Maidstone and Tunbridge Wells NHS Trust

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Complaints and PALS – Annual Board Report 2018

Requested/ Required by: Patient Experience Committee
Trust 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 2018

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 2017-18. • A review of performance in responding to complaints in 2017-18. • 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

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1.0	First annual Board report	June 2013
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3.0	Third annual Board report	May 2015
4.0	Fourth annual Board report	May 2016
5.0	Fifth annual Board report	May 2017
6.0	Sixth annual Board report	June 2018

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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:

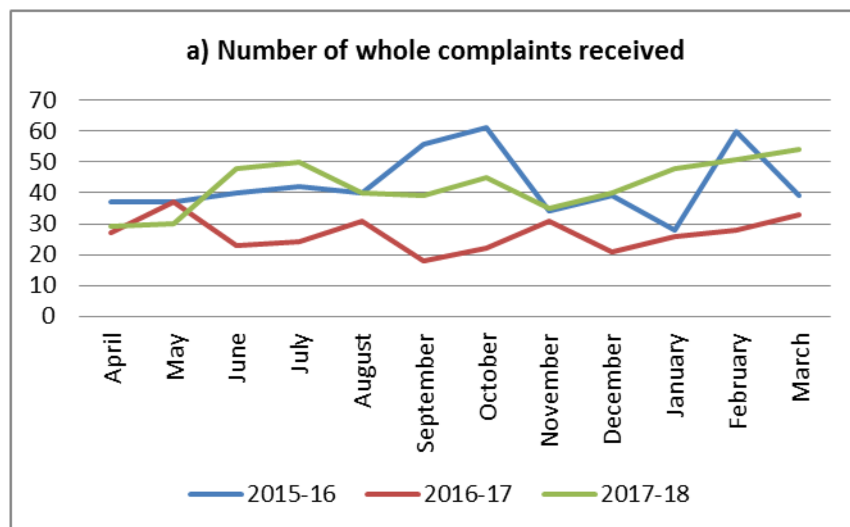
- specifies the number of complaints received
- the number of complaints which were well founded (upheld)
- the number of complaints referred to the Health Service Ombudsman (PHSO)
- summarises the subject matter of the complaints received
- any matters of general importance arising from those complaints 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. The management of complaints is also a Key Line of Enquiry used by the Care Quality Commission in their annual assessment of the Trust.

2. Introduction

The year 2017-18 has been a challenging one in terms of staffing. Whilst the Patient Advice and Liaison Service (PALS) has remained fairly stable, the complaints team continued to carry a vacancy until August 2017. Compliance with performance in responding to complaints remained the priority for the service, but the staff vacancies did impact on this and as a consequence of the long term vacancy, a backlog of complaints developed, which has proved difficult to clear as quickly as hoped.

3. Complaints received

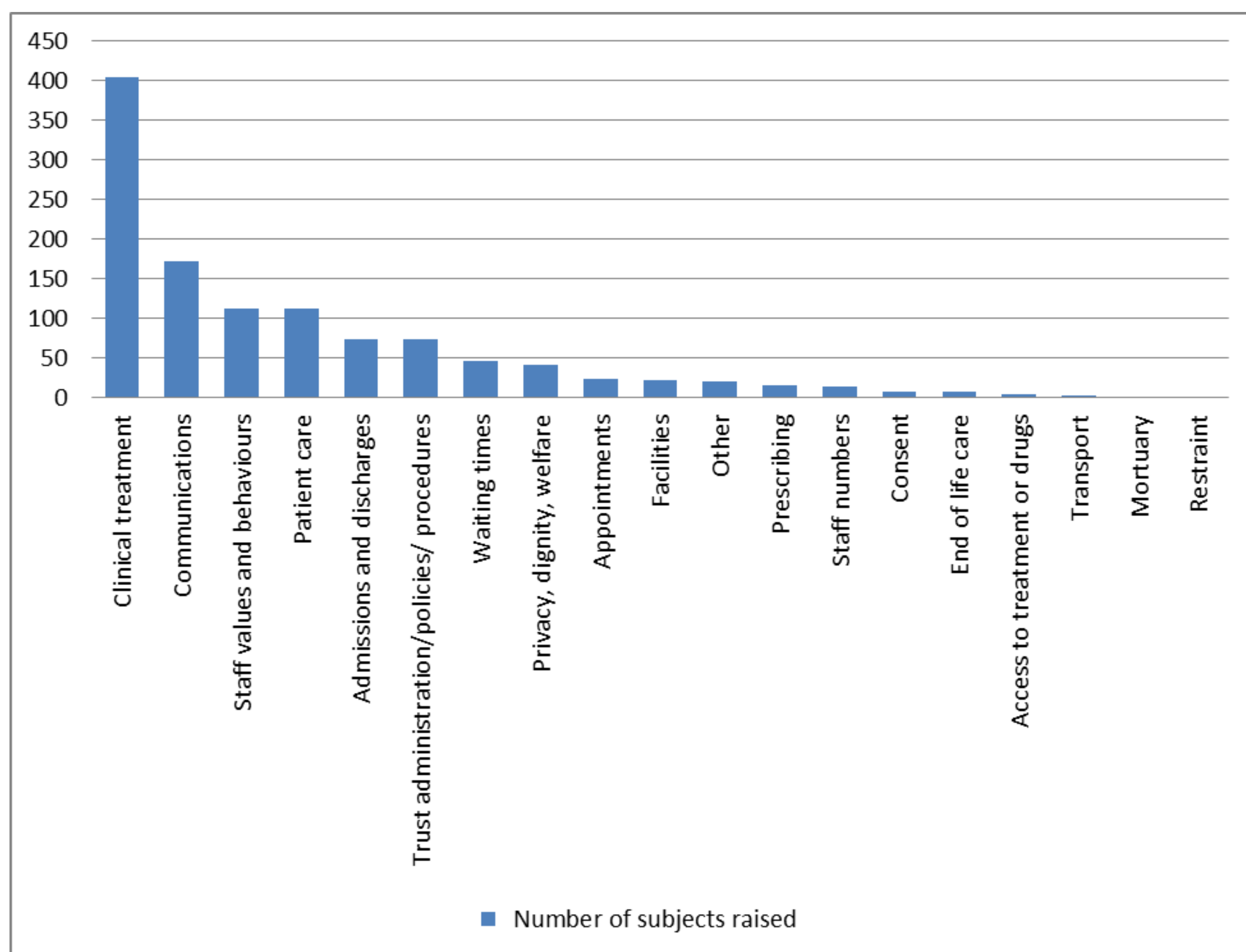


For the year 2017-18, the Trust received 503 formal complaints, a significant increase of 182 complaints from the previous year (321 complaints received 2016-17). On the face of it, this may give rise to concern, however, this is a result of improved triaging of complaints between PALS and complaints to ensure that those cases requiring a more formal investigation have followed the complaints pathway correctly. Graph 3a shows more detail around the 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 2017-18, the Trust received complaints about 1157 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 2017-18, totalling 404. 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:

'It became obvious that there were very few staff, very little care and no procedures performed over the weekends which left Daniel[†] in a very uncomfortable states, this was verging on cruelty. Overall the service was very fragmented and their [sic] was a lack of communication with the different departments making it difficult to formulate, and put into practice a care plan in an expeditious manner.'

[†] All names have been changed to protect patient confidentiality

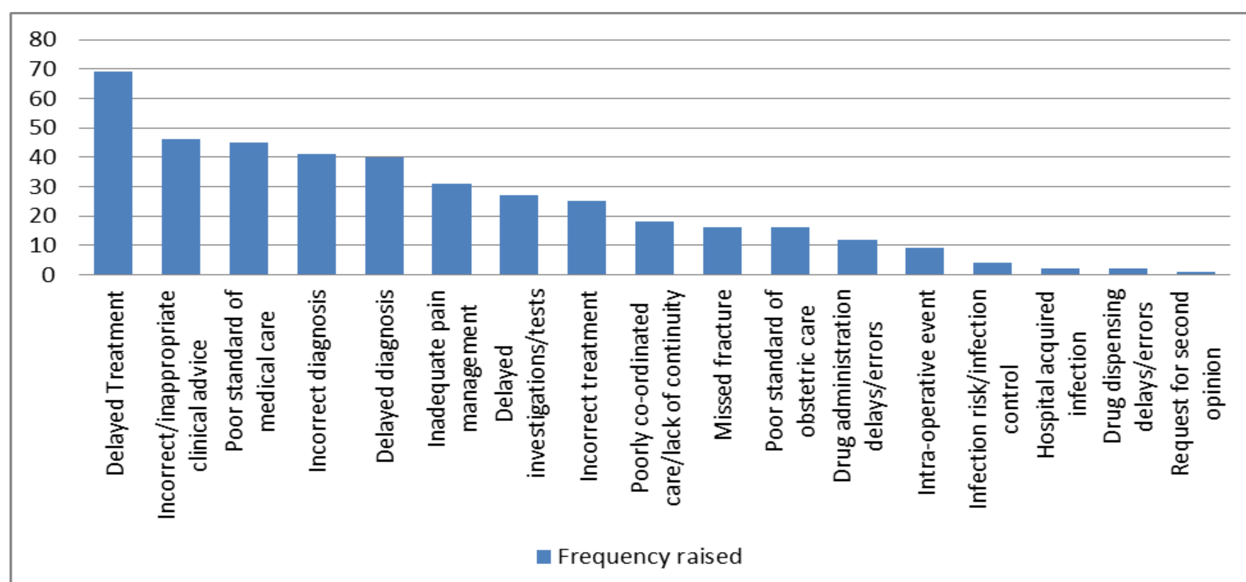
Due to the significant difference in overall numbers of complaints between 2017-18 and 2016-17, these have been converted to indicate a percentage of all subjects raised, shown in the table below. This shows that proportionally, there has been a decrease in the complaints about clinical treatment. However, it is disappointing to note the increasing proportion of complaints in many other areas, including communication, patient care and Trust administration.

Subject	% of subjects raised 2017-18*	% of subjects raised 2016-17*
Clinical treatment	↓ 35	↓43
Communications	↑ 15	↓12
Staff values and behaviours	→ 10	↑10
Patient care	↑ 10	8
Admissions and discharges	→ 6	6
Trust administration/policies/procedures	↑ 6	5
Waiting times	↑ 4	↓2
Privacy, dignity, wellbeing	↑ 4	3
Appointments	↑ 2	1
Facilities	→ 2	↑2
Other	↑ 2	↑1
Prescribing	↓ 1	↓2
Staff numbers	↓ 1	↑2
Consent	→ 1	1
End of life care	→ 1	1
Access to treatment or drugs	→ 0	↓0
Transport	→ 0	0
Restraint	↓ 0	↑1
Commissioning	→ 0	0
Integrated care	→ 0	0

*rounded to the nearest whole percent; arrows show change from previous year's data

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 incorrect/inappropriate clinical advice and poor standards of medical care.

Patient story

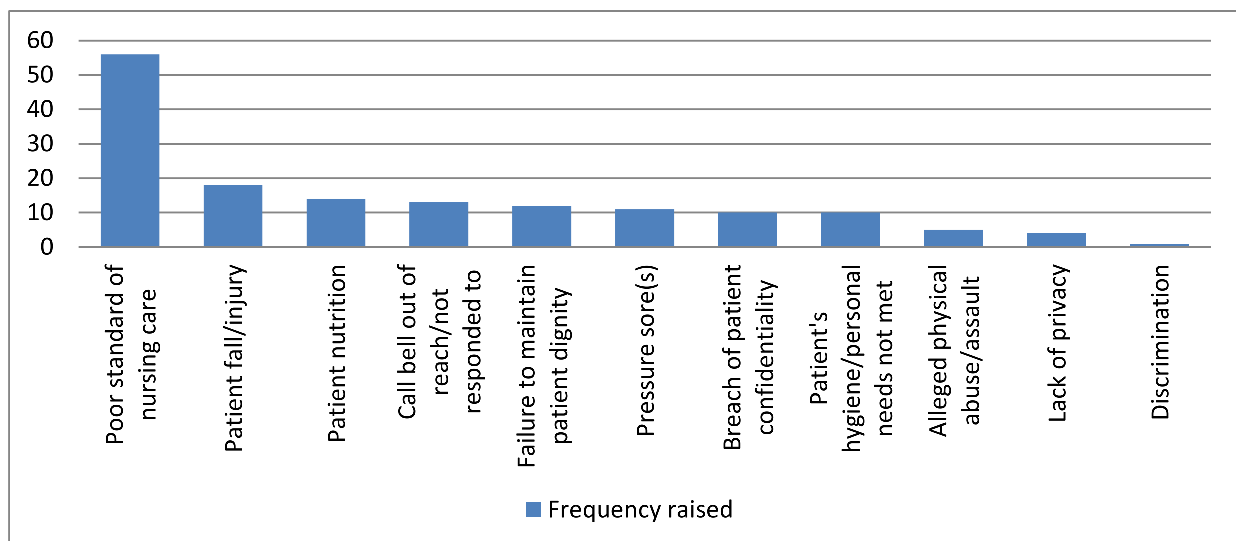
Mrs Brooke attended the ED in December 2016 with a fractured fibula. She was x-rayed, given a support boot and painkillers, and an outpatient appointment was made for her. At that appointment, the registrar noted that there were no signs of healing, but encouraged Mrs Brooke to continue with the boot, ice packs and elevation. At her next appointment one month later, Mrs Brooke was told the fracture was showing signs of starting to heal and to continue with the support boot. Six weeks later, Mrs Brooke was reviewed again and discharged from the clinic to have physiotherapy. Mrs Brooke expressed concern that she was still in a lot of pain, with swelling and bruising, and could not walk comfortably.

The physiotherapist was concerned with Mrs Brooke condition and recommended she request another x-ray via her GP. Following this x-ray, Mrs Brooke was re-referred to the orthopaedic team. At this appointment in June 2017, it was identified that she had a non-union, a CT scan was carried out and she was added to the waiting list for surgery. Although listed as an urgent patient, Mrs Brooke was still facing a 3 months wait for surgery.

This complaint was reviewed by the consultant responsible and the clinical director for Trauma and Orthopaedics. They concluded that the initial conservative management was clinically appropriate. However, given that the x-rays taken in March, April and May showed evidence of non-union, Mrs Brooke should not have been discharged from clinic and an earlier CT scan should have been requested. This could have resulted in Mrs Brooke undergoing surgery earlier. Apologies were offered to Mrs Brooke and the case was discussed at the directorate's clinical governance meeting to share the learning.

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.

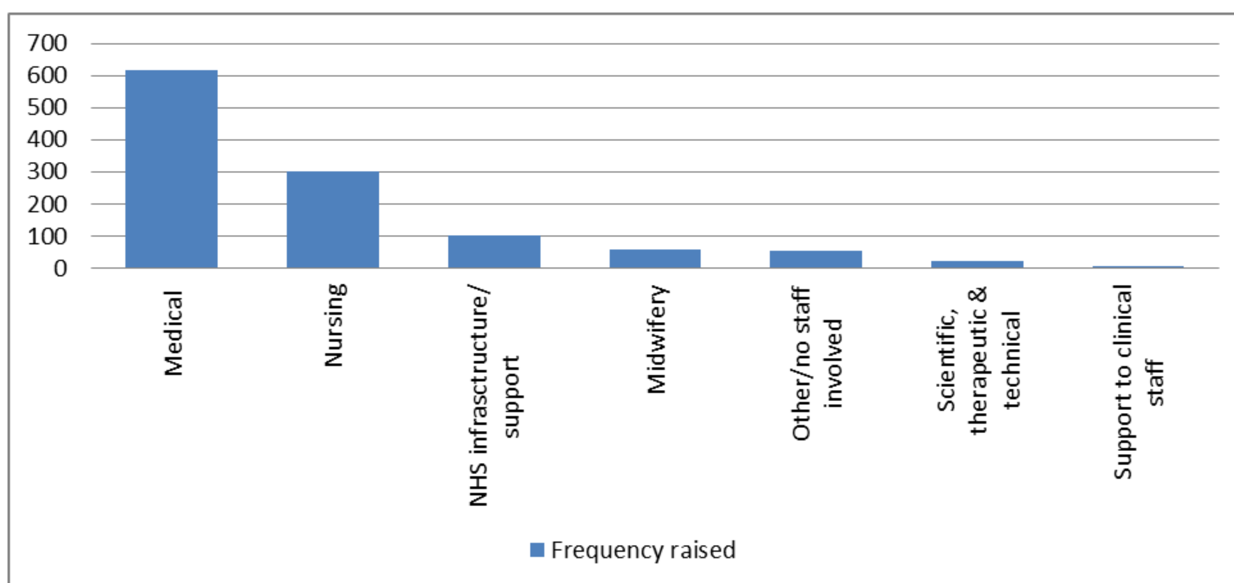


As can be seen, the most frequently raised issue is poor standard of nursing care followed by patient fall/injury.

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 2017-18 related to medical professionals (doctors of all grades and specialties).

Again, due to the significant difference in overall numbers of complaints between 2017-18 and 2016-17, 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:

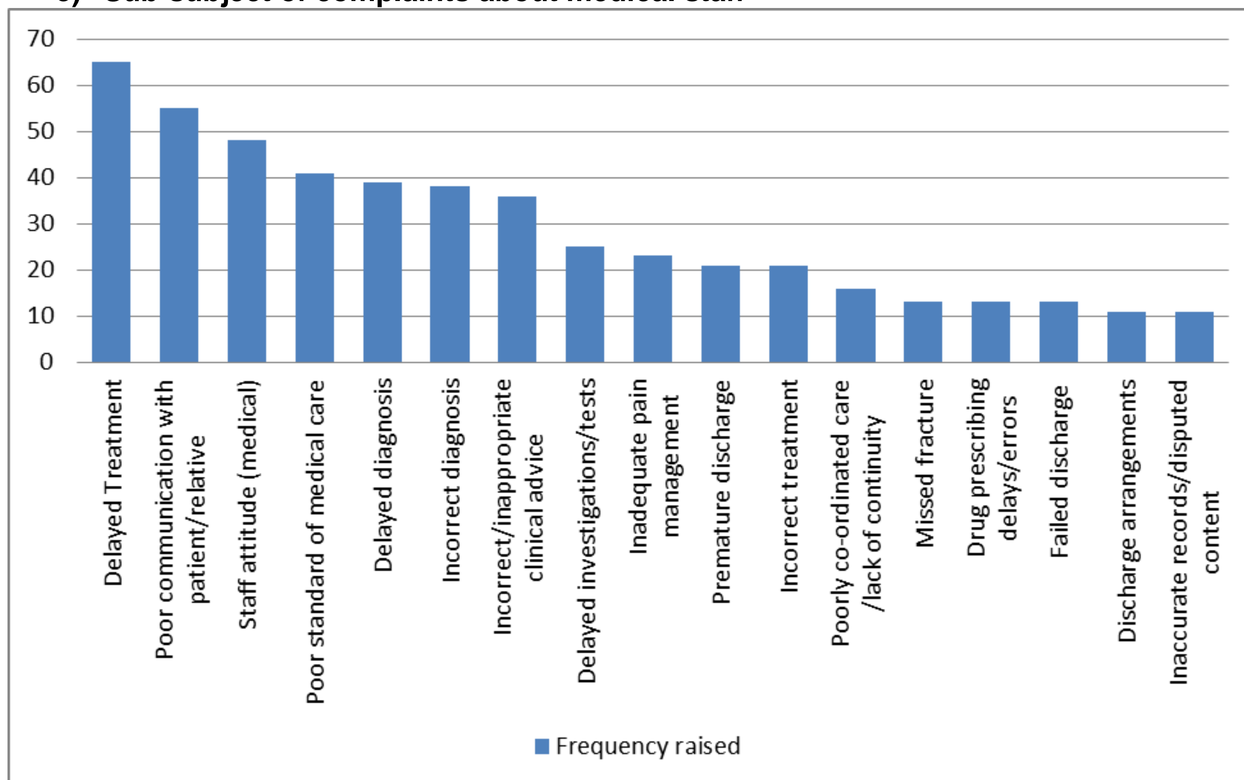
Staff group	% of all subjects raised 2017-18*	% of all subjects raised 2016-17*
Medical	↓ 53	↓60
Nursing	↑ 26	↑24
NHS Infrastructure support	↑ 9	↓ 4
Other/no staff involved	→ 5	↑ 5
Midwifery	↑ 5	3
Scientific, therapeutic & technical	↓ 2	↑ 4
Support to clinical staff	→ 0	0

*rounded to the nearest whole percent; arrows show changes from previous year.

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, although, as a proportion, this shows the greatest reduction. Looking at these in more detail, complaints about doctors is broken down in the following graph (5e).

