor in clinic.	No indication in correspondence that results needed to be sent to St Thomas. Apologies for breakdown in communication.
18696	LOW	HEADN	15/09/2016	Delay in communicating test results. Manner and attitude of staff member.	Assurance offered that test results were sent when pt contacted hospital. Test results are sent once a week but we cannot track when individual results are sent. All clinics now being centralised onto one booking system to improve oversight. Apols for attitude of staff member - feedback shared with manager for the area.

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18593	LOW	AE	20/07/2016	Concerns raised that staff acted inappropriately and delays in tests being undertaken.	Apologies offered for experience. Concerns discussed with receptionists and expected standards reinforced. Reminded that they must not provide patient's with food/drink and certainly not sweets. Receptionists should not provide patients with medication, even if it's their own supply - they should refer to a nurse. Documented that patient did have tests performed, blood results are documented, blood sugars documented.
18486	LOW	GYNAEC	09/05/2016	Concerns raised regarding the lack of co-ordinated care provided and delayed treatment.	apology offered that care was not coordinated well and left the patient feeling that nobody was taking ownership of her care. Discussed at clinical governance.