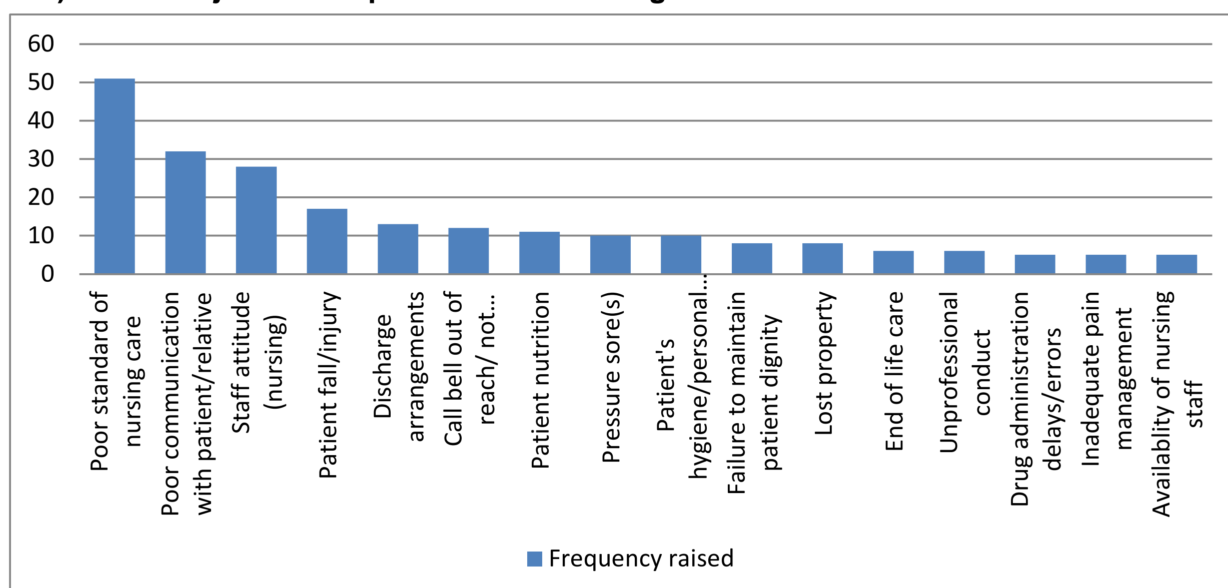
e) Sub-subject of complaints about medical staff



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 Deputy 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 nursing care. However, as compared to last year, there has been a signinficant rise in the number of complaints received about poor communication from nursing staff.

Extract from a complaint:

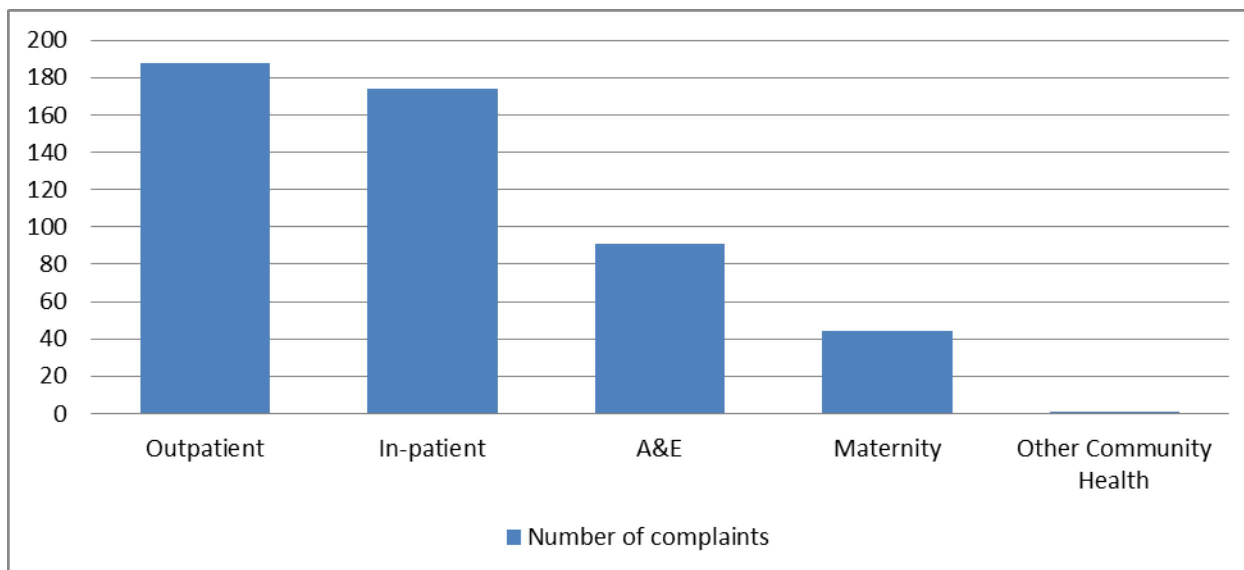
'The level of care was awful as my mum is non weight bearing due to her fractured leg and needed help with everything and trying to get to the toilet was a real issue. When she pressed the buzzer to go to the toilet the nurses did not come quick enough therefore she wet herself and also pooed herself and was left sitting in it for sometime. I am sorry to say but this is not acceptable. The doctors opinion was that my mother should be non weight bearing for 3 to 6 weeks to allow the fracture to heal but she kept being made to put weight on it by some members of staff and her stool was taken away and so she had to sit with her leg bent which was uncomfortable……..I spoke to the Dr in charge. I told him that she felt isolated and lonely. No one spoke to her during the day to check on her or help her. This clearly didn't help her as she suffers with dementia. After speaking to the Dr the communication got better and my mum felt better in herself.'

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.

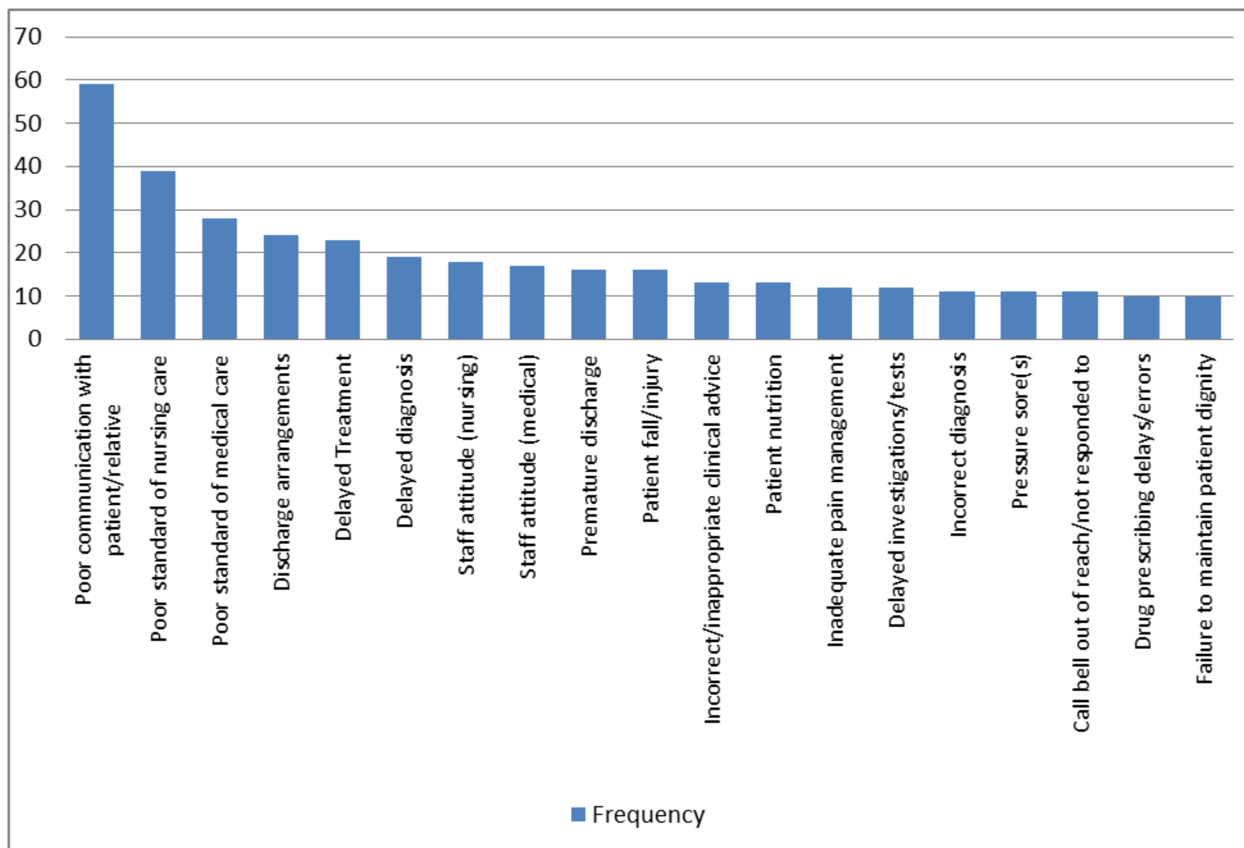
g) Complaints by service area



This demonstrates a shift when compared to the previous reporting period, as the Trust received a higher number of complaints about outpatient servces than inpatient services. This is likely to be attributable to challenges arsing from the implementation of Allscripts in October 2017 and issues relating to the telephone service provided by the Clinical Administration Units. Nonetheless, the number of concerns raised about inpatient and outpatient episodes are comparable. This is

significant in that the Trust recorded 105,942 admissions and 511,127 outpatient episodes in 2017-18, reflecting a higher proportion of complaints arising from inpatient services.

h) Subjects raised in inpatient complaints



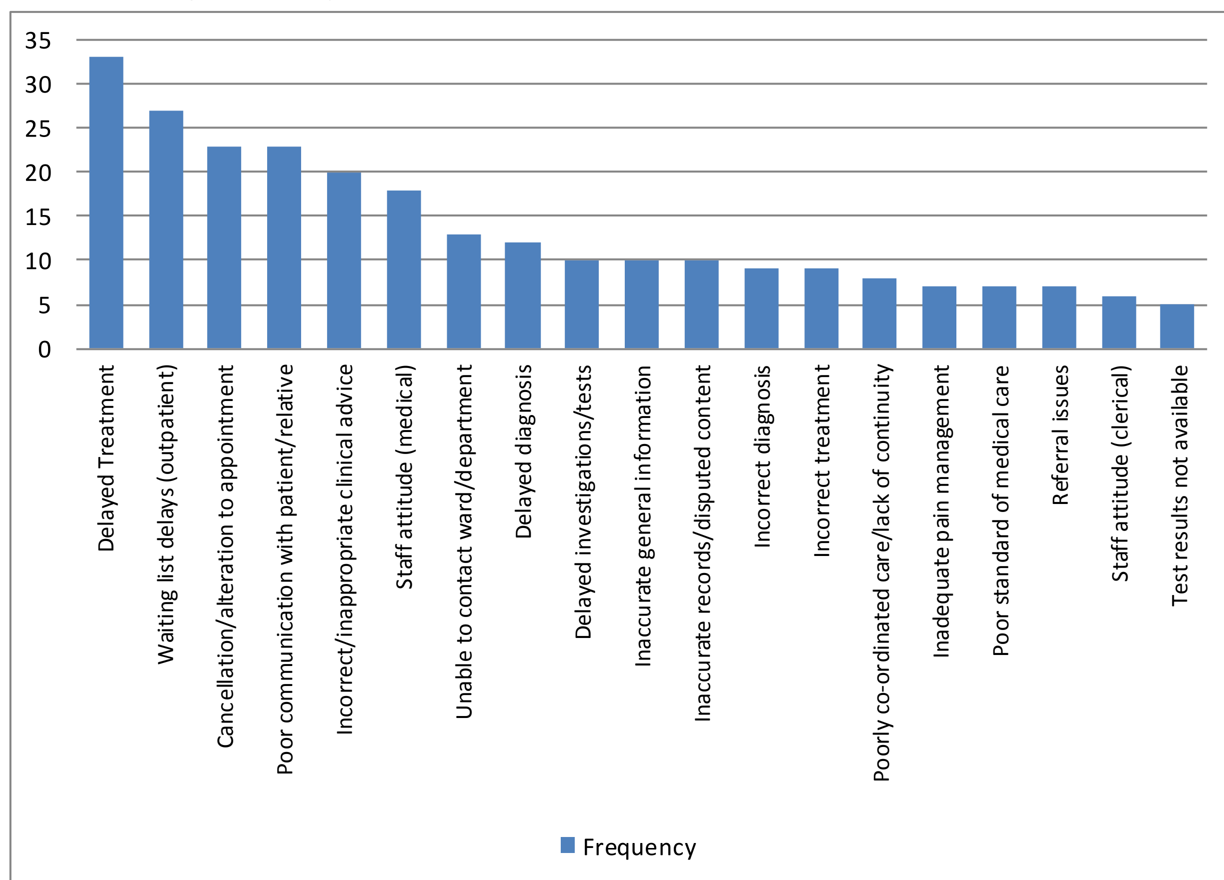
The graph above (5h) identifies those issues with 10 or more incidences reported during 2017-18. This highlights that poor communication was the most frequently raised issue in complaints about inpatient care.

Patient story

Carol attended the hospital for a planned procedure. At 7.45am, she booked in, was informed that she was the second patient on the theatre list and was directed to the waiting room. Carol was then left alone in the waiting room until 11.45am, when a nurse walked by and Carol asked her what was happening. The nurse returned five minutes later and advised Carol that there was a room available for her. Carol was shown to the room, but was then left alone until 1.45pm. At that time, Carol was taken down to theatres, but on arriving there a member of staff came out and advised that the theatre would not be free for another hour. Carol was taken to Recovery and left there until 3.00pm.

After investigation, apologies were offered that Carol had not been kept informed of progress during her wait for the procedure that morning. Assurance was offered that changes had been made so that now, elective patients are asked to report to the Short Stay Surgery Unit, where there is a dedicated admissions nurse to oversee patients arriving for surgery and who can keep them informed.

i) Primary sub-subjects raised in outpatient complaints



This graph highlights those issues with 5 or more incidences reported during 2017-18. Of note is the number of outpatient complaints about delayed treatment and outpatient waiting list delays.

Patient story

In April 2016, Mary had a left ureteric stent fitted and was advised that she would be seen in clinic in 2 months' time. She underwent a renogram in May 2016, but was not seen again in clinic until January 2017. At that time, the consultant expressed concern and surprise that the stent was still in place and suggested that this was causing Mary's persistent bladder symptoms. Arrangements were made for Mary to be admitted the following week to have the stent removed.

Investigation of the complaint showed that Mary had been offered an outpatient appointment for June 2016, in line with the plan, however, she had cancelled the appointment, which was rebooked for July 2016. Unfortunately, Mary then cancelled this appointment as well. Trust policy is to discharge a patient back to their GP if they cancel two consecutive appointments, but in the case, as it was recognised that Mary needed to be reviewed, a third appointment was made for August 2016. Regrettably, Mary also cancelled this appointment.

Given the repeated cancellations, a member of the booking team tried to telephone Mary to explain that she would now be discharged back to her GP, but they were unable to contact Mary, so a letter was sent to her and her GP advising them of this. The consultant received a new referral from Mary's GP in November 2016 and an appointment was made for January 2017. Although the stent was never intended to be in place for this length of time, staff had tried to progress Mary's treatment in a timely manner. While stents can cause irritability, it was not possible to say with certainty that it was the stent causing Mary's ongoing symptoms.

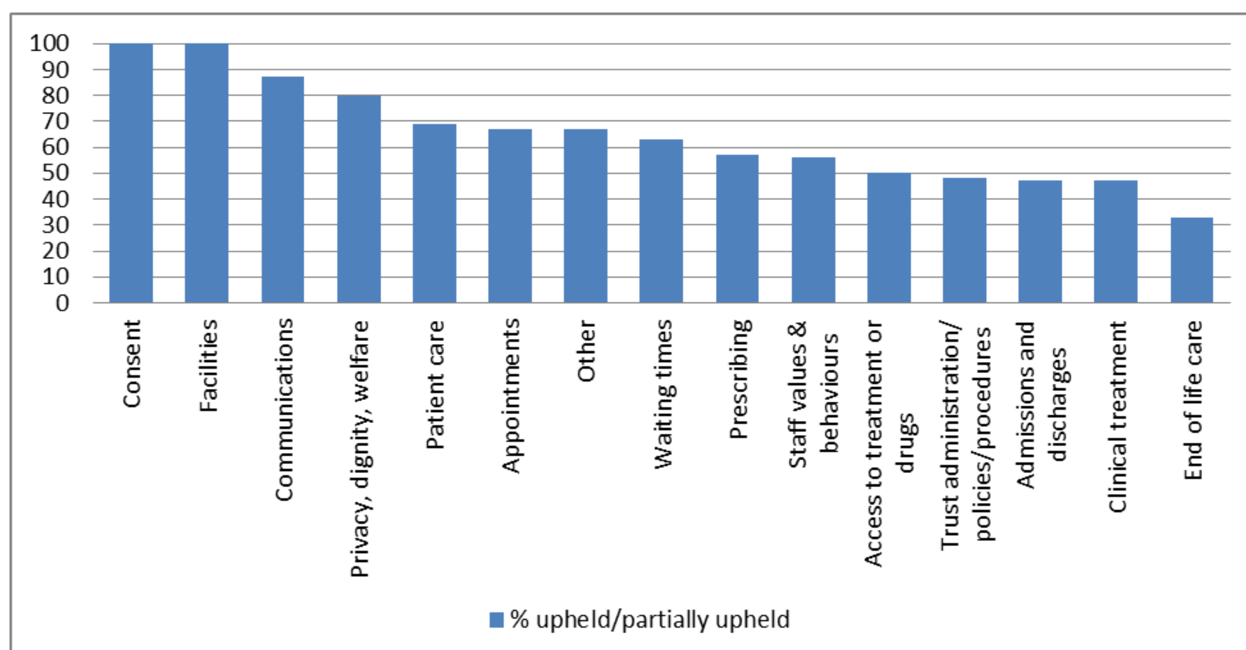
7. Upheld complaints

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. A summary of all the outcomes for all complaints closed in this reporting period can be found at appendix A.

The Trust is asked to report on the overall outcome of complaints as part of the data return to NHS Digital. 215 complaints were reported as upheld or partially upheld, an increase from 2016-17 (148). The Trust offered financial remedy in 2 cases, totalling £47.27.

The following graph (7j) shows the outcome of each upheld or partially upheld complaint as a percentage of the number of whole complaints received, based on the primary (i.e. the main) subject raised in the complaint.

j) Percentage of complaints upheld or partially upheld by primary subject



Although 100% of complaints primarily about consent and facilties were upheld, it is important to note that only 1 complaint about consent and 2 complaints about facilites were received. The consent complaint related to a DNACPR decision which, whilst made in the patient's best interests, was not communicated to the patient or next of kin, in line with Trust policy. The first complaint relating to facilities was around the inappropriateness of the single room environment for a patient with a long term mental health condition and that the environment caused a deterioration in her health. The second related to a problem with toilets being out of order in the oncology centre.

Comparing the data above with that from the previous year, there has been a marked increase in the percentage of complaints upheld or partially upheld about communications (57% 2016-17 compared to 87% 2017-18). Other areas showing an increase in the percentage of upheld/partially upheld complaints are privacy, dignity and welfare and patient care.

However, it is encouraging to note a decrease in the percentage of upheld/partially upheld complaints about end of life care. For 2016-17, although the number of complaints responded to

was small, 67% of complaints about end of life care were upheld or partially upheld. That has dropped to 33% for 2017-18.

The percentage of upheld/partially upheld complaints about staff values and behaviours has also shown a reduction, from 71% (2016-17) to 56% (2017-18) on a background of an increase in the number of complaints responded to. Likewise, the data also suggests an improvement in the area of admissions and discharges as the percentage of upheld/partially upheld complaints has reduced from 59% (2016-17) to 47% (2017-18).

The lower proportion of upheld or partially upheld complaints about clinical treatment is influenced by the large number of complaints received. The Trust responded to 212 complaints about clinical treatment, of which 99 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. A monthly summary of key Trustwide learning from complaints is presented to the Trust's Clinical Governance Committee, with a quarterly report to the Patient Experience Committee including specific examples of actions taken as a result of complaints. A report is also provided twice a year to the Quality Committee. 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 actions have been recorded and allocated to a handler, 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 2017-18 can be found at Appendix A.

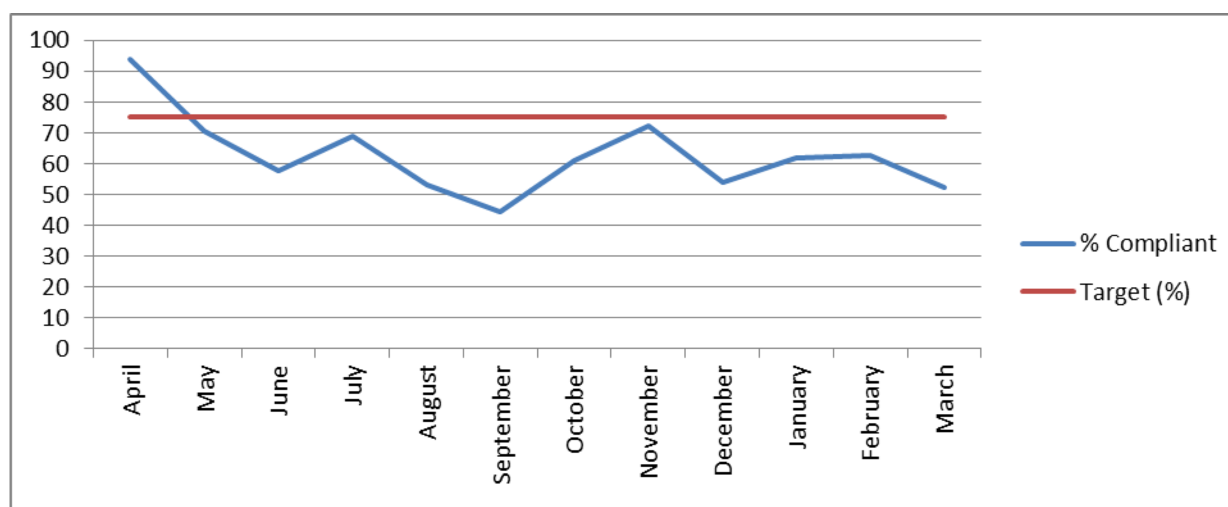
Some highlights include:

- Training delivered to junior ED doctors on 'first fit' presentations
- Changes made to processes for women attending the hysteroscopy clinic to ensure they understand the procedure they are attending for and to improve the recording of consent
- Process for identifying women to be called for breast screening strengthed to ensure that GP practices are aware of the importance of validating the lists
- Changes made to patient pathway so that patients with a known history of lung cancer who are under the Trust's care for surveillance will have imaging discussed in the radiology chest meeting.
- Development of a flow chart for ED staff around the paediatric pathway, paediatric triage training and paediatric sepsis training provided to ED staff.
- Complaint discussed at cardiac network (externally)
- Training delivered to ENPs on management of DVT and calf injuries
- SOP developed for the management of third party claims

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 60.2% compliance for the year (69% 2016-17). Monthly compliance is shown in graph 10k.

k) Performance compliance 2017-18



As the above shows, following a strong start, performance showed a declining trend throughout the year. This was the result of a combination of factors including an ongoing Complaints Lead vacancy until mid-August, a sustained rise in the number of new complaints received and conitnuing high levels of clinical activity, which impacts on the capacity of directorate satff to deal with complaints. Performance in all areas was escalated to and closely monitored by the Chief Nurse and recovery plans were requested from the directorates concerned. 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	80	83.3	28.6	60	53.8	66.7	90.9	66.7	57.1	75	62.5	57.1
Specialist Medicine	100	100	100	83.3	66.7	50	75	100	70	75	60	70
Cancer, Haematology & Radiology	N/A	100	50	80	50	50	100	0	66.7	100	N/A	50
Corporate Services	N/A	N/A	N/A	N/A	N/A	N/A	0	100	100	100	100	N/A
Critical Care	N/A	50	100	50	0	100	0	100	100	100	N/A	100
Pharmacy & Pathology	N/A	N/A	N/A	0	33.3	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Paediatrics	N/A	66.7	50	N/A	66.7	0	0	33.3	0	N/A	100	0
Surgery	100	66.7	50	83.3	54.5	50	33.3	66.7	33.3	16.7	71.4	37.5
Trauma & Orthopaedics	100	0	100	33.3	50	0	50	0	33.3	66.7	25	50
Womens' Services	100	N/A	20	100	62.5	0	55.6	63.6	N/A	66.7	50	0
Head & Neck	100	0	75	100	40	33.3	100	100	0	25	40	75
Sexual Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100
Trust overall	**93.8**	**70.4**	**57.6**	**68.8**	**53.2**	**44.4**	**61.0**	**72.3**	**53.8**	**61.8**	**59.5**	**52.1**
Private Patients	N/A	N/A	N/A	100	N/A	100	N/A	N/A	N/A	N/A	N/A	N/A

10. Satisfaction survey

Extract from a complainant's email:

'Following our meeting on Wednesday 11th October 2017 I will begin by expressing that I felt our concerns over the nursing care of our Mother ……… whilst a patient with you, were accurately listened to and we were shown sincere empathy. '

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 2017 and March 2018, an approximate response rate of 8%, a slight reduction on the previous year. Key feedback from the survey is as follows:

- 76% of respondents found it easy or quite easy to make their complaint. However, comments offered by the other 24% of respondents did not relate directly to actual difficulties in making a complaint.
- The main sources of information on how to complain were PALS (38%) and the Trust website (35%). None of the respondents had indicated that they could not find any information on how to complain
- 50% of respondents felt that they were kept adequately informed of the progress of the investigation
- 53% of respondents **had not** been contacted by anyone investigating their complaint
- 78% of respondents found the response to their complaint easy to understand. Comments provided by the remainig 22% suggest that respondents felt that some issues of their complaint had not been addressed or that the they disagreed with the response.
- 55% of respondents **did not** feel that the response to their complaint had addressed all their concerns.
- 38% of respondents felt that their complaint had been fully or partly resolved. 27% of respondents did not feel that their complaint had been resolved and were planning to contact the Trust again. 19% of respondents did not feel that their complaint had been resolved and were planning to contact the Parliamentary and Health Service Ombudsman.
- 41% of respondents felt that their complaint had made a difference. Negative comments suggested that respondents felt unable to comment on this as they had no means of measuring the impact.
- 29% of respondents scored the Trust 4 or 5 (5=excellent) for their overall experience of the Trust's handling of their complaint. 28% of respondents scored the Trust 1 (poor). Comments suggested the need for improved communication and updates during the investigation period and quicker response times. However, many comments revisited the substance of the complaint itself, which is less helpful in assessing the complaints service.

Considering the feedback provided, despite staffing challenges in the complaints team, we have maintained satsifaction rates around keeping people updated, although this has substantial room for improvement. This has been recognised a communication with complainants is monitored via our local KPI's. 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 and it is encoouraging to note an improvement in this area. 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.

Areas showing improvement (when compared to the previous year) included results around whether the response to the complaint had addressed the concerns and whether the response had resolved the complaint.

11. Patient representative review of complaints

In line with previous reports, an invitation was extended to members of the Patient Experience Committee, to undertake a review of a selection of complaints managed during 2017-18. This offer was taken up by three patient representatives. The reviewers were given an anonymous list of all the complaints received, from which they were able to select cases for review.

Feedback from the reviewers fell into two parts: the management of complaints and more general comments about the issues raised in the complaints they reviewed. With regards to the management of complaints, in the main, the comments made were positive. One reviewer commented that the complaints team were 'working hard and well in the patients' interest' and that they had seen 'a big improvement in the [response] times, over previous years'. With regards to the process, the reviewers noted that there were some delays in directorates providing comments to the complaints team and that the quality of the comments provided were not always of the appropriate standard. The root cause analysis process followed for the most serious complaints was commended. The reviewers felt that in general, the responses provided to complainants were kind and informative, with appropriate apologies. One reviewer commented that 'the final replies are generally much more comprehensive,' but it was noted by another that a few had been 'a bit cold'.

An area of concern noted by the reviewers was the difficulty in providing assurance that changes had been made following a complaint investigation. This is an area that the patient representatives are keen to support and this is being explored further with the Deputy Chief Nurse.

In respect of the subjects raised in complaints, the reviewers highlighted the issue of communication and one suggested that there needed to be a systematic process at the end of each consultation to allow the patient and practitioner to agree on what had been said and done, whilst another commented on the importance of being honest with patients about the situation. One reviewer raised concern that there appeared to be a reluctance on the part of staff to apologise. The reviewers also noted that some of the issues raised particularly around wards and nursing care were reflected in the PLACE and internal assurance inspections.

The Trust would like to extend its thanks to the patient representatives for their support in undertaking this review.

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

Extract from a Parliamentary and Health Service Ombudsman report:

'Our adviser also said that overall the management and care of Mr B by the stroke unit was excellent and in line with NICE guidance.'

During 2017-18, 9 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	5	0

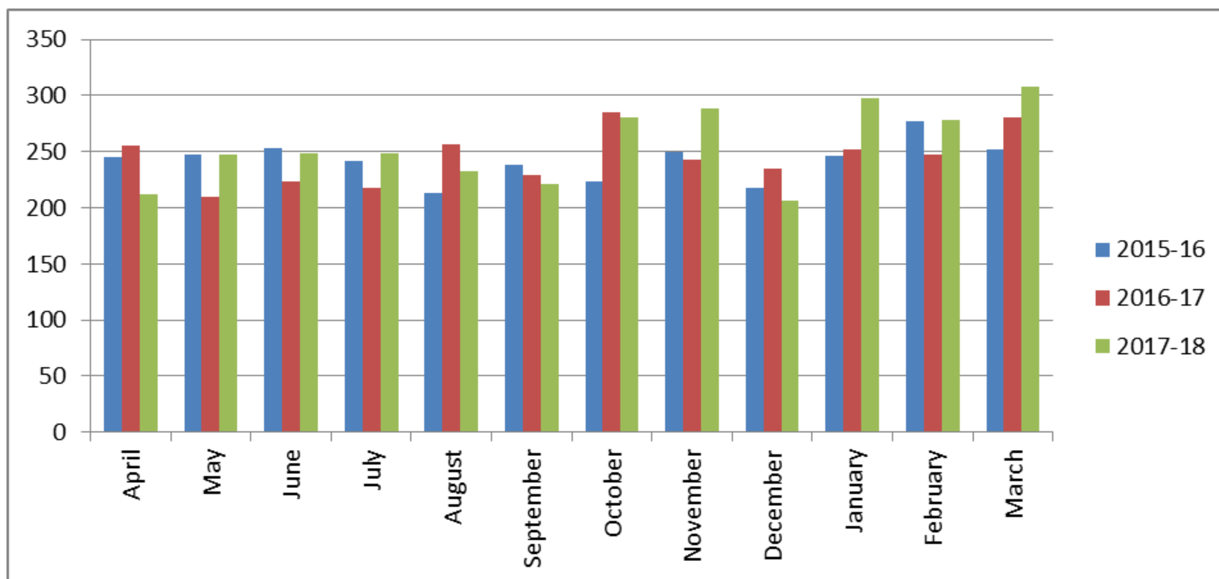
For every case upheld or partially upheld by the PHSO, the Trust has accepted their recommendations and provided evidence to the Ombudsman of our compliance with their recommendations. Financial redress was recommended by the PHSO in two cases, at a total of £500.00. It is encouraging to note that the PHSO have not upheld any complaints against the Trust.

13. PALS contacts

For the year 2016-17, the Trust received 4906 PALS contacts an decrease of 352 on the previous year (5258 received 2016-17). The PALS receives different types of contacts for different

purposes including: general enquiries, concerns and compliments (including NHS Choices feedback). Focusing specifically on the concerns raised, the activity levels can be seen in chart

I) PALS concerns received by month



Although the overall number of contacts made to PALS has reduced as compared to last year, the data above illustrates that the volume of case work is actually increasing. 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.

Extract from a relative's email to PALS:

'I just wanted to thank you for handling my complaint. You did it in a compassionate and timely manner, which is much appreciated. I'm sure you are aware that I have spoken to [Matron] and the staff nurse present when my father died. Both conversations were extremely helpful and have enabled me to move on and now focus on my grief. Thank you again for your attention.'

14. 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.

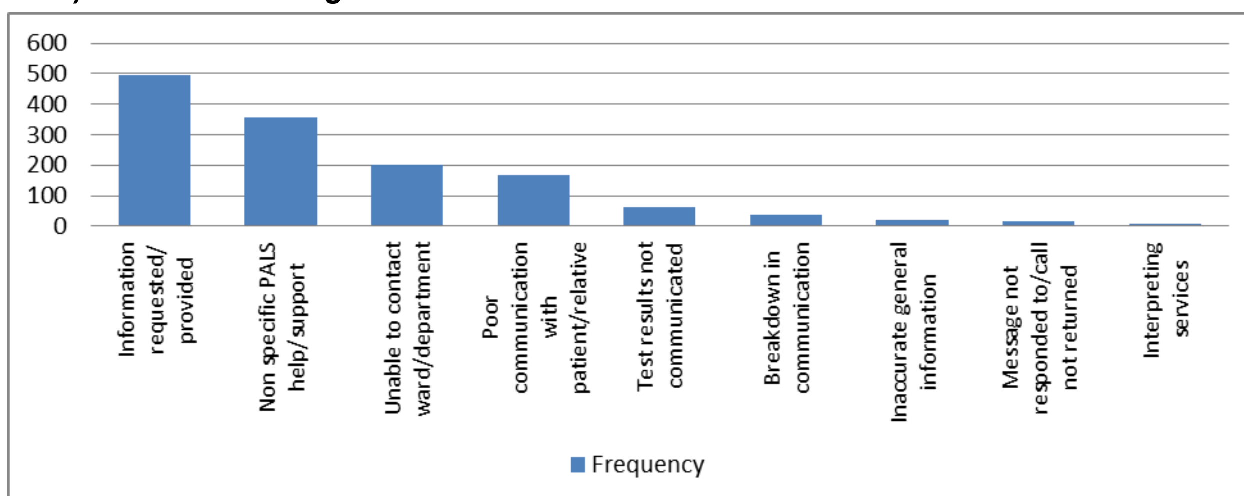
m) Subjects raised in PALS contacts

Subject	Frequency
Communications	1842
Trust administration/policies/procedures	471
Clinical treatment	366
Waiting times	354
Staff values & behaviours	258
Appointments	182
Facilities	139
Other	136
Admissions and discharges	123
Patient care	81
Privacy, dignity, welfare	78
Access to treatment or drugs	65
Staff numbers	24
Prescribing	19
Consent	6
Transport	6
Commissioning	4
End of life care	3
Restraint	1

Graph 14m shows the frequency of PALS concerns by subject. This clearly illustrates that the main subject raised with PALS relates to communications. The number of issues raised relating to this subject has significantly increased by 601 on the previous year. This is followed by problems relating to Trust administration and clinical treatment.

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 14n.

n) Contacts relating to communication



As outlined earlier, this shows that the highest use of PALS in relation to communication (495 contacts) is where information has been requested, which the PALS team would normally be able to respond to independently. However, it is significant that they have recorded 201 contacts from people where the main issue related to them being unable to contact a ward of department. This is a marked increase on the year before (76).

Extract from a patient's email to PALS:

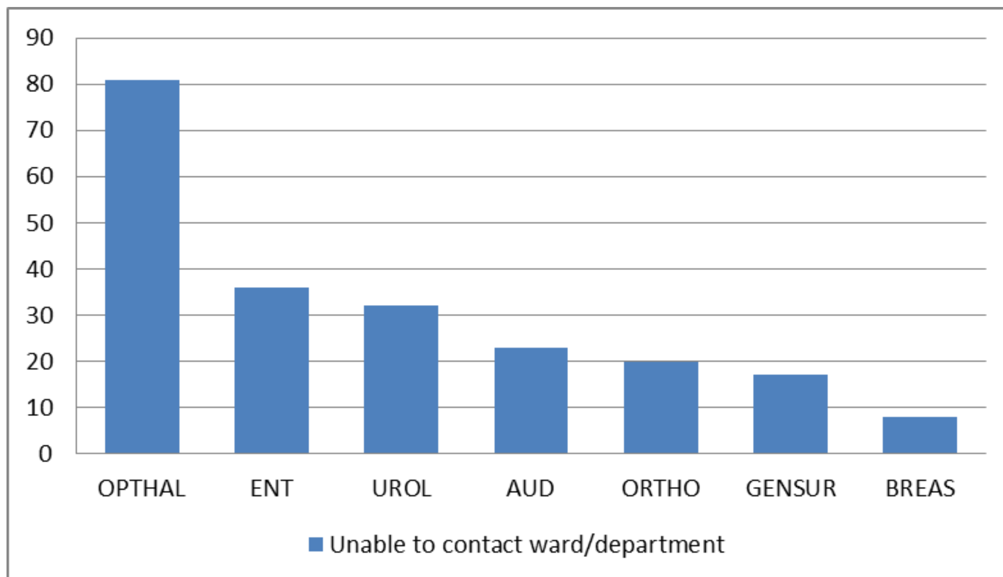
'Last Monday 15/01, I was left a message on my answer phone asking for me to telephone 01622 2282XX to make an appointment with Alison. I have tried to do this twice daily, some 14 calls and each time I was put in a queue. This ranged from position 6 to 10. One time after 30 mins in a slowly reducing queue, I actually got down to 2, but alas it seemed to get stuck on 2 and I nearly lost my will to live!!. However I persevered this afternoon determined not to let any wasted time annoy me. I settled down, phone on loudspeaker, newspaper to read, determined I would do whatever it took to speak to someone.

And so it began, 4.56pm, call made - position no.6, I have time to make a cup of tea, I could have eaten a 4 course meal before it got to position no.2. Nearly there I thought, won't be long now, put the kettle on again and then - I was CUT OFF!!!!!. What happened. What about the patients in no. 2 &1?. I rang straight back and the very polite answer phone lady said "The office is closed, opening times are from - 8.00am until 6.00pm". The time was 5.31pm !!!!!!!!!!!. Forget the tea, large brandy needed.

I did try to leave a call back no. but that too did not work after several attempts. I wonder if I drove to your hospital, would I be able to speak to Alison?, I somehow think not.

I fully realise and I can see the issues there are in all NHS hospitals on the news but joking apart, your outpatients booking system is not fit for purpose'

o) Concerns raised about inability to contact wards/departments



Examining all issues raised about inability to contact wards/departments, we can see that the majority relate to planned care services, predominantly Head and Neck. This is illustrated in graph 14o which shows all services where 5 or more concerns were raised. This issue has

remained under close review by the Chief Nurse, who has received regular reports on the number of concerns being raised about problems with people being unable to contact the Clinical Administration Units.

15. Innovations

Unfortunately, due to ongoing staffing challenges during the year, progress with innovations has been limited. However, a key improvement has been in utilising the Datix risk management database to capture actions arising from complaint investigations. This database offers much improved reporting and monitoring functions. This was launched in complaints in December 2017 and whilst there is still work to do to maximise its effectiveness, it has moved the Trust considerably forwards in now having easier oversight of all actions and being able to identify those which remain open.

In January 2018, work began on providing a regular summary of learning and outcomes from complaints. This was prompted from feedback from a Listening Into Action (LIA) pulse check in 2017. So far, this has been made available on the intranet for staff, but this will be extended to the public website, once a sustainable programme has been established. This summary document is also being used to identify themes which cause complaints to help the Trust identify target areas to address over the coming years.

During the year, the complaints team enhanced the process of recording outcome codes when complaints are responded to. Now, instead of just having one overall outcome code per complaint, we are recording outcomes against each specific element of the complaint. This will allow for improved reporting from April 2018 onwards.

A new system telephone system was implemented 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 are also able to transfer their call to switchboard if they are simply calling to contact a ward or department.

In March 2018, the PALS office at Maidstone was temporarily relocated whilst building work is carried out. A new office is being built in a similar location, which will open to the public Summer 2018.

16. Summary and conclusions

Overall, the year has been a challenging one. The Trust has seen a healthy rise in the number of formal complaints due to improved triaging, however, given this, the staffing gaps in complaints and sustained operational pressures, the Trust struggled to achieve the performance target.

Although 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 area falls within the remit of the Best Care Programme, which will provide an excellent driver to move this forwards. In the interim, this continues to pose the greatest present challenge to the Trust in terms of complaints management.

17. Objectives for 2018-19

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 six-monthly to governance team leaders meeting.
Achieve 75% compliance with meeting response times Trustwide	Performance reported monthly.	Complaints & PALS Manager	Associate Director for Quality Governance; Directorate Leads	Progress will be monitored monthly as part of the Trust's Quality and Governance Dashboard	Trust target is to respond to 75% of all complaints within identified timeframe.
To achieve 50% satisfaction rate in the PALS service by the end of the year.	Reported to PEC	Complaints & PALS Manager	Associate Director for Quality Governance	Progress will be monitored by lead and reported to the Patient Experience Committee.	Reported six-monthly to governance team leaders meeting.
Achieve at least amber on PALS and complaints KPIs by the end of the year.	By March 2019. Reported to management meeting six-monthly	Complaints & PALS Manager	Associate Director for Quality Governance	Progress will be monitored via monthly management meeting	As defined.

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APPENDIX A

Learning from upheld/partly upheld complaints closed 2017-18

ID	Grade	Sub Spec	Closed	Description	Outcome
18893	HIGH	PAEDS	08/05/2017	Concerns raised that patient was prescribed too high a dose of antibiotics for age and weight. Patient suffered adverse reaction requiring reattendance to Hedgehog Ward	Apology offered. Weight misinterpreted from lbs to kgs. Pharmacy have actioned process to minimise the risk of this event occurring in the future.
18902	HIGH	ELDER	15/05/2017	Concerns raised that patient discharged with active C Diff infection still present. Patient unable to mobilise and was incontinent of faeces.	Pt was confirmed to be a CDiff carrier but was not infected. Appropriate treatment was started with antibiotics under the advice of the microbiologists and infection control team. Patient was medically fit for discharge on 1/2/17 to go home on 3/2/17. Patient did achieve baseline mobility once during admission but this was variable and probably should have been highlighted with the medical team. Apologies offered for poor communication around medical decision to discharge and the two episodes of faecal incontinence the patient had during admission. Referral to DN did not include need for catheter care. Actions identified to address these issues. Decision to discharge was appropriate.
18865	HIGH	AE	23/05/2017	Concerns raised that delayed diagnosis of ruptured AAA led to patients death .Feel that they and the history given from the GP was not considered.	Apologies offered. Investigation concluded that there were missed opportunities to diagnose the AAA and that earlier diagnosis may have led to repair, which could have prevented the patient's death. Lessons learned including: Additional training for the triage staff around the need to complete observations and escalate appropriately; The importance of appointing to nursing vacancies in the department; Reminders to the medical staff around the need to consider and rule out differential diagnoses; Review and clarification of the policy for requesting CT scans 'out of hours'; Importance of adhering to departmental guidance on referring all patients representing to the department to a senior clinician. Individual practitioners have also undertaken professional reflection with their supervisors.
18552	HIGH	PAEDS	16/06/2017	Concerns raised regarding the initial assessment and diagnosis of child's condition. Patient subsequently died.	Complaint independently reviewed. Conclusion that patient should have been reassessed before decision to discharge was made. A number of recommendations made including changes to paediatric documentation/PEWS charts, requirement for registrar to review and document prior to discharge, improvements made to patient information leaflet about ambulatory service. Individual learning taken forwards with all staff members involved. Apologies offered to family.

ID	Grade	Sub Spec	Closed	Description	Outcome
18918	HIGH	GYNAE	06/07/2017	Concerns raised that not consented for colposcopy procedure and unaware of what procedure involved. No leaflet provided with appointment letter so not prepared. Consultant did not explain procedure or detail process when undertaking colposcopy and biopsy. Patient feels consultant negligent	Apologies offered for distress caused by experience. Patient was not given sufficient information about procedure at appt beforehand and didn't get patient information leaflet. All staff present on the day confirm that consultant's practice is to explain what she's going to do during the procedure. Actions identified: administrative processes have been strengthened to ensure that all women invited to attend the hysteroscopy clinic receive a copy of the patient information leaflet with their appointment letter; the gynaecology team have been instructed to ensure that all women being referred for a hysteroscopy are given a brief explanation of the procedure and are offered an opportunity to ask any questions about it in the outpatient clinic +/- providing the information leaflet during the outpatient consultation; staff working in the hysteroscopy clinic have been instructed to check with patients on arrival that they are aware that they are attending for a procedure. Staff will check that the patient has received and read the patient information leaflet. If the patient indicates that they have not, they will be given a copy of the leaflet and asked to read it before the appointment progresses any further; the hysteroscopy staff have been asked to consider the value in obtaining feedback from patients following their procedure in order to assess the quality of the service and help identify any problems experienced at an earlier point; complaint shared with staff working in the hysteroscopy clinic and discussion has taken place around the need to be sensitive to non-verbal indicators of discomfort or distress; nursing team will ensure that they enquire as to the welfare of all women immediately post-procedure and if any concerns are expressed, women will be asked to remain in the clinic and receive support until they are fit to leave; gynaecology consultants have been asked to consider the value of a consent form for hysteroscopies, to ensure there is documented evidence to confirm that the patient has been fully informed in advance of the procedure commencing. Arrangements made to transfer care to another gynaecologist.
19040	HIGH	ELDER	29/08/2017	Concerns raised by patient's wife regarding circumstances of fall following hip replacement surgery. Were all preventative measures in place? How will family be involved in incident investigation? Why haven't they had a duty of candour letter? Why hasn't the patient safety team been in contact with them?	Investigated as SI. Copy of SI report provided to complainant. Conclusion was that fall was potentially avoidable had a falls alarm mat been used. Actions identified around need to complete nursing falls assessments, training on falls prevention equipment, improving availability of falls prevention equipment, reviewing internal transfer documentation.

ID	Grade	Sub Spec	Closed	Description	Outcome
18969	HIGH	AE	12/09/2017	Concerns raised round two delays in diagnosis. Echo ordered in November 2016 - results not communicated to patient. Patient then presented to ED with chest pain. Troponin was raised in ED. Wait to see cardiologist who reviewed echo and stated this showed abnormalities. Cardiologist confirmed major heart attack had been evident on arrival at ED and patient should have been transferred to tertiary centre for treatment.	Explanations and apologies given regarding lack of medical care. . Following Investigation a number of areas where improvements are required have been identified, including: - Improving the quality of documentation completed in the ED - Further education for staff who reviewed the 4.50am ECG - Education around the importance of reviewing all available ECGs and the use of serial ECGs - Review and standardisation of storage of ECGs in patient records - Education around the importance of prompt prescription of medications - Promoting the importance of staff reporting patient safety incidents as they occur - Review of the roles and responsibilities of the cardiology consultant of the week to ensure capacity for ward reviews The complaint is also being discussed anonymously but in its entirety at the medical clinical governance meetings to ensure that learning from the complaint is shared across the wider team. Doctor has also asked for this case to be discussed by the cardiac network, which includes Trusts other than our own, to highlight the learning in a wider context.
18977	HIGH	AE	13/09/2017	Concerns raised that decision to discharge patient home from ED with treatment for pneumonia was incorrect. Later that evening patient from a sudden cardiac event.	Explanations and apologies given that patient did not receive care in line with the Trust's Sepsis Policy and Procedure, which was clinically indicated in this case. Investigation has highlighted areas for learning, including further education and raising awareness of staff of the Sepsis Policy. A clear pathway is also required for patients brought in by ambulance who have had a positive sepsis screen pre-hospital.
19062	HIGH	AE	15/09/2017	Concerns raised that patient was insufficiently assessed in ED and discharged with a viral infection. Patient referred to paediatricians by Gp later that day and admitted with a diagnosis of meningitis.	Explanation of care and treatment given along with apologies. Actions taken following the complaints are: - Development of a flow chart for ED staff around the paediatric pathway, with input from the consultant paediatricians - Paediatric triage training to be provided for ED nurses - Training on paediatric sepsis to be provided to ED staff

ID	Grade	Sub Spec	Closed	Description	Outcome
18888	HIGH	ENDO	06/10/2017	Allegations that injuries sustained during endoscopy procedure (bruising, burst blood vessels and blood shot eye). Claims that despite asking for procedure to be stopped, it was not. Patient felt they were suffocating as she was choking so much. Said nurse was holding her face causing bruising.	Explanation provided to endoscopy procedure and assurance offered that nothing untoward occurred during the procedure. However it was identified that some work needs to be completed around ensuring patients are fully informed of what to expect whilst undergoing the procedure.
19090	HIGH	PAEDS	16/10/2017	Concerns raised that umbilical wound was over cauterised using a high dose of silver nitrate causing burns to skin. Despite parents requests, the doctor involved continue to come and see them and the patient following patient's admission to treat the burns.	Investigation concluded the the incorrect strength of silver nitrate sticks used and also the incorrect technique. Silver nitrate sticks have been removed from the paediatric wards and different technique now being used for this problem. Measure in place within pharmacy to flag up the strength of these silver nitrate sticks and that they are not suitable for use on children. Department to look at how they manage requests from parents when they ask for certain staff not to be involved in caring for the patient.
19138	HIGH	RESPIR	02/11/2017	Multiple concerns raised regarding standards of nursing care, including outcome of KASAF investigation. Issues relating to pressure damage, mouth care, management of hypoglycaemia, lack of hydration whilst on high pressure oxygen, other elements of skin care, withdrawal and reinstatement of active treatment.	Clarification offered around learning taken from KASAF investigation including MCA assessment process, use of an individualised care plan for the dying patient and mouthcare. Discussions took place with the family around withdrawal of treatment, which occurred when patient deteriorated and was felt unlikely to survive. Patient had one episode of hypoglycaemia which was treated appropriately. There is evidence to show that patient's pressure areas were being assessed and managed regularly by staff. Patient's hydration levels were monitored daily and suggested good renal function.
19159	HIGH	AE	09/11/2017	Concerns raised that presenting symptom of seizures was attributed to the alcohol consumed at a family event the day before. Patient since diagnosed with a brain tumour. Pt also unhappy with lack of treatment provided by OOH GP for infected finger.	Apologies and explanations provided. Root cause analysis investigation carried out and clinical lead has discussed this case with the doctor involved who has learned from these events and will include this in her appraisal this year. Clinical Lead has also spoken at length to the middle grade doctors regarding their misjudgment and feedback has been provided to them. Training to doctors on the management of "first fit" presentations will also be delivered.
19126	HIGH	BREAS	17/11/2017	Patient underwent breast surgery in 2015. In 2016 at one year mammogram check, a marker was found on an area which had not been removed in 2015. Patient has undergone further surgery and developed an infection. Wants to know how this could have been missed.	Investigation revealed that marker should have been picked up prior to routine mammogram. Radiologists now have time allocated to prepare cases for MDM discussion. Treatment planning appointments lengthened. New pre-operative checklist designed and content being agreed with specialty staff.
19201	HIGH	STROKE	09/01/2018	Concerns raised regarding conduct of nurse and "rough handling" of patient. Nurse washed patient's face while she was sat on the toilet. Tried to insist patient walked without using non-slip socks despite concerns raised by patient. Patient was left unattended in toilet and had a fall. Nurse responded defensively when family raised concerns.	Explanation provided that investigation carried out in to rough handling of patient found no evidence to support the allegation. Apologies given and explanation provided that Associate Director of Nursing had met with a number of nursing staff on the unit and feedback to them how their attitudes had impacted on the patient and her daughter.
19214	HIGH	AE	16/01/2018	Concerns that blood sample taken for testing showed clotting issues when child had been bleeding consistently for 15 hours with a head injury. Family concerned that these results were not acted upon. Child was later found to have severe haemophilia type B.	Apologies given that there were missed opportunities to make an earlier diagnosis. Action plan has been developed which focus on the need for compliance with Trust policies and procedures and reviewing the current processes for escalating abnormal test results. This case will also be presented at the ED and paediatric clinical governance meetings to highlight the importance of reviewing all test results.

ID	Grade	Sub Spec	Closed	Description	Outcome
18962	HIGH	ORTHO	24/01/2018	Concerns raised about standards of nursing care. Allegations of rough handling by staff. Poor management of continence/dignity. Inappropriate transfer to MFFD ward. Poor communication from ward staff with family over challenging behaviour from patient. Unhappy with how concerns were dealt with by staff at the time.	Apologies offered for rough handling, although investigation concluded that recognised manual handling techniques were used. Explanation provided around continence and dignity issues. Apology for poor communication on the ward. Transfer to MFFD ward was appropriate. Apology offered that concerns on the ward were not escalated to the Matron at the time and ward staff have been reminded of this requirement. Actions as per RCA report.
19222	HIGH	GENSUR	19/03/2018	Following appendectomy, felt unwell and returned to hospital and further operation for abscess and sepsis. Following surgery activac put in place and wound packed with dressings. Several days later when the district nurse was changing the dressing, they found old packing in the wound which activac had drawn to the surface. District nurses confirmed that they do not use the type of dressings found in the wound.	RCA investigation concludes that no swabs or dressings were retained following first procedure. However there is inconclusive evidence to support that all packing ws removed during dressing changes following second surgery. Actions as per SI action plan.
19096	HIGH	GYNAE	11/04/2018	Concerns raised that surgeon inserted a coil without removing existing one. This has come to light as coil now needs replacing, and appears that two are present.	Process in theatres not robust in detailing what, if anything was removed during a procedure. Documentation says coil changed but does not clearly state that a coil was removed. Directorate to consider SOP for when products/devices are removed and/or replaced during surgery to ensure the required action has been taken. Reminder to staff of the need to be explicit when documenting operative events, to indicate exactly what has been remove and replaced.
19003	HIGH	AE	25/05/2018	Concerns raised regarding a lack of treatment provided following admission to hospital. No efforts made to drain fluid build-up, not clear why patient had to be isolated and that delay in treatment resulted in patient's death.	Explanation provided that the initial treatment plan was agreed with the renal team at GSTT and followed appropriately. However, there was a delay in further action being taken once the diuretic infusion had completed and it was identified that patient's condition had not improved. Advised that we cannot know with any certainty how earlier action at this stage might have influenced the outcome and apologies offered. Explanation given that decision to place patient in a side room on admission was correct and based on the fact that he had had a previous admission to GSTT. Explanation provided that patients who have recently been an inpatient at a London hospital have an increased risk of CRE.
18876	MOD	PAEDS	03/04/2017	Concerns raised that report written by consultant paediatrician was inaccurate (and later proved to be so in court) but that this report resulted in social services initiating proceedings to remove the child involved from his parents. Concerns also raised regarding environment on paediatric ward, standards of care and poor communication with parents.	Explanation of action taken by consultant. Assurance that consultant met his professional and legal obligations in referring the unexplained injury to Children's Services. Action taken in response to referral was outside the control of the Trust. Bed linen and drinks provided for parents staying with children. Documented that staff did communicate with family about what was happening. Staff reminded to ensure that sterilising water is changed regularly.
18915	MOD	AE	04/04/2017	GP lead. Concerns raised around decision taken by triage nurse to refer patient to GP stream for assessment.	Triage nurse apologises for choice of language when discussing the most appropriate service to assess the patient - being addressed by matron. Consultant has reviewed nurse's clinical decision making and agrees referral to GP stream was clinically appropriate at the time.

ID	Grade	Sub Spec	Closed	Description	Outcome
18909	MOD	RESPIR	05/04/2017	Concerns raised re lack of discussion with patient and family around DNACPR decision. Delays in call bells being responded to resulted in patient experiencing some episodes of incontinence. Concerns about levels of nursing staff. Poor shower facilities. Concerns around chaotic discharge process.	Apologies for breakdown in communication between medical teams around DNACPR form. DNACPR is a medical decision but should be discussed with pt/NOK and countersigned by senior clinician. Issue highlighted with both medical team. Form is being removed from the records. Confirmation provided of staffing levels on the ward. No target time for responding to call bells but feedback from patients in Feb 2017 scored the ward 100% in responding to call bells. Apologies that staffing ratios on website were out of date - these have been updated. Explanation offered for discharge arrangements.
18917	MOD	ELDER	06/04/2017	Issues of concern - difficulty in obtaining accurate updates on patient's condition. Loss of items of patient property. Unable to speak with anyone who could explain what had happened re patient's death. Delay in obtaining the death certificate.	Apologies that comments around patient being on the wrong ward caused concern - staff reminded to be mindful of the impact of such comments. Explanation offered around obtaining clinical history in the event of an emergency admission. Issues around poor communication from nurses has been discussed at ward meeting. Staff also reminded to ensure records are kept of all conversations with patients/relatives. Apologies offered that patient property policy was not followed. initially patient's clinical condition took priority but disclaimer was never completed. Both ward teams advised that a disclaimer must be completed for every patient and will monitor via local audit. Apologies for difficulty in speaking with a dr following patients death - complaint to be highlighted to medical staff via clinical governance meeting. PALS did respond to all enquiries made by relative until relative referred issue to a solicitor. PALS constantly looking at ways of improving response times.
18904	MOD	AE	06/04/2017	Concerns raised at misdiagnosis of shoulder injury in the ED. Patient was informed she had soft tissue injury and referred for physio. Patient's GP subsequently referred pt to orthopaedic outpts and she was diagnosed with anterior glenoid fracture and partial cuff tear. Pt now on waiting list for surgery.	Injury was very subtle on x-ray hence was missed - to be discussed at discrepancy meeting. Delayed diagnosis did not impact on eventual need for surgery. Apologies for confusion over appt - staff could/should have advised pt to attend appt/return to ED given reports of pain.
18911	MOD	ELDER	06/04/2017	Concerns raised around how staff managed the challenging behaviour displayed by the patient on the ward. Concerns that patient was administered unlicensed medication. Unhappy with input from psychiatry and delay in obtaining second opinion. Why was transfer to psychiatric unit not facilitated earlier in admission? Unhappy with ward environment. No carers assessment completed.	Explanation provided of the strategies used to support and stimulate the patient. 1:1 nursing care provided. Input sought from medical team and mental health services. Apologies offered re lack of carers assessment; ward manager will consider this in future.
18912	MOD	ELDER	06/04/2017	Concerns raised re condition of patient on 12/12/16 - patient was hypoglycaemic. Family feel staff were slow to respond and report that a dr acknowledged that the patient has not been checked on, resulting in hypoglycaemic episode. Concerns raised that changes to insulin are not working. Unhappy with lack of feedback following meeting with Matron to resolve concerns raised in 2016. Poor communication with family around discharge in May 2016. Further concerns raised in relation to admission in 2015.	Nurse involved in first episode is not a permanent member of staff and efforts to contact her have failed. Discussed with CSW who has been given instruction about using the emergency buzzer to summon help. Training being delivered to ward by diabetic nurse specialist. Dr hadn't interpreted seriousness of situation when called by ward - apologised at the time. Explanation provided re medical management during admission in 2015. Ward sister to address issue of staff speaking in own languages via ward meeting. Matron apologises as did not appreciate complainant wanted a written response after their meeting.

ID	Grade	Sub Spec	Closed	Description	Outcome
18920	MOD	GYNAE	10/04/2017	Concerns raised with care received in the ED and on Ward 33. Pain not controlled effectively and staff unwilling to give stronger pain medication. Difficulty taking blood. Attitude of nursing staff poor.	Apologies for long wait for gynaecology review - staff have to prioritise activities by clinical need and patient was clinically stable at the time. Apologies for poor interactions with nurse and doctor in the ED - matron to discuss complaint with them. Apologies offered for poor pain control - challenging due to patient being pregnant which limited some of the analgesia which could be given. Explanations offered around interaction with nursing staff on ward re 'refusal' to allow blood to be taken and not providing morphine when requested.
18925	MOD	GYNAE	11/04/2017	Concerns raised with fertility appointments and lack of continuity of care and lack of empathy shown. Medical records lost and tests not undertaken. Attitude of secretary and consultant.	Apologies offered for poor communication around referral pathway - explanation offered and issue discussed with secretary. Explanation provided re blood tests - cystic fibrosis test wasn't requested hence the results were not available - this was clinically correct. Apologies that notes went missing and as a result, consultant didn't have full background information to hand. Not clear why appt wasn't cancelled as advised. Service now provided by consultants from GSTT who have streamlined and improved pathway.
18663	MOD	MID	18/04/2017	Concerns raised about the obstetric care received. Poor pain control. Manner of registrar. Delay in diagnosis of infection.	Apology offered for delay in reply and for the poor communication during labour and delivery. Explanation offered around pain and apology offered that this was poorly controlled. Assurance offered that the correct policies and protocols were followed with regards the delivery.
18785	MOD	GYNAE	25/04/2017	Patient has history of post traumatic stress associated with previous hospital experiences. Patient informed husband would be able to accompany her to anaesthetic room, however this was not the case. Manner and attitude of consultant anaesthetist and missing clothing.	In view of patient's anxiety, anaesthetist offered for her husband to accompany her to theatre at the pre-assessment appointment. When this was relayed to the surgical team on the day, the surgeon did not feel this was in the patient's best interest. Discussion between anaesthetist and husband was difficult due to aggressive behaviour from husband. Communication between teams to be discussed at clinical governance.
18892	MOD	ANAES	25/04/2017	Concerns raised with attitude of anaesthetist and nurse on SSSU prior to surgical procedure. Patient suffers from PTSD with regards to surgery and felt she was made to feel vulnerable and frightened by anaesthetist and SSSU nurse.	Anaesthetist offered personal apology to patient for distress experienced on the day. Clinical director discussed complaint with both anaesthetist and the clinical support worker referred to.
18905	MOD	AE	28/04/2017	Concerns raised re advice given by nurse in ED to stop medication prescribed by GP for possible DVT. DVT subsequently confirmed by scan arranged via GP.	Patient should have been further investigated by way of a d-dimer blood tests while in the ED before a DVT was ruled out. Case has been discussed with ENP to ensure full understanding of DVT protocol. Additional training being delivered to ENP's on management of DVT's and calf injuries.
18935	MOD	AE	03/05/2017	Concerns raised regarding lack of urgency in assessing and treating patient brought in to resus. Insensitive communication around DNACPR status. Staff behaved 'jovially' in the presence of the recently deceased body.	Due to activity levels in the department, there was a delay in the nurse taking observations following triage and setting up monitors. Apologies for this, but delay did not contribute to patient's death. Apologies offered for distress caused around DNACPR discussion - it was appropriate for the staff to broach the subject. Apologies offered by staff that their behaviour appeared disrespectful. Care provided has been assessed against DoH care quality standards and assurance offered that these standards were met.

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18898	MOD	CARDIO	08/05/2017	Concerns raised regarding lack of cardiac follow-up following diagnosis of aortic stenosis. Why wasn't patient referred to St Thomas' for cardiac surgery in September?	Apologies for delay in receiving follow-up appt, due to backlog in waiting lists. Work ongoing to validate waiting lists, increase nurse-led clinics etc to bring down waiting times. Documented that patient was to have follow-up with consultant 3 weeks after discharge from hospital - not clear why appt wasn't arrange. Consultant has instructed her team to book all follow-up appts rather than hand over to other staff to complete. Patient was discussed with staff at St Thomas' who felt patient wasn't fit for cardiac intervention. Review of case suggests alternative management would not have changed the clinical outcome.
18934	MOD	RESPIR	08/05/2017	Concerns raised around poor ward environment and nursing care. Patient left with blood stained tissues, bin not emptied, stained bed linen. Ensure drinks not served chilled despite requests due to there being no fridge available. Staff unable to respond to enquiries about meals. Requests to change to IV meds not responded to. Patient transferred to Guy's with no documentation. Concerns raised around use of morphine when patient had a kidney problem. Chemotherapy diary inadequately completed. Inappropriate advice given to restart blood pressure meds resulting in patient collapsing. Why wasn't lung abscess and fungal infection diagnosed?	Apologies offered re delay in emptying bin - highlighted with domestic supervisor. Explanation offered for provision of tissues as patients may injure themselves if left with suction equipment. evidence to suggest bed linen was changed on most days, but staff reminded to check condition of sheets if patient declines assistance with personal care. No harm caused by serving ensure drinks at room temperature - there is restricted fridge space on the ward so priority is given to temperature regulated consumables. Apologies that staff unable to identify pureed meals - catering staff have been asked to leave clear films with labels in place when providing these meals to the ward. Assurance offered that patient was prescribed IV and subcutaneous medication. Notes were copied and handed to ambulance crew for transfer to Guy's. Low dose of morphine was prescribed to control pain - decline in kidney function was felt to be a reaction to the contrast used in the CT scan. Explanation offered around chemotherapy diary - this is optional, formal records are maintained by Kent Oncology Centre. No evidence to support that nurse advised the patient to restart blood pressure medication - normal practice would be to advise the patient to see their GP. Lung abscess and infection may have been revealed if the patient had undergone the further planned imaging, but the patient was transferred to Guy's before this was completed.
18570	MOD	MID	17/05/2017	Patient believes her labour and delivery were mismanaged. She states she experienced poor communication and conflicting information.She also has concerns regarding her post natal care and the advice given regarding her sons care.	Confirmation offered that complaint in its entirety will be shared with appropriate teams. Meeting held. Apologies offered that elements of care did not meet expected standards - reassurance offered that changes have been made since that time to improve service.
18958	MOD	ELDER	24/05/2017	Concerns raised that no brain scan was carried out when patient was admitted with headaches. Patient was subsequently readmitted and diagnosed with stroke. Relatives found it difficult to get information from consultant. Patient seen by multiple different doctors with little consistency or explanations for changes to care plan. Unhappy with comment made by ED dr that tablets given by GP were 'rubbish' - was feedback given to the GP if this is the case? Felt there was a lack of compassion shown by staff following patient's death. Family still unclear about what cause of death was.	Case reviewed by Stroke CNS who concludes that imaging of he brain should have been performed. Apologies offered. CNS to deliver training to medical and emergency doctors on indications for brain imaging. Apologies offered that communication with family did not meet their needs - evidence supports that the ward doctors did keep family informed. Consultant was not aware that family wished to speak with him and would have made himself available to them. Apologies for poor impression given following death of patient. complaint discussed anonymously at ward meeting and individual nurse offered a communication course.

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18831	MOD	AE	01/06/2017	Concerns raised that there was a delay in investigating, diagnosing and treating a PE.	Review of presentation shows that drs did not give enough suspicion of DVT and should have thought about ordering a CTPA scan. Discussed with their educational supervisors for ongoing support. No specific leaflet re patient advice around DVT/PE in use on ED - Matron will look at possibility of developing this. New paragraph on upper limb DVT being added to Trust policy for further clarity.
18986	MOD	GAST	05/06/2017	Concerns raised that patient was informed she had secondary brain metastases, but was later told she did not have cancer. Feels she has been subjected to unnecessary stress. inconsistent messaging during initial admission, moved to 5 different wards.	Explanation provided of care pathway. Apologies offered for number of ward moves. Patient asked dr early on what the worse case scenario could be and was informed cancer was a possibility but further investigations were required. Best practice is to keep patients informed of possible diagnoses - recognise that in this case, this did change dramatically. With hindsight, it may have been possible to refer case to the King's MDM one week earlier, which would have allowed consultant to share their findings earlier. Acknowledgement that there were missed opportunities to communicate the findings of the King's MDM to patient - apologies offered. The directorate will ensure that the King's neuro-oncology MDM proforma and timescales are shared across the clinical team to try to prevent avoidable delays in the future.
18985	MOD	AE	06/06/2017	Concerns raised regarding management of finger by ENP. Patient's mother subsequently informed that injury should not have been left as it was.	Management of injury reviewed by consultant orthopaedic surgeon. Assurance offered that treatment given will not have affected recovery. Apologies offered by ENP that she gave the impression of being frustrated.
18993	MOD	AE	06/06/2017	Pt's mother feels that Dr who initially saw pt failed to diagnose that the pt's wound was infected and pt was left to suffer before being prescribed antibiotics by GP. Concerns that patient's diabetic status wasn't considered and no sugar-free medicine available.	Initial management was correct - patient was low risk and was safe to wait to be seen. Decision taken to leave the department and return the following morning was not unreasonable. Apologies that sugar-free paracetamol wasn't available - actions being taken to provide this in future. On reattendance, infection should have been considered and antibiotics commenced - additional training being provided to ENP and case to be discussed at ENP monthly meeting.
18996	MOD	ANAES	12/06/2017	Patients mother advised that as they could not control patient pain they had given large dose of pain medication which resulted in overdose. Concerns raised with attitude and language used by anaesthetist. Did not receive a follow up appointment.	Explanation provided around the pain medication given and why and that this did not cause an overdose. Follow up appointment was made but outside of the indicated timeframe due to service pressures.
19001	MOD	AE	14/06/2017	Concerns raised that fracture to hip was missed on x-ray. Went on holiday and due to increase in pain, underwent surgery for fractured hip. Seeking reimbursement of costs incurred.	Review of imaging shows fracture was missed - apologies offered. Case to be discussed at the radiology clinical governance meeting. Offer made to refer case to insurers.
18947	MOD	RESPIR	16/06/2017	Concerns that abnormalities on x-ray in 2015 and 2016 not identified and lead to a delayed diagnosis of cancer.	Investigation revealed there were abnormalities visible on earlier imaging which were not acted upon. Apologies offered. Case to be discussed at clinical governance meeting. Doctors to be encouraged to discuss their proposed management of all complex patients (including cancer patients) with a senior consultant following clinical review and to discuss patients with unreported imaging with a senior consultant. Patients with a known history of lung cancer who remain under our care for surveillance imaging will be discussed in the departmental radiology chest meeting. Incident raised for missed diagnosis.
18976	MOD	GENSUR	19/06/2017	Concerns raised around delay in histology slides being sent to Kings. Also concerns around delay in referral to MDM being made.	Investigation concludes that there were no delays in MDM referrals,however there was a delay in sending histology slides to Kings - changes implemented to avoid this happening in future.

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18910	MOD	MID	26/06/2017	Number of questions asked about attitude to midwifery staff, and care provided during labour and delivery. Concerns raised that risk associated with episiotomy and assisted delivery not explained, felt obstetrician in a rush when suturing episiotomy which caused an infection. Numerous further visits to maternity triage day unit and delay in recognising infection. Episiotomy complications which were not fully addressed until a month following delivery.	Poor communication recognised. Explanations around lithotomy position and why used. Explanation around the need for assisted delivery and apology that not fully informed of the risks. Apology offered for wait for post natal bed. Recognised that information around perineal care is lacking - leaflet being developed. Explanation offered around treatment given on visits for infection.
18900	MOD	ORTHO	28/06/2017	Concerns raised that management plan following knee replacement surgery was not completed in timely manner and that physiotherapy appointments were not arranged.	Apology offered for delays in accessing physiotherapy treatment. Physio to look at leaflet provided at pre-op clinic with regards to ensuring patients are aware of who to contact if post-op physio appointment is not received.
19021	MOD	AE	03/07/2017	Concerns raised that waiting environment insufficient for patient in mental health distress, long wait for review and for crisis team to attend. Food not easily accessibly and crisis left hospital without reviewing patient.	Apologies offered for poor experience. Patient should have been referred to in-house psychiatry team by triage nurse - this wasn't done. Addressed with team by lead nurse. Patient then had a long wait to see the ED dr who then referred her. However, in-house team had by then finished so patient had to wait for crisis team to attend. CDU is a quieter area but not ideal. Vending machines since installed. CDU staff would have been able to offer patient refreshments - sorry this wasn't done.
19015	MOD	COLOR	04/07/2017	Concerns raised that treatment and care provided was inadequate. Family unaware of cancer diagnosis and communication provided by surgeon poor. Concerns raised that patient confidentiality breached by both wards. Concerns that poor dietary intake not monitored. Concerns that discharge inappropriate, resulting in readmission 5 days later.	Explanation provided of care and treatment. Staff reminded to accurately complete option fields on EDN. Need to keep relatives informed of medication changes to be discussed at directorate clinical governance meeting. Management of deceaseds' property to be discussed at ward meeting.
19033	MOD	GENSUR	10/07/2017	Concern that discharged without discharge letter and no plan for symptoms. Was advised would get letter and pain medication but did not. Feels the doctor who reviewed was arrogant and rude.	Explanation of care and treatment provided. ED looking at ways in which to speed up registration and triage. Patient was provided with copy of discharge letter prior to leaving. No evidence that pain medication was due to be prescribed for discharge. Apologies dr was found to be rude - reminder issued to surgical team regarding expected standards of communication.
18967	MOD	GYNAE	12/07/2017	Concerns raised regarding poor standard of care and treatment provided in the ED. Nurse and dr lacked compassion when dealing with patient. Why was patient not seen by a gynaecologist? ED dr asked patient to take high vaginal swab sample herself. Why would EGAU not see patient when community midwife requested them to? Concerns that obs were not checked prior to discharge. Patient subsequently diagnosed with sepsis and experienced miscarriage.	Apologies scan request couldn't be accommodated quicker. Patients observations in ED were stable and did not indicate clinical urgency. Gynae reg was contacted at the time but did not feel it necessary to review patient in view of presenting observations and scan earlier that day. Dr asked patient if she preferred to take vaginal swab herself due to being a nurse and the intimate nature of the procedure - assurance that dr is competent to perform this. Apologies for length of time taken to get results. ED staff reminded not to leave the area unattended overnight. When results discussed with gynae reg, this should have prompted gynae review - DMD to discuss with reg and will include learning in jr dr newsletter. Apologies offered.
19049	MOD	ELDER	14/07/2017	Family unhappy with conclusion of RCA investigation into fall - seeking apology. Family would like clarification of all measures used to maintain patient's safety. Seeking improvements to care of patients with dementia, including listening to relatives/carers better. Seeking funding for ongoing care needs. Seeking reimbursement for replacement of lost spectacles.	Apology offered to family. Explanation of interventions used to reduce risk of falls. Assurance offered around measures taken to reduce risk of dementia patients falling. Apologies offered that family did not feel listened to. Family invited to come in and see if spectacles found belong to patient.

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19050	MOD	TRAUMA	17/07/2017	Concerns raised with treatment on Ward 30 following surgery to both wrists. No assistance given with eating and advised could mobilise to the toilet independently. Advised by plaster room that bandages applied in the ED were incorrect.	Nothing documented to reflect any issues with bandaging of wrists. Concerns raised around experience on ward was discussed with patient by ward sister who has shared complaint with team. Apologies letter sent following this discussion was unsatisfactory.
19058	MOD	GENSUR	19/07/2017	Concerns raised that there was a significant delay in obtaining a CT scan and then a further delay while waiting for this to be reviewed. Patient believes review only occurred due to partner (who is a member of staff) contacting the site practitioners. Surgery was undertaken, appendix removed and section of intestines. Patient is querying what would have happened has his partner not prompted action.	Apology offered for long wait in ED and explanation provided around rationale for transfer and the need for the patient to be seen by the triage nurse again on arrival at TWH. appendicitis was suspected but given patient's previous medical history, a CT scan was requested to confirm the diagnosis. Apologies offered for delay in surgeons reviewing the scan and that patient's partner felt she had to intervene - delay was due to surgeons being engaged in other clinical activity. CT indicated that surgery was required, and operation revealed that patient had a perforated Meckel's diverticulum.
18939	MOD	AE	19/07/2017	Concerns raised that on attendance to ED hip fracture missed as x-ray only taken of knee. Left in wheelchair for long period. OT assessment undertaken, patient in pain. Not reviewed by senior doctor during attendance. Attitude of nurse on CDU. Concerns that family advised patient was a social admission. Attitude of patient transport driver. Concerns that when at Sevenoaks, Dr did not recognise patient in pain or request further x-rays. When returned to ED was transferred to Ward 31 who were unaware of his arrival. Lost consent form.	Dr and therapist did not recognise that pain in knee could have been referred from hip. Apologies for delay in diagnosis. Management of presentation discussed with dr and further training being delivered to therapy team. KCHT have reminded staff about booking BSL interpreters when needed. BSL interpreter should also have been booked to take consent for surgery and on MTW ward - directorate teams reminded of this.
18957	MOD	GENONC	19/07/2017	Concerns raised about the treatment and advice provided for terminally ill patient. Concerns that not enough was done to address symptoms caused by cancer meaning that patient was unable to access certain treatment options. Clarification sought as to why pleurex drain was fitted. Lack of nursing and medical input during final admission.	Diagnosis of carcinoid syndrome was made in a timely fashion, but heart symptoms were not considered to be linked to it. Apologies that the MDT did not consider this earlier and therefore opportunities were missed to provide symptomatic treatment. Definitive treatment by way of surgery would not have been an option for the patient, due to her cancer status. Current guidelines do not recommend routine screening for carcinoid heart disease. However, there is national guidance due to be released regarding a screening blood test, which the Trust plans to implement later this year. It is worth noting that the guidance emphasises that the signs and symptoms of carcinoid heart disease are often subtle and variable.

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18943	MOD	OPTHAL	19/07/2017	Series of questions concerning treatment why MRI imaging was not reviewed and why a neurological appointment was not made. Patient had surgery in Japan.	Explanation of care and treatment provided. Consultant recognises that in retrospect he should have requested a copy of the MRI rather than just rely on the patients assurance that it was normal. Unable to say if subsequent diagnosis could have been made earlier.
19061	MOD	GENONC	20/07/2017	Incorrect diagnosis. Patient informed she had cancer, subsequently told this was not the case.	Apologies offered for distress caused. Reporting of scan suggested presence of cancer. Patient seen urgently in clinic and news broken. Second opinion sought who agreed with diagnosis, but tertiary opinion from neuroradiologist confirmed this was not cancer. This was a diagnosis that only a specialist could have made. No criticism leveled by expert at radiology, but case discussed at radiology meeting to raise awareness.
19034	MOD	AE	24/07/2017	Attended following fall at home. CT head and x-ray to wrist and shoulder. No fractures identified. Re-attended same day following a further 2 falls. X-ray reviewed by ED doctor, no fracture seen. Patient discharged with antibiotics for UTI. Attended Sevenoaks due to continued pain in wrist, x-ray revealed a fractured wrist.	Apologies that fracture was missed in ED and subsequently when the x-rays were reported by radiology. Patient was offered HIT review prior to discharge but declined - this may have been a missed opportunity to identify the fracture. Also missed opportunity to re-x-ray when patient reattended a few hours later.
19038	MOD	RESPIR	26/07/2017	Concerns raised regarding long waiting times between appointments, delays in tertiary referrals, culminating in a delayed diagnosis and delay in commencing treatment. Patient has much reduced lung function as a result.	Detailed summary of care and treatment provided. On a couple of occasions, planned investigations were not ordered, but they were all picked up at a later date. Changes made since then to processes to ensure that all requests have been actioned. Conclusion that patient had an approx 5 weeks delay in being referred to a tertiary centre. Diagnosis was complicated and couldn't have been made earlier. Patient's condition remained stable until he was already under the care of the tertiary centre.
18927	MOD	VASC	04/08/2017	Concerns that delays in treatment for gangrenous toe resulted in first one toe being amputated then three toes then leg below the knee. Family asked to transport patient to Medway, why no blue light transfer?	Apology offered that the operation was cancelled twice and measures already put in place to ensure clinical review of any patients cancelled for the second time to ensure it is safe to do so. Explanation offered that did not meet the criteria for a blue light transfer and therefore ward staff felt it would be quicker for the family to facilitate the transfer to Medway.

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19037	MOD	ORTHO	04/08/2017	When concerns raised by patient that they did not have full range of movement in wrist following injury to radial head bone, no further x-ray ordered to establish why. When attending further outpatient appointment patient advised that in hindsight further x-rays should have been undertaken at previous appointment. Patient required surgery. Concerns raised with manner and attitude of surgeon. Long wait for physio appointment.	Patient should have been referred for consideration of surgery given the extent of loss of movement. Further x-ray was not clinically indicated as would likely have shown no change to the first imaging. Management discussed with individual doctor for learning and shared with the wider team through clinical governance. Apologies for length of wait for physio appt - due to capacity issues. Assurance offered that consultant was happy to come and speak with patient post-operatively - apologies this is not how it appeared.
19079	MOD	GENSUR	04/08/2017	Concerns raised that lymph node removed under local anaesthetic which caused severe pain to patient. When pain experienced, no sedation or GA requested. Manner and attitude of Registrar and breach of privacy and dignity. Wasn't advised would be left with larger lump than the one removed.	Apologies that patient experienced pain. Surgeon was aware of this and asked anaesthetist to come to administer GA or sedation, but following additional local anaesthetic, patient reported being able to carry on. In future, surgeon will ask patients what they prefer. Apologies for insensitivity shown when requesting the patient's piercing be removed. Surgeon will be more discreet in future. Patient has since seen consultant who has confirmed wound is healing well.
19070	MOD	CT	09/08/2017	Patient involved in traffic accident and attended ED. Had CT scans which reported no head injury but broken arm. Following an MRI scan, a fracture to the skull was identified.	Apology offered that initial CT scan was mis reported and assurance offered that this has been followed up via the appropriate pathway. Assurance offered that treatment would have been conservative, however apology offered that this caused a delay to the surgery to the arm.
18999	MOD	ELDER	15/08/2017	Pt underwent surgery to hip and discharged from Chaucer ward, where dentures went missing. 4 days later reattended and admitted to Ward 2. Concerns voiced by family that patient unable to cope at home on discharge. No equipment sent home with patient. Patient at home a few hours when fell and was readmitted with fractured pelvis, swelling to brain and fractured thumb. Raised as SI.	Apologies offered for loss of dentures. Records reflect one call from relative to express concerns, but this wasn't the person identified as NOK or who staff had been liaising with. Apologies offered that this was a missed opportunity to capture and address these concerns - being followed up with ward staff. Absence of walking frame investigated as SI - apologies offered and actions identified around improving discharge processes within occupational therapy and Home First.
19111	MOD	AE	16/08/2017	Patient presented to ED following a fall and was discharged home. Patient reattended the following day and was x-rayed, revealing 3 rib fractures.	No clinical indication to order imaging of the ribs on first attendance. Had fractures been found, they would have been managed conservatively. Not clear if patient was discharged with analgesia - this has been discussed at clinical governance. When patient represented with history of collapse, fractures were an incidental finding. Apologies offered that fractures were not diagnosed on first attendance.

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19006	MOD	AE	16/08/2017	Patient attended ED twice within 24 hours and on both occasion was diagnosed with constipation and discharged with laxatives. Patient represented the following morning and was admitted for surgery for a bowel obstruction caused by a tumour. Concerns raised re incorrect diagnoses.	Apologies offered that obstruction not diagnosed on first 2 attendance. First presentation was reasonably managed. On second occasion, patient should have been discussed with or seen by a consultant - dr reminded of departmental protocol. Case to be discussed at clinical governance.
19101	MOD	MID	18/08/2017	Concerns raised that inaccurate result of quad test provided as incorrect age of egg donor used to calculate risk. Not advised that size is a factor in the combined test and therefore when arrived for the test, baby too large to undertake testing.	Assurance offered that initial scan for combined test was offered within correct timescale - not possible to predict that foetus would be outside of the size parameters at that point. Quad test therefore offered. Accuracy rate for both tests is comparable. Insufficient details provided on request form which meant analysis of risk was based on mother's age rather than egg donor's age. Dept looking at what information is required for different types of testing. Request for reimbursement for DNA test declined.
19109	MOD	ELDER	21/08/2017	Unhappy with discharge planning, lack of respect shown to spouse. Minutes from discharge planning meeting not provided. Also long wait in ED without being updated by dr. Patient was able to access scissors on ward and used these to cut catheter.	Explanation provided that discharge planning was appropriate and that staff involved in patient's care were trying to facilitate the best possible care for the patient and were also trying to support the patient's wife, whilst working in the best interests of the patient. Apology offered that patient's wife felt she was shown a lack of respect. Minutes from planning meeting provided. Apology offered that ED staff did not communicate plan to family in a timely way. Explanation provided around nursing safety scissors and apology that these were accessible to the patient.
19131	MOD	AE	05/09/2017	Pt raising concerns that fracture to finger was incorrectly treated when she attended ED and she was inappropriately referred for outpatient follow-up when she actually needed surgery. Patient unhappy that she was not discharged home with stronger pain relief.	Patient's injury was correctly treated and explanations given. Patient was not given a prescription for adequate pain relief on her discharge and doctor will ensure that patients pain levels are re-assessed before being discharged.
18746	MOD	UROL	12/09/2017	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.
19145	MOD	OPTHAL	13/09/2017	Concerns that operation was not successful in right eye. Feels that the talking in the operation room along with the music was inappropriate.	Explanation provided about the operation in the right eye which did not go as smoothly as the operation in the left eye. Apology offered for the talking and music in theatres and measure put in place to ask patients this prior to surgery

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19153	MOD	CARDIO	18/09/2017	Concerns raised that although pt was unable to complete angiogram due to breathlessness, he was allowed home from clinic. Patient went to see GP who directed him to ED where he was admitted and diagnosed with heart failure. Concerns raised that records incorrectly record the amount of fluid lost and that patient was not admitted to a cardiac ward, resulting in a delay in seeing a cardiologist. Concerns regarding incorrect information on EDN regarding patient's weight.	Explanations given regarding patient's angiogram being abandoned due to him being unable to lie flat because of his cough. Apologies offered that information on EDN regarding patient's weight) was incorrect. The need for accuracy will be reinforced across the medical staff at the next clinical governance meeting.
19161	MOD	RESPIR	26/09/2017	Long lapse of time between undergoing blood tests on 27 January 2016 to be reviewed in clinic in December 2016 when advised blood tests confirmed Hypogammaglobulinaemia.	Apologies offered for the delay in patient receiving her follow up appointment and blood test results. Administration processes within the department are under review and improvements have already been made to the booking of respiratory follow up appointments. This review is ongoing and further work is being done to reduce the follow up waiting list backlog. The department has a new consultant in post which has increased the capacity within clinics, and waiting times are subsequently reducing.
19051	MOD	THEATR	26/09/2017	Complaint about poor standard of care received when attending for day surgery. No reception staff to greet patients and poor communication by theatre staff. Moved several times during recovery as areas closing. Discharged without medication. Nurse removing cannula was not wearing gloves.	Apology and explanation offered around need for patient to be moved several times during recovery due to hospital site being fully escalated which also impacted on the standard of nursing care received. Apology offered for attitude of staff, however staff do not recall the incidents mentioned.
18972	MOD	AE	28/09/2017	Patient's son would like to know why his mother was discharged from A & E without being examined and no diagnosis. Long delay in patient being seen by ED doctor.	Explanation provided regarding the examination, care and treatment provided to patient. Explanation also given regarding patient's diagnosis. Apologies given for delay in patient being seen by doctor in department.
19116	MOD	AE	29/09/2017	Patient presented to ED with anxiety. Patient requested medication, but dr did not attend. Following psych review, patient was asked to leave ED although she did not feel safe to do so.	Apologies for delay in psychiatry team attending - ED staff made numerous calls to them to remind them patient was waiting to be seen. No record of a conversation taking place when patient asked for medication to be prescribed. No record of patient raising concerns at point of discharge - further risk assessment would have been carried out if staff had known.
19151	MOD	GENSUR	29/09/2017	Patient very unhappy with manner in which consultant spoke with her. Concerns also raised that despite efforts of patient, MRI results were not available for outpatient appointment.	Apology offered for manner to doctor who advises that he was trying to offer reassurance. Apology and explanation offered re wait for MRI scan and results not being available

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18949	MOD	REHABI	05/10/2017	Concerns raised with the treatment of patient on Chaucer Ward prior to discharge. Patient sustained a fall, family not advised, lost 21% of her body weight during admission and was depressed. Concerns with attitude of night staff. Why were family not informed patient was C.diff carrier.	Apologies that family not informed of fall - incorrect telephone number had been documented so staff unable to contact them until they arrived to visit. Apologies offered for occasions when staff were unable to respond to requests for assistance as quickly as required. Reassurance was offered to patient and family at the time that patient should not be anxious about asking for help. Apologies patient lost weight during admission - patient was seen regularly by dietician and appropriate supplements prescribed and encouragement/support offered. Consideration of NG tube was made, but felt not to be in the patient's best interests. Patient developed depression and was seen by psychiatrists - this was concluded to be linked to her loss of independence following her fall and shingles. No evidence that patient was a C.diff carrier - patient never experienced diarrhoea so was never tested.
19186	MOD	AE	11/10/2017	Patient came into A & E as collapsed at work, she was fitted with a cannula and due to the line not being flushed it caused an infection and a blood clot. Patient then had to stay in hospital a further two weeks and was unable to undergo angiogram due to infection.	Explanation provided to patient that doctor believes it is unlikely that a phlebitis would occur purely due to a lack of flushing of the cannula. Apologies given that documentation not completed that three daily flushing occurred. Sister will work with staff to ensure documentation is completed.
19167	MOD	AE	16/10/2017	Concerns that antibiotics not commenced despite urine being positive for nitrates and leukocytes. Advised by staff that bloods were normal when the EDN suggests that they were not. Why was medication for fluid retention stopped which was required due to history of heart failure.	Explanation provided that antibiotics were commenced as soon as the urine culture results were available. Explanation also provided that medication discontinued as there were no signs of fluid overload and no worsening of patient's symptoms of heart failure. Apologies given that EDN states inflammatory markers were raised, when they were not.
19193	MOD	RESPIR	16/10/2017	Concerns raised that patient has received too high a dose of hydrocortisone and none of his regular medication during admission. Staff have not liaised with his specialist at the tertiary centre. Patient does not believe his peak flow readings are being charted correctly. Patient has found sharps and medication left on his bedside table. Patient took his own discharge due to lack of confidence in care.	Explanation and assurances provided to patient that he received all the appropriate acute medications in accordance with the guidelines for the treatment of an acute asthma attack. Apologies offered to patient that sharps were left by his bedside. Patient advised that ward manager has recently completed a medications and sharps safety audit.

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19179	MOD	AE	24/10/2017	Number of concerns raised regarding treatment including mistakes in medications and steroid dosage. Not overseeing confused patients taking their medication and the flippant approach of staff on finding pills on the floor and tables. Lack of care and cleanliness. Inappropriate discharge.	Explanation provided that there were no mistakes in medications or steroid dosage. Patient was overseen by nursing staff taking his medication and no problems were documented regarding this. Apologies offered regarding lack of communication regarding medication found on floor, this will be discussed at the next ward meeting and fed back to the nursing staff to ensure care is taken when administering medication and provide reassurance to relatives. Explanation provided regarding appropriate discharge.
19217	MOD	GENMED	30/10/2017	Various concerns regarding lack of nursing care and assistance, patient found it very difficult to get a hot drink on the ward after 3pm, long waits for patient's call buzzer to be answered by staff when she had soiled her bed, rude and uncaring attitude of nursing staff, poor communication skills by nurse which patient believes is due to her poor English. Patient also raised concerns that doctor failed to diagnose patient's chest infection. Lack of information provided by orthopaedic team to patient regarding her fractured shoulder and right knee damage following a fall and advice for aftercare of her injuries on discharge.	Apologies given that patient had difficulties getting a hot drink, delays in her buzzer being answered, concerns regarding attitude of staff, and nurse's poor communication skills. All of these issues will be raised at the next ward managers meeting. Explanation provided that doctor did not find any evidence that patient had a chest infection. Explanation provided that adequate information was given to the patient regarding her orthopaedic care and treatment.
18938	MOD	ORTHO	02/11/2017	Concerns raised that clinical opinion and advice given regarding treatment for club foot was inappropriate and inaccurate. That the first corrective procedure was incorrectly undertaken and there was a long wait for a review following the surgery. Conflicting advice given by physiotherapy. Second opinion sought who agree with treatment advice given by physiotherapy.	Explanation that clinical opinion was differing regarding treatment. First procedure completed correctly however, when it was noted that cast had slipped, this should have been removed and replaced. Risk of failure was a known complication.
19132	MOD	GYNAE	06/11/2017	Long wait to see gynaecologist following presentation at ED. Lack of investigation of symptoms, not empathy shown towards patient,	Explanation provided that patient had to wait for the gynaecology team to attend the ED. Apology offered for incorrect expectation set by GP. Apologies patient's needs not met while awaiting the gynae team. Other gynae emergencies were prioritised over patient and apology offered that this wasn't explained to patient at the time. ED matron to discuss complaint with team.

ID	Grade	Sub Spec	Closed	Description	Outcome
19160	MOD	MID	07/11/2017	Difficulties experienced in 2015 during labour and feels that due to the previous problems experienced, should be consultant led during current pregnancy. Feels haemorrhage following first delivery was caused by doctor removing the placenta with force. Concerns also raised that she was left too long before being take for delivery.	Apologies offered for delay in induction - changes since made to service and ante-natal midwife now specifically allocated to discuss all women awaiting induction at every shift handover. Explanation offered around manual removal of placenta. Procedure was necessary and it is traumatic, but no evidence to suggest that excessive force was used. Apologies offered that patient was not given advice regarding accessing support for her psychological trauma and explanation of role of community services in facilitating this. Apologies for unhelpful response when patient contacted consultant's secretary about referral for current pregnancy. GM will address with secretarial staff.
19238	MOD	OPTHAL	08/11/2017	Concerns regarding delays in patient's treatment for her eye condition. Patient believes the delays have resulted in her losing the vision in her right eye. Patient unhappy that appointment was cancelled and put back.	Investigation concludes that there was no clinical indication for treatment prior to appointment made. Vision was lost due to known complication of treatment. CAU staff to be reminded to proactively redirect enquiries for other services when required.
19065	MOD	AE	09/11/2017	Concerns raised regarding a missed fracture. Patient presented after having a fall, no x-ray performed. Patient reattended and x-ray revealed broken collarbone. Patient provided with ill-fitting sling. No f/up appt made until patient's mother chased.	Explanation, information and apologies provided that x-ray was not carried out and fracture was missed. Management of presentation discussed with individual doctor by ED Consultant. Complaint to be discussed as part of doctors appraisal. Explanation and apologies given regarding ill-fitting sling and that follow up appointment was not arranged. VFC has transferred to therapies to streamline process and deliver better service.
19211	MOD	GAST	13/11/2017	Elderly husband of patient with advanced cancer was asked by staff to take his wife to the hospice in his car as an ambulance was not available. Family very unhappy that transport was not arranged and patient could not sit on her bottom, in a car, due to the pain she was in. Family also unhappy with the lack of communication and information provided to them by staff regarding her treatment and prognosis. Family very unhappy that patient was informed she had terminal cancer without any family members being present to support her. Concerns regarding rude attitude of nurse on the ward when patient's husband attended the ward to collect his wife. Lack of end of life care and patient's dignity in her final days.	Apologies given that elderly husband of patient with terminal cancer was asked to transport her to the hospice in his car when she was unable to sit upright due to the pain she was in. Apologies offered for the distress and upset caused to patient's husband.

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19234	MOD	MID	15/11/2017	Patient had a recognised dural puncture whilst siting an epidural and did not receive a review or blood patch until 7 days later. Patient raised concerns that she was not listened to by the staff when complaining of pain. Patient advises that EDN is incorrect. Patients suggests could have been discharged sooner had headaches been acted upon and asks why there was no midwife present at debrief meeting.	Apology offered that when headache initially reported, this was not raised to the anaesthetic team. The team have been reminded of the need to escalate. Assurance offered that EDN was not incorrect in diagnosis but should have mentioned the epidural patch and apology offered. No evidence to support that could have been discharged sooner. Midwifery team were unaware of debrief meeting and therefore did not attend.
19249	MOD	MID	21/11/2017	Concerns that student midwife incorrectly weighed a new born baby and incorrectly measured his head circumference. This only came to light when baby was home and was reweighed and deemed to have lost 16 1/2 percent. Patient also unhappy with the way the student midwife tested her blood sugars.	Unfortunately cannot conclude with any certainty as the student midwife has returned to university. Apology and explanation offered. Student Link midwife will discuss concerns with student at earliest opportunity. Maternity notes support measurement of weight several times, however two differing head circumference measurements are recorded by the student midwife and neonatal check. nothing to suggest blood sugars were taken incorrectly.
19081	MOD	AE	22/11/2017	Poor experience in the ED. Long wait to see a doctor, lack of clear information/ communication around blood test results. No vending machines available.	Apologies for length of wait to see a dr, but given patient's clinical condition and activity in the department, this was not unreasonable. First blood test gave a high haemoglobin level which was felt to be an anomaly, but decision taken to repeat test to be sure. As it was felt to be an anomaly and patient had been in the department a long time, the suggestion was made that she could go home. Apologies that communication around this was lacking. Clinical lead will use complaint anonymously with team to highlight impact of poor communication. Apologies vending machines were not well stocked - contract was being changed over at the time. Nursing staff could have offered refreshments - ED matron asked to pick this up with the team.
19253	MOD	AE	23/11/2017	Concerns regarding appropriateness of elderly patient's discharge following seizures and appropriate tests not being carried out whilst he was an inpatient. Daughter unhappy that father was told to go to his GP for him to refer him to neurology.	Decision to discharge was appropriate as investigations showed no acute cause for the fits and appropriate medication had been initiated. However, referral should have been made by ward to the 'first fit' clinic, not left to GP to do. Issue discussed with ward team for learning.
18712	MOD	ORTHO	24/11/2017	Delayed treatment. Poorly coordinated care. Concerns regarding initial admission area.	Explanation provided around care and treatment given, no gaps identified in investigation. Omission by nursing staff to contact the integrated discharge team on the second admission, to be discussed at team meeting.
19258	MOD	MID	27/11/2017	Concerns raised about the attitude the language the doctor used during this woman's labour and delivery.	Apologies offered for poor conduct of dr. Discussed with him by DMD and record added to his file. Midwifery staff also reminded of correct process for escalating concerns about conduct.

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19263	MOD	BREAS	29/11/2017	Concerns raised that missing notes have impacted on treatment.	Apology and explanation provided around the measures taken to locate the medical notes. Apology offered that treatment plan had to be changed however advised that it was acceptable for procedure to be undertaken under local anaesthetic. Advised that MRI scan for pituitary tumour being discussed at KCH MDT and doctor will contact once results known. Incident to be raised for missing notes.
19078	MOD	ORTHO	29/11/2017	Concerns raised that fibula fracture not treated correctly which has resulted in being listed for surgery with a 3 month wait, several months after the fracture occurred. Feels a CT scan and x-rays should have been taken sooner.	Explanation that fracture did not require surgical intervention earlier as these usually heal with conservative treatment. However non union occurred which does require surgery. This would not have shown earlier on a CT scan. 27/11/17 - outcome revised to upheld. Clinical Director reviewed x-rays which show non-union and therefore patient should not have been discharged to physio. CT scan was indicated at that stage. Apologies offered. CD to present complaint at Directorate clinical governance meeting.
19176	MOD	AE	29/11/2017	Concerns raised that burn to the back of the leg missed when attended ED following a road traffic collision. No information provided regarding potential concussion symptoms.	Full assessment not completed which meant staff did not look for other injuries affecting other parts of the body, including the leg. Apologies offered. Had burn been discovered, it would have been cleaned and dressed and consideration could have been given to antibiotic cover. Dr states she gave patient verbal advice about his head injury but didn't give him a leaflet. She will adjust her practice accordingly.
19187	MOD	UROL	30/11/2017	Concerns that if UTI's had been treated in October 2016, would not have gone onto develop sepsis. MRI scan results not received and unaware that when attending for procedure, that tumour would be removed.	Meeting with patient and family in which it was explained that on all the MSU's taken around the time patient contracted sepsis, only the one taken at the time of his admission to hospital, was there an infection. It is not clear if the MRI scan results and MDT meeting decisions were relayed to the patient and surgery have been asked to action this request, and apology offered for poor communication. Plan agreed for management of this patient going forward.

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19166	MOD	GENMED	30/11/2017	Concerns raised that patient discharged in poor condition and dehydrated. Relative not advised patient was for end of life care. Patient was not advised a diagnosis of dementia had been made. Feels that the patient went into hospital with no sign of incontinence or dementia and was discharged with double incontinence and dementia. Feels transport problems exacerbated poor discharge. Patient discharged on paracetamol for pain medication and relative does not feel this was adequate. Relative would like a full explanation as to what happened between the Tuesday evening when it appeared patient was slightly improved to her discharge. Patient has sadly passed away.	Patient was not for end of life care, so unclear why she was not returned to hospital when she deteriorated post-discharge. Diagnosis of dementia was communicated to staff during clerking, supported by the fact that staff were told the patient's current care home were looking for an EMI bed, due to the patient's challenging behaviour. Common for patients to experiencing some urinary incontinence after having a catheter removed, but patient was not faecally incontinent. Patient had not been displaying signs of pain and had declined analgesia in hospital. However, most appropriate pain assessment tool wasn't used consistently and Matron will raise this at next ward meeting. Apologies for condition in which patient arrived at the nursing home. Patient had remained on ward until collection. Poor documentation around oral care provided and WM will review this with the team. Apologies for poor communication around discharge planning, ward is now receiving more support from the discharge liaison team.
19265	MOD	RESPIR	01/12/2017	Patient attended a new outpatient appointment and was informed by the consultant that he had terminal lung cancer. Two months later, following further tests and investigations, the patient was informed he did not have terminal lung cancer but a lung infection. Patient unhappy with the way the consultant advised him of this diagnosis and the distress caused to him. Concerns also raised regarding delays in discharge medication and discharge letter.	Explanations provided that consultant advised patient of CT scan findings in a polite and empathetic manner. She explained that what had been seen on the CT scan was suspected to be a malignancy, but that biopsies were required to confirm this. Patient advised that further tests and investigations would be arranged and his case would then be discussed in the lung multi-disciplinary team meeting, who would agree the diagnosis and clinical management . Apologies given for delay in discharge medication and letter. Patient advised that pharmacy is working hard to improve services to ensure medicines are dispensed safely and as effectively as possible.

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19247	MOD	ELDER	04/12/2017	Various concerns regarding lack of nursing care and attention for elderly patient, lack of oral hygiene, lack of communication from nursing staff to relatives regarding patient's condition. Family unhappy that patient died alone and assume that the door to her room was shut and she died unnoticed. Family feel that nursing staff did not care. Death certificate also not completed correctly by doctor causing the Registrar to have to contact the ward for further information before being able to complete the paperwork.	Apologies give for poor standard of mouth care. Complainant advised that mouth care charts have been implemented on the ward so that staff can document whether patients are independent or require assistance with mouth care. The Directorate will also be approaching the Mouth Care Matters Nurse to undertake focused work across all wards with regards to mouth care. Explanation given that in order to maintain patient confidentiality, staff are discouraged from providing detailed information to telephone callers. Explanation given that patient's door to her room was open so that staff could observe her. Apologies given for the delay in family being contacted and advised of patient's death due to a medical emergency that occurred on the ward at the time. Apologies offered that death certificate not fully completed by the doctor. This will be highlighted with doctors via the clinical governance meeting.
18973	MOD	RESPIR	06/12/2017	Specific concerns raised: lack of action taken by GP in respect of blood test results; patient transport didn't arrive to take patient to King's; inadequate care in place to support discharge from MTW; patient left in a 'disgraceful condition'; delays in operation being undertaken at King's; error in MTW EDN.	Responses provided from GP and King's. At time of patient's discharge from MTW, she was self-caring and independent and there was no indication that she needed to be referred for assessment of care needs. Apologies for error on EDN - consultant will highlight need for accuracy and attention to detail with junior team.
19274	MOD	BREAS	11/12/2017	Complaint raised about the number of cancelled appointments for follow up appointment after mammogram and that an appointment was offered for an occasion when the patient had notified the team she would be unable to attend.	Apology offered for the cancelled appointments and explanation around the new annual follow up programme which is being developed which will help to reduce the number of cancelled appointments and which will also offer patients who do not need to return the clinic the option of a telephone appointment. Apology offered for delay in communicating mammogram result.
19283	MOD	GENONC	15/12/2017	Concerns that patient was not referred for immunotherapy as requested prior to having surgery or radiotherapy treatment. Patient believes that the immunotherapy would have treated his entire body rather than just the lesions and potentially could have prevented a further return of the melanoma. Patient unhappy that he was referred for immunotherapy drug trial treatment but was told when he attended the appointment that he was not a candidate for it as he did not meet the criteria.	Explanations provided to patient about the clinical reasons that he was not referred for immunotherapy treatment as requested prior to having surgery and these decisions were made in the patient's best interests. Apologies and explanations given that consultant misinterpreted the inclusion criteria and that patient did not meet this. Consultant acknowledged she did not hold full information on the criteria for the study and should have contacted the centre running the trial.

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19272	MOD	ELDER	19/12/2017	Various concerns regarding lack of nursing care and attention for elderly alzheimer's patient who had a fractured leg. Lack of help from staff to assist patient to toilet and delays in her call buzzer being answered which resulted in patient soiling herself, lack of patient's dignity. Lack of communication with patient from staff, poor attitude of nurse who was eating crisps whilst carrying out patient's observations. Daughter also unhappy at delays in her mother being transferred to nursing home as home had been incorrectly informed that patient was non compliant and violent. Patient also discharged to home with a pressure sore.	Apologies and explanation given regarding delays in patient's call buzzer being answered. The ward sister is currently reviewing how the team take their breaks to ensure maximum staff numbers are on the ward at all times. Not clear that patient was always given verbal prompts about non-weightbearing when mobilising with staff. Handover process strengthened with the introduction of a handover sheet. PDN is also reviewing patient boards to ensure mobility plans are included. Ward manager reviewing the availability of foot stools on the ward. Apologies given for the breakdown in communications and staff have been reminded of the need to communicate effectively with relatives and other staff members. Ward sister is also meeting with nurse (temporary member of staff) who was eating crisps whilst taking observations - apologies offered for standard of behaviour . Staff also reminded of their responsibility to challenge unprofessional conduct. Explanations given regarding delays and problems experienced with transfer to nursing home as home would not accept patient after behaviour charts had been sent to them. Explanation given that behaviour charts did not document that the patient was violent or non compliant. Information given that patient was not discharged to nursing home with a pressure sore.
19112	MOD	AE	20/12/2017	Concerns raised that patient was inappropriately discharged from ED twice in quick succession and on each occasion, patient reattended with worsening symptoms. Patient subsequently diagnosed with sepsis, e.coli and viral meningitis. Concerns raised that patient's behaviour while delirious was interpreted as non-compliance and influenced plan to discharge him a third time.	Explanation and apologies given that the initial diagnosis of pyelonephritis was reasonable on patient's first two presentations, as was the decision to discharge him home with antibiotics. However, the patient had clearly deteriorated by his third attendance and he should have been admitted for inpatient treatment at this point. Apologies given that this did not happy until patient's wife intervened on her arrival at the hospital.
19248	MOD	UROL	21/12/2017	Complications following trans-vaginal tape (TVT) insertion. Patient unhappy that she was not advised of the complications associated with the surgery and is still experiencing problems with urinating. Patient is very distressed at lack of care and treatment for her ongoing problems. Delay in cystoscopy being arranged.	Meeting to discuss issues where apology was offered for the delay in arranging the flexible cystoscopy. Measures have been taken to mitigate the risk of referrals being missed in future, which include ensuring that clinic outcome letters are reviewed and typed in-house, rather than outsourcing this function Patient advised that the complications were discussed and consent form signed. Cystoscopy arranged and urethra dilated which is hoped will assist with the ongoing problems

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19194	MOD	MID	27/12/2017	Concerns raised regarding comment made by community midwife and appropriateness of overseas manager asking for forms to be completed 20 minutes after the birth of the baby. Asked for breakdown of delivery costs invoiced.	Apologies made for distress caused by conversation with midwife, however midwife refutes making any comments between Thai people and down's syndrome. Apologies for distress caused by timing of overseas manager's visit but it was appropriate for her to speak with patient while still in hospital. Error with invoice has been corrected and amended invoice issued.
19244	MOD	TRAUMA	28/12/2017	Concerns regarding delay in surgery being carried out for child's knee. Mother also unhappy with lack of communication from orthopaedic team and virtual fracture clinic. She feels that her son should have been treated sooner.	There was a delay in the virtual fracture clinic receiving the referral - improvements have since been made to the process. Apologies that parents did not receive the information they requested when calling the VFC - manager has reminded staff of need to respond to all telephone messages in a timely manner. There was no indication to order an MRI scan until the x-ray report was available. The MRI revealed an injury which required specialist knee surgery. Apologies offered for the delay in patient going to theatre; this was due to high demand for major trauma/life-threatening injury patients, who were clinically prioritised.
19261	MOD	PAEDS	28/12/2017	Concerns raised that staff more concerned with safeguarding issues than the condition of the child. Mother feels staff acted inappropriately by not offering a private room for a phone call to social services and why the examination made the patient scream in distress.	Patient had a full examination by paediatrician to rule out any injuries, including heart, lungs and abdomen. Apologies offered that patient was distressed during examination - often the case when 'strangers' approach children. Apologies offered that mother was not offered a private area to speak with social services - staff reminded to consider this in future. Apologies also offered that staff were celebrating a colleagues birthday - discussed with staff to raise awareness that this was inappropriate.

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18811	MOD	GENSUR	02/01/2018	Concerns raised over mis-diagnosis of ovarian cyst and the impact this has had. Pt transferred to TWH to Maidstone in ambulance without adequate pain relief. Long wait for diagnosis and then surgery.	NHS England investigation revealed that diagnosis made in ED by IC24 doctor was not unreasonable given presenting symptoms, however NHS England uphold that documentation recorded by GP on further visit was not to the required standard and may have caused a delay in diagnosis of the ovarian cyst. Apology offered for transfer to Maidstone to TWH without adequate pain relief for the journey and for delay in providing pain relief. Apologies for delay in surgeon reviewing patient and that once decision was made not to operate, no refreshments were offered. Apology offered for lengthy wait for surgery due to more clinically urgent cases. Apology that f-up appointment was not made as planned, although this would not have prevented the post-operative infection. ACTIONS: Discussions ongoing with transport provider about inter-hospital transfers for non acute patients. Ward staff asked to familiarise themselves with Trust's NBM P&P. Ward staff reminded of need to assess and document patients' pain levels on arrival. Assurance requested that specific nursing staff are up to date with their PGD training. Ward team to be reminded of the correct escalation pathways if there are delays in doctors attending the unit. Gynaecology team to be reminded of need to check operation notes when completing EDN's to ensure any follow-up actions are completed.
19169	MOD	GENMED	04/01/2018	concerns raised that treatment on ward for infected ulcerated leg was no affective. Patient suffered an allergic reaction to some of the medications being given. Following a CT scan on the chest, patient informed they have cancer in both lungs and that there was little that could be done. Transferred to Ipswich Hospital where is was concluded that patient did not have cancer. Patient feels the care has been negligent and that a mis-diagnosis was made.	Detailed explanations provided to patient regarding the appropriate care that was provided to her in line with Trust policy for treating sepsis. Apologies given that there was a delay in patient being seen by the appropriate team for a biopsy to be taken of her wound. This will be discussed at the next clinical governance meeting. Assurances provided that patient was not given any medication which resulted in her having an allergic reaction. Explanation provided that consultant was lead to believe from scans, that had been reported by a consultant radiologist, that these were suggestive of cancer and that additional testing and a biopsy would need to be carried out.

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19213	MOD	GENMED	04/01/2018	Concerns regarding lack of nursing care and attention whilst a patient on the ward. Patient was able to walk with sticks on admission, but family friend alleges that she was left in bed and not encouraged to mobilise by nursing staff. Lack of assistance from nursing staff to help with patient's eating and drinking, lack of cutlery given to patient at meal times, lack of information and communication from nursing staff when complainant raised concerns about patient's care. Concerns also raised regarding patient's missing handbag, glasses and slippers following her death.	Explanations provided that patient was given appropriate nursing care and treatment whilst on the ward. Information given regarding patient's mobility and that she required two members of staff to support her with mobility in bed and staff used slide sheets to help change her position. Patient was supported to get out of bed, but this was limited due to age related changes and patient's painful legs. Apologies offered that patient was not assisted with eating and drinking, not provided with adequate cutlery and for lack of information and communication from nursing staff when concerns raised about patient's care. These concerns will be raised at the next Ward Managers Meeting. Apologies given that normal practices were not followed on the ward regarding patient's belongings. As a point of learning for the ward, they have introduced a more simple property form which is easier to complete. The ward sister has also highlighted at the recent ward meeting regarding a patient's responsibility of their own property and how this can change if a patient's condition deteriorates.
19206	MOD	MID	08/01/2018	Concerns raised about length of time to arrange a debrief meeting. Did not feel listened to in ante natal clinic as consultant refused to see the patient. Patient advised wanted elective c.section due to medical problems but consultant unwilling to book this, Resulted in emergency forceps delivery. Wasn't explained that she sustained a 3rd degree tear and did not receive any follow up for this. Baby given formula feed against parents wishes.	Explanation offered about the booking of debrief meetings. Apology and explanation provided as to why the consultant could not review the patient in the antenatal unit. Apology offered that c.section was not considered and that staff were not fully aware of the implication of the medical condition. Explanation provided around perineal tear which was an extended episiotomy. Apology offered that baby was given formula feed against parents wishes and assurance that new documentation in place to minimise this risk.
19219	MOD	AE	09/01/2018	Family concerned regarding failure to diagnose fractured femur when elderly dementia patient attended ED on three separate occasions. Lack of nursing care and patient's son had to give his mother a drink and request her incontinence pads be changed as she had not been seen by staff for 3 hours. Son unhappy that nurse did not plaster patient's leg as requested by orthopaedic team. Patient's DNR form was lost and calls left on PALS answerphone not returned.	Apologies given that elderly patient's fracture was not diagnosed on two separate occasions and patient was discharged home. Fracture was diagnosed when patient subsequently attended ED several days later. Explanations given that x-rays were reviewed by clinical lead for radiology and fracture was very difficult to diagnose. This will be shared at ED & radiology clinical governance meetings. Apologies also given that patient was not offered a drink and for delay in incontinence pad being changed. These issues will be highlighted at ED staff meeting. Explanation provided that staff tried to apply plaster as high as possible as requested, but this was difficult due to patient's incontinence. Apologies given that DNR form was lost and call not returned by PALS.

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19233	MOD	ELDER	17/01/2018	Concerns that patient was not informed in a caring and compassionate way that he had lung cancer, patient and his wife only found out from EDN. Concerns also raised that patient was discharged from hospital with no care package in place, no pain relief prescribed and social services not informed. Daughter also concerned that patient was not given antibiotic treatment for a chest infection on a previous admission.	Apologies given that it is unclear from the medical records whether they were told explicitly of the suspected cancer diagnosis. This will be raised with staff at directorate clinical governance meeting. Explanation given that patient did not require a care package on discharge and no concerns voiced by family with regards to requiring any support on discharge, no referrals required to care manager or social services. Pain relief not prescribed as patient was not in pain at point of discharge. Explanation provided that patient did not require antibiotics on a previous admission for a stroke, as he did not have a chest infection.
19257	MOD	MID	17/01/2018	Number of questions raised around processes following the unexpected death of a baby soon after birth. Concerns that mother's personal contact details given to coroner without permission, that baby was not christened, and that the birth certificate was not available for a number of weeks.	Apology that staff did not offer the option of a blessing following the death of the patient and that staff did not inform parents that they may be contacted by the Coroner's office. Both issues to be raised at clinical governance meeting.
19321	MOD	ENT	18/01/2018	Patient attended ED with foreign body in the ear lobe. Despite examination, ENT review and ultrasound scan, patient discharged as foreign body not found. A few days later the patient reattended the ED and a foreign body removed from ear lobe.	Explanation provided as to examination and scan undertaken to identify foreign body, which could not be identified during ED attendance, despite both ENT and ED doctor reviewing patient. When patient reattended, foreign body was removed.
19334	MOD	GYNAE	25/01/2018	Patient attended ED due to bleeding at 12 weeks pregnant, was not offered a scan and waiting long period of time to be reviewed by a doctor. Patient feels communication was extremely poor and felt that nobody was taking concerns seriously.	Explanation provided around process for patients who attend with bleeding at 12 weeks and why a scan was not offered. Apology that communication was poor, and action for directorate to reiterate to staff the correct process for referral for an early pregnancy scan so that we can offer accurate advice and give a realistic expectation to women as to when they will receive a scan.
19288	MOD	MAMMO	25/01/2018	Concerns that patient was sent a letter inviting her for breast screening but patient had a bi-lateral mastectomy several years ago following breast cancer.	Explanation and apologies given that patient's details were not removed as no contact received from GP Practice following proforma being sent to the practice requesting which patients should not be sent invitation to breast screening. Following the complaint the process has been changed and staff in the Unit will now make active contact with the Practice Manager ahead of emailing or faxing the proforma to the Practice. Staff in the Unit will also contact the practice if they fail to return the proforma in a timely manner. The GP Practice has also been contacted to make them aware of the upset caused.

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19254	MOD	PAEDS	29/01/2018	Concerns raised that H-type fistula was not diagnosed at birth despite concerns being raised by the parents and attendances to the ED and GP.	Apology offered that diagnosis was not made sooner, however this is a very rare condition and appropriate referrals were made when the diagnosis was suspected.
19295	MOD	GAST	29/01/2018	Concerns raised around poor end of life care and lack of communication. Patient found in an undignified state, trying to leave the ward. Patient not provided with food or fluids. Family not alerted that patient was nearing death and therefore were not with him when he died. Lack of care shown to family following death, including letter of complaint not being answered.	Explanation and apologies offered regarding the impact of the communication in this case with the complainant and family. Explanation also provided that medical staff were not expecting the patient to die as he appeared stable and there were no clear indications that he was likely to deteriorate. Clear evidence in nursing records that staff were offering and providing assistance to patient with eating and drinking. Complaint will be discussed at directorate's clinical governance meeting.
19129	MOD	GENMED	30/01/2018	Concern that patient was discharged in an unfit state and required readmission the following day. Query as to why urine test was not completed on readmission. Various concerns about lack of care/intervention following readmission, why patient wasn't on oxygen or fluids.	Explanations provided regarding patient's appropriate care and treatment. Apologies given that investigation of complaint highlighted a number of occasions where record keeping has not been maintained at an acceptable standard. These have been highlighted with the relevant staff and the complaint will be used anonymously to illustrate the importance of thorough documentation. Missed opportunity to undertake observations when attending to patient during the night.
19099	MOD	HAEM	01/02/2018	Patient was referred to haematology and she understood was going to have a blood transfusion. On the day was informed this was a consultation. Unhappy with attitude of haematologist and lack of action taken at appt. Problem with labelling of blood sample resulted in delayed treatment in ED. Delay in patient being admitted and conflicting information given by dr. Blood transfusion stopped in error - nurse responded poorly to situation. Patient not informed of side effects of pain relief. Concern about length of time between transfusions.	Explanation provided that the normal practice is for a patient to be seen in clinic by the haematologist, who will make a decision regarding a treatment plan, including any need for transfusion. Apologies given that this was not clearly communicated to patient. Apologies offered regarding consultant's attitude. Explanation provided that blood samples are labeled with pre-printed stickers which is standard practice, apologies given for the impact this had on the patient. Explanation and apologies given that hospital was extremely busy at the time of patient's admission and for the poor explanation given at the time. Explanation given regarding blood transfusion being stopped and apologies offered for the additional stress caused. Apologies given that patient was not informed of side effects of medication and any misunderstanding regarding length of time between transfusions.

ID	Grade	Sub Spec	Closed	Description	Outcome
19127	MOD	HAEM	01/02/2018	Concerns re delayed administration of treatment. Medication was inappropriately opened by staff but no action taken to resolve this which caused a break in treatment. Poor communication around what medication to take and arrangements for scan.	Explanation and apologies offered for delayed treatment, Matron has asked the team to ensure that any delays are documented on the information boards in the waiting room, so that patients are aware and understand why they are waiting. Apologies offered that medication was opened in error by a new member of staff working in the department, this was addressed with her at the time and she acknowledged her mistake and reflected on the impact that this had on the patient. Information and apologies given for poor communication.
18916	MOD	HAEM	02/02/2018	Concerns raised about poor coordination of care between King's & MTW. Delays in application to NHSE for permission to prescribe treatment. Delays in action being taken in response to blood test monitoring. Records not updated resulting in appt letters being sent tot he wrong address. Keyworker at MTW is often unavailable. Concerns that advice given by King's is not being followed by staff at MTW. Delays in referrals for ophthalmology & ENT appointments. Investigation to look for possible source of bleeding never arranged. Platelets not ordered for planned appointments in HODU and endoscopy. King's unable to access most recent tst results from MTW.	Explanation and apologies given for delays in application to NHSE. Apologies given for delays in action being taken in response to blood test monitoring, HODU staff no longer provide results to patients. Apologies given for incorrect address, staff are now expected to check all key contact information with patients at every appointment, to maintain accuracy. Explanation given that other CNS's could be contacted if key worker not available. Apologies given that there has been poor communication between Trusts and both Trusts will look to improve on this. Apologies given that referrals were not made, this has been highlighted to the consultant concerned. Apologies also given for delays in platelets being ordered and explanation provided that some products have to come from Tooting and may take time to arrive.
19107	MOD	ORTHO	02/02/2018	Number of concerns raised with treatment on Ward 31 including inconsistent staffing, lack of continuity of care, incorrect medication prescribed, lack of investigations into urine frequency and faulty equipment and cleaning. Compliments also given for a number of staff members.	Explanation offered that it is not possible to allocate one or two nursing staff to care for a patient throughout their admission due to shift allocations. Handovers take place to support continuity of care and staff would be expected to check with a patient if they were unsure about their level of function. Apology offered for poor conduct of an agency nurse. Assurance offered that correct medication was prescribed. Urine testing was carried out even though dip test had been negative and patient had no other clinical signs of an infection.
19343	MOD	UROL	05/02/2018	Concerns that patient received a copy of a clinic letter that was headed up as being about him but actually referred to another's patient and their consultation rather than his consultation.	Apology offered and assurance provided that the Trust are aware of this issue. Staff have been reminded of checking personal demographics before saving and sending letters.
19349	MOD	MID	08/02/2018	Concerns that on the post natal unit, a midwife whom the patient had asked not to attend to her and her baby entered her room to assist another midwife. Feels that requests made to midwife during labour were not actioned.	Apology offered for the distress caused by the midwife attending to assist another midwife. Explanation provided regarding the presence of staff during the delivery of the baby.

ID	Grade	Sub Spec	Closed	Description	Outcome
19340	MOD	BREAS	12/02/2018	Concerns regarding long delay in patient with Stage 3 breast cancer being advised of her mammogram results following treatment. Long delay in follow up appointment to be seen.	Acknowledged that there is currently a long wait for results due to capacity issues. Work being done to redesign service to reduce timeframes for results.
19355	MOD	MID	12/02/2018	Concerns raised that monitoring did not identify that foetus had no heartbeat, was the monitoring correct? Why was a scan not arranged when concerns raised with the community midwifery team? Concern raised that midwife was negligent. Also concerns raised around language used when attending for blood tests and length of time taken for blood tests results to be returned.	Explanation provided that fetal heartbeat monitoring is not recognised as a reliable measure of well being under 24 weeks gestation. Apology offered that a scan or further monitoring was not arranged. Apology offered for language used during blood tests, this was not intentional and apology for delay in providing results. As a result of complaint, Matron has identified that there is some clarity required in the Trust's antenatal foetal auscultation and monitoring guideline and has contacted several senior staff within the directorate to highlight that the current guideline is not clear for community midwives. The guideline will be reviewed and amended, as required.
19367	MOD	AE	13/02/2018	Concerns that 12 week pregnant patient was advised by doctor that he could detect the baby's heartbeat during an ultrasound scan when patient attended the department following a road traffic accident. Patient attended the obstetric and gynaecology ultrasound department the following day for a scan and was advised that there was no heart beat and baby had died at 7 weeks. Lack of information in discharge note to GP referring to pregnancy.	Explanations and apologies given to patient that it is not within the ED doctor's normal practice to carry out an ultrasound scan but doctor wanted to provide some reassurance to the patient as he was aware how concerned she was about her pregnancy. Doctor has been advised by Clinical Lead to ensure he works within his remits in future. Apologies also given that patient's pregnancy was not mentioned is discharge summary to GP. Doctor has been advised by Clinical Lead that this information should have been included.
19360	MOD	GAST	14/02/2018	Concerns that patient received another patient's clinic letter, breach of confidentiality.	Apologies given for human error. Explanation provided that staff in the unit have been reminded to send all patient sensitive correspondence through the hospital IMail system to prevent a recurrence of this happening.
19276	MOD	PAEDS	15/02/2018	Concerns that doctor did not offer alternative treatment and was dismissive towards relative. Doctor showed a lack of compassion and referral was sent to the incorrect location.	Apology offered for lack of compassion, this is not the usual practice of this doctor and he does not recollect events as described in the complaint letter. Apology offered that referral was sent to the incorrect location and for any delays in treatment this may have caused. Explanation provided regarding ceiling of treatment available locally.

ID	Grade	Sub Spec	Closed	Description	Outcome
19227	MOD	HAEM	28/02/2018	Concerns regarding extremely long delay (157 days) in receiving treatment following his diagnosis of chronic lymphocytic leukaemia. Concerns that patient's condition has deteriorated by being left untreated.	Explanation provided of diagnostic pathway. it was necessary to complete further tests in order to make definitive diagnosis as this would influence treatment plan. Following urgent re-referral to ENT for biopsy, appt could have been accelerated a couple of weeks. Timing of treatment would not have influenced the outcome as the diagnosis has a very poor prognosis.
19359	MOD	AE	28/02/2018	Patient's daughter believes there was insufficient nursing staff on the unit which resulted in a lack of nursing care and attention for her elderly mother. Patient had a fall whilst on the unit sustaining a mild head injury. Patient was also advised to wet the bed if a nurse could not attend to her quickly enough as there was a lack of incontinence pads, lack of patient dignity.	Explanation provided that there were some difficulties in covering shifts whilst patient on the unit and apologies offered. Explanation provided that all relevant risk assessments carried out when patient transferred to the unit and apologies given that patient had a fall whilst trying to mobilise to the toilet. Explanation given that incontinence pads were available on the unit and patient had requested one as she was concerned about soiling her bed at night, apologies given for breakdown in communication.
19388	MOD	RESPIR	01/03/2018	Concerns regarding delays in being seen following scans for suspected cancer, family believe that patient was lost in the system and this may have impacted on his prognosis. Concerns that family were not updated on patient's condition/treatment on a subsequent admission. Patient also had a fall on the ward and family were not contacted and informed of this by ward staff. Family unhappy that doctor discussed patient's resuscitation status with his family in front of him when he was very unwell.	Explanation and apologies provided for the delays in scans being reviewed at MDM and patient being further followed up as the CT scan findings did not raise immediate suspicion of cancer and therefore was not added to the tracking system, consultant is unable to categorically say whether this delay impacted on the prognosis. Explanation given regarding communication staff had with family members about patient's condition/treatment. Apologies given that staff did not contact family members immediately following patient's fall, explanation given that patient did not appear to have suffered any injuries at the time so staff were going to contact family later in the day. Comments provided that it is considered good medical practice to discuss a patient's resuscitation status with them and their next of kin, under appropriate circumstances. Apologies given for the additional upset caused.
19391	MOD	CHRPA	05/03/2018	Patient unhappy with the waiting time to see the pain team and commence treatment.	Apology offered for the delay in being seen by the pain team and advised that process changed in order to ensure appointments are made in a more timely way.

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19115	MOD	COLOR	05/03/2018	Patient attended for surgery and developed an ileus. During the following 10 days only received sips of water, concerns raised that patient became malnourished. Patient had been taken off a medication for prostate cancer by urologist at Medway, which was restarted but no explanation given as to why and despite daughter asking or doctor to contact Mr Masood, no contact was made. Manner and attitude of Doctor.	No evidence to support that patient lost any weight during admission and in fact he was found to have gained weight when weighted. Patient also received high calorie drinks which were declined. Evidence supports that appropriate referrals were made and nutritional intake was closely monitored. Apology offered that medication was given sporadically, however doctor contacted GP for medication regime which was then followed. Apology offered regarding manner of the doctor who recognises that communication had broken down and has reflected on this.
19387	MOD	OPTHAL	05/03/2018	Concerns raised that despite consultant indicating an appointment in 6 months time, this appointment was not received for a year and 3 months. Concerns that delay will have impacted on already deteriorating eyesight.	Apology and explanation provided around capacity within the service and what is being done in the community to increase the capacity. Assurance offered that delay did not negatively impact the patients condition.
19282	MOD	ORTHO	06/03/2018	Concerns that staff on Ward 30 not competent in using back brace. Surgery to foot cancelled as surgeon had not seen the scans and patient transferred to King's unnecessarily.	Apology offered that staff not able to use brace and assurance offered that staff are being trained and reiterated to staff where to obtain support if required. Transfer to KCH was at their request being the specialist centre. Apology that surgery to foot cancelled however this was the correct decision.
19370	MOD	STROKE	09/03/2018	Concerns regarding over-zealous methods employed by discharge co-ordinator in contacting patient's family about finding a suitable care home for patient to be discharged to, patient's daughter felt constantly pressurised.Concerns that patient was transferred to another ward which then had an outbreak of norovirus and patient could not be discharged to the care home. Concerns that patient's hearing aid was damaged whilst he was in hospital. Daughter not contacted by staff to advise that he was being discharged so that she could be at the care home to meet him.	Explanations provided regarding reasons for family being continually contacted regarding location of patient's discharge and apologies given for the distress caused. Apologies given that there was an outbreak of norovirus on the ward which delayed patient's discharge to care home. Apologies also given that daughter not contacted regarding patient's discharge as requested and assurances given that this issue will be discussed with the relevant staff. Explanation and apologies given regarding hearing aid.
19328	MOD	AE	12/03/2018	Concerns regarding failure to diagnose blocked bowel when patient attended ED. Patient subsequently re-attended two days later and required surgery. Patient also unhappy that surgeon withdrew her epidural pain relief less than forty hours following surgery when she had been told it would be in for seventy two hours.	Apologies given that patient's small bowel blockage was not diagnosed. Clinical Lead has fed this back to the doctors involved and stressed to them that a diagnosis of small bowel obstruction should have been actively looked for given the patient's symptoms and past medical history. Clinical Lead has also stressed to the doctors involved that they should consider a differential diagnosis and to document this. Case will be presented at ED clinical governance meeting to highlight to all ED doctors. Explanation provided that epidural infusion was removed day 3 post op, and that it is usual practice to remove epidural infusion three days post op and patient given pain relief and also referred to pain team.

ID	Grade	Sub Spec	Closed	Description	Outcome
18842	MOD	ELDER	13/03/2018	Extensive concerns raised regarding frequent admissions and repeated failed discharges spanning acute, community and social services. Feels family not being listened to around concerns about patient's ability to cope at home. Staff focused on patient's COPD causing symptoms but these have now been attributed to a cardiac condition.	Explanations offered by SS around rationale for discharge decision making - patient was assessed to have capacity to make her own decisions. Some issues to be highlighted in MTW newsletter around ensuring staff are aware of patient's preferred name, management of patient property and need to consider carer's assessments.
19273	MOD	AE	14/03/2018	Various concerns regarding lack of nursing care and attention for alzheimer's patient, patient not offered food or drink, incontinence pad not changed for many hours even though wife asked that this be changed. Lack of information and communication with patient's wife by nursing staff.	Explanations and apologies given for lack of nursing care and attention and lack of communication with patient's wife by staff.
18798	MOD	AE	14/03/2018	Concerns raised around initial discharge home. Catheter tap was closed, so urine not draining well. Patient fell at home and was readmitted. Patient became very drowsy and confused. No assistance given with eating - patient spilled breakfast over himself and no-one attended to change him. Lack of clear explanations provided around treatment plan. During admission it was identified that patient had been overdosed on morphine. No investigation of or treatment given for constipation. Pneumonia listed as cause of death - not mentioned during admission.	Explanation offered as to medical decision to discharge on first occasion. Discharge was arranged to coincide with carers visit to patient's home that evening, but transport was delayed so the patient missed the carers. Apologies offered that ward staff did not factor this in and hence no advice was given to patient re managing catheter bag. Issue discussed at ward meeting. Following readmission, patient had butrans patch prescribed and applied. Following day, patient appeared alert in the morning and able to feed himself. When complainant arrived, patient was more drowsy. Consideration given to low haemoglobin causing drowsiness so O2 administered. Patient received oramorph following reports of severe pain. Patient continued to be drowsy - investigated for stroke. Naloxone given to reverse effects of opiate medication until resolved. Patient died later that day. Apologies offered for occasions where communication with family was poor.
19287	MOD	AE	14/03/2018	Various concerns regarding lack of medical and nursing care and treatment when patient attends the department. Patient has been classed as a "special case" and believes this is the reason why she is treated differently and her symptoms are not taken seriously. Delays in pain relief, patient left in urine for 5 hours, call buzzer left out of patient's reach. Uncaring attitude of doctors and nurses.	Explanation provided that patient received appropriate medical care and treatment for presenting symptoms. Letter on ED system has been amended as agreed with the patient and apologies given for the distress caused.

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19409	MOD	CARDIO	14/03/2018	Concerns that patient's slipped disc, between his shoulder blades, was not diagnosed when he was admitted a few months following a fall. Patient feels that the investigations and tests carried out to establish if he had a cardiology condition was a waste of time. Patient also concerned that he suffered an aneurysm following an angiogram procedure which left him in pain for some time after. Concerns regarding lack of communication from staff regarding procedure.	Explanation provided that patient was admitted with chest pain on exertion and investigations and tests carried out were appropriate due to his presenting symptoms. Explanation provided that patient was advised of risks of angiogram procedure. Apologies given for lack of communication provided to patient.
19385	MOD	RESPIR	15/03/2018	Concerns regarding lack of medical care and treatment for patient's confused state, despite being told by her family that it was completely out of character. Concerns regarding lack of nursing care and attention, patient had a fall. Family concerned that patient was not given 24/7 care for the 2/3 days they were told she needed it resulting in patient removing her cannulas. Lack of communication from the CT department to ward to advise patient had an appointment that then had to be cancelled causing patient distress.	Detailed explanation provided that patient's care and treatment was appropriate. Case also reviewed by another consultant physician who advised that he would not have done anything different and that he also felt her care and management was appropriate. Explanation provided regarding appropriate nursing care and treatment given. Information and apologies given for patient's fall and family advised that no injuries were sustained by the patient at the time. Explanation and apologies given that there was a delay in one to one nursing care being provided due to lack of staff availability. Explanation provided that patient's ultrasound scan was delayed due to a lack of available staff on the ward to escort patient to the ultrasound department and also due to an acutely unwell patient on the ward.
19368	MOD	ENT	21/03/2018	Pt attended ENT opa on 30/11/17 only to be informed that it had been cancelled, without pt's knowledge. Appointment was booked for 4 January. When attending on 4 January, informed that clinic had been cancelled again. No notification was received for either cancellations.	Apology offered regarding cancelled appointments and letters not being sent. Explanation provided that this is a recognised concerns which is currently being investigated.
19377	MOD	ENT	21/03/2018	Concerns raised that GP referral letter not received by ENT team and conversation between GP and SHO not documented, resulting in delay in obtaining an urgent appointment.	Apology offered that GP referral was not received and assurance offered that GP surgeries are aware of the preferred method of referral. Apology offered that SHO did not act on conversation.
19414	MOD	GENSUR	21/03/2018	Patient discharged early in the morning. Medication and EDN arrived by courier but were for a different patient.	Apology offered for patient being discharged in the early morning as this is inappropriate and SSSU staff to be reminded that patients must not be discharged prior to 8am. Apology that incorrect medications were given to the patient on discharge and assurance that patients data has not been breached.

ID	Grade	Sub Spec	Closed	Description	Outcome
19189	MOD	UROL	23/03/2018	Concerns raised that following appendicitis surgery, catheter was required as unable to pass urine following the surgery. Catheter went on to caused numerous urine infections and multiple trips to hospital. Further surgery attempted to rectify the problem but unsuccessfully. Patient wants to know why this all happened and the plans for the future.	Apology offered for discomfort etc however investigation concludes that appropriate measures taken when patient attended hospital. Patient awaiting further diagnosis from UCLH
19292	MOD	OPTHAL	26/03/2018	Concerns raised that patient has been waiting a long time for an appointment and feels has been overlooked. Worried the eyesight deteriorating with no clear plan going forward. Failure by doctors to book appropriate appointments and difficulties contacting booking team as telephones unanswered.	Apologies offered for poor communication with patient about appointments, and some confusion caused as patient also being seen privately. Assurance offered that there is a management plan for this patient. Apology offered for difficulties in contacting the booking team and advised of COO group looking into this issue.
19172	MOD	NHB	10/04/2018	Concerns raised that disabled facilities at both sites are inadequate and that clinic appointment had to be cancelled as room was not adequate for specific disabilities. No space on choose and book system to add comments to highlight need for accessible room.	Apology offered that facilities do not meet patients specific needs, however are in line with DDA requirements. Apology offered that room not available, and measures to be put in place to ensure staff are aware of requirements in future. Letter to be sent to GP advising that referrals need to include specific patient needs.
19221	MOD	PATSAF	12/04/2018	Son very unhappy with the SI investigation and report he received and the inaccuracies contained within the report . Concerns that patient had a fall on the ward and sustained a fractured neck of femur and patient subsequently died. Daughter also concerned that she was not contacted by ward staff and informed of patient's fall. Patient was still in soiled bedding when his daughter visited him the day after his fall and his wounds had not been freshly dressed. Lack of communication between medical staff that patient was not fit enough to undergo surgery for his fractured hip.	Apologies offered for inaccuracies in SI report. Concerns raised in complaint have been shared with the falls panel chair for ongoing review. Explanation and apology offered for delay in notifying relative of fall. Apologies offered that patient was found in bloodstained bedding. Patient had leg wound and broken hip - changing the bedclothes would have caused discomfort at that point. Dressing had not been changed so as not to disturb healing process. Assurance offered that initial decision to operate was clinically appropriate.
19337	MOD	OPTHAL	12/04/2018	2 month delay in receiving clinic letter advising of a change in prescription. Differing readings given for intraocular pressures.	Apology offered for long wait to receive clinic letter. Explanation provided as to the differing eye pressure readings which can be given from different machines ad this is recognised and accepted.

ID	Grade	Sub Spec	Closed	Description	Outcome
19225	MOD	SCBU	18/04/2018	Several concerns raised regarding poor communication with mother from staff on SCBU, why consent was not requested for procedures (lumbar puncture and x-ray), why not allowed to stay with baby or hold him, and why mother was not informed what was wrong with the baby. Request made for a copy of the baby's medical records, which was not acted upon by the ward manager.	Apology and explanation offered, consent was not required for procedures as these were emergency interventions and explanation offered about why mother could not stay on the unit with the baby. It is detailed in the notes that mother and father were made aware of condition of the baby and ward manager offered to write condition and treatment down for parents. Apology offered that copy of notes was not actioned and ward manager has been made aware of requirements to action requests such as these in future.
19352	MOD	PAEDS	01/05/2018	Concerns raised that RSV injections not offered for her daughter, given that her daughter was born with underdeveloped lungs. Also is unable to contact consultant's secretary to arrange follow up appointment.	Vaccination was not clinically indicated for baby, hence not offered. Secretary was on leave but alternative instructions were provided on answerphone message to contact staff covering - apologies offered nonetheless.
18760	MOD	GENSUR	02/05/2018	Questions raised regarding delayed diagnosis of gallstones. Pt experienced delay in colonoscopy being carried out due to onset of extreme pain. Patient admitted and had USS. Family queried possibility of a problem with the gallbladder but were dismissed. Patient readmitted and doctor in ED advised that USS had shown gallstones.	Assurance offered that inflamed gallbladder was not present on first admission, however scan did reveal gallstones which the GP and patient were not advised of. Explanation provided that the correct decision was made regarding the colonoscopy as patient was too unwell for this procedure. Explanation provided that it was reasonable to attribute pain to opiate toxicity. Investigation has highlighted that there was a failure in not following the patient up after his initial discharge. Case presented at directorate clinical governance meeting and chronic pain team will be asked to attend a future meeting to provide education on managing patients with chronic pain.
19094	MOD	GENSUR	16/05/2018	Concerns raised that misdiagnosed with constipation on first attendance to ED, back 3 days later and admitted but received no treatment. When discharged attended private hospital and underwent surgery for adhesions.	Assurance offered that management of first presentation was acceptable, given the clinical signs and symptoms reported. The plan was to discharge patient to GP for outpatient colonoscopy to investigate the cause of the symptoms. When patient represented, a diagnosis of bowel obstruction was made. Initial management was to withhold solid food to rest the bowel. An NG tube was fitted to release any gas/fluid from the stomach by the patient was not able to tolerate this and removed it. The patient's condition improved with conservative management such that he could be discharged home. Unfortunately, private surgeon cannot recall why he made the decision to proceed to surgery.

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19426	MOD	CARDIO	18/05/2018	Concerns regarding long delays in patient being followed up and treated for heart condition.	Explanation given that patient did not attend an appointment arranged for him and apologies given for delay in subsequent follow up appointment, patient advised that actions taken in an attempt to reduce the delays in follow up appointments including sonographer and cardiology nurse led valve replacement follow up clinics, appointment of locum consultants, use of additional weekend clinics. Decision to remove automated reminders to be reviewed in light of complaint.
19226	MOD	HAEM	04/06/2018	Concerns that patient was not contacted by hospital staff to inform him or the nursing home that his chemotherapy medication was ready for collection. This resulted in a three week delay in patient starting his treatment.	Apology offered for delay in pt commencing chemotherapy. Pt was very unwell so chemotherapy options were limited. Normal practice for dr to prescribe therapy following consultation for collection the following day. Changes since made to process: if prescription is not collected from pharmacy, consultant/CNS is alerted so that they can follow up. CNS now attends appt to support patients and act as further failsafe. Neutropenic sepsis was always a risk.
19092	MOD	MID	07/06/2018	Concerns raised that post natal treatment in 2016 was not adequate and the attitude of staff was poor. Environment concerns on the post natal unit.	Concerns expressed by patient regarding ward environment were discussed with her by ward manager and delivery suite manager at the time, with apologies and explanations offered as appropriate. Patient threatened to self-discharge and staff persuaded her to stay. Spinal anaesthetic had to wear off before patient could be wheeled to special care baby unit. Apologies that photos taken of baby were not delivered to the patient immediately. Apologies that staff didn't offer patient a sandwich/snack and as a result, patient had to cut visit to baby short. Apologies offered for lack of communication around discharge arrangements.
19397	MOD	CT	19/06/2018	Concerns that patient's CT scan results were not consistent with images and patient told that her cancer had spread. It was later found that images are correct images for this patient but report applies to a different patient. Concerns also raised that ED nursing staff did not know how to access her portacath to take bloods.	Explanation and apologies provided on how this error occurred and staff have been reminded that they must check the patient's details on the images to ensure they are the correct patient, regardless of the use of the automated system. Reporters have also been reminded of the importance of checkings patients demographics when commencing reporting on images. Explanation and apologies provided that nursing staff do receive appropriate training for dealing with portacaths, but need to complete their competency before they can access portacaths.

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18932	LOW	UROL	18/04/2017	Concerns raised that second part of a procedure which should have been 3 weeks following initial procedure was not booked and has been further delayed.	Explanation given that the second part of the procedure was not identified on the booking form and therefore delays occurred when booking this procedure. Assurance offered that delays were not due to CCG restrictions but to our own booking processes.
18936	LOW	AE	27/04/2017	Patient dissatisfied with the wait to see an ED dr and then the wait for a surgical review. No offers of help/support were made during her time in the ED. Felt there was a lack of priority in getting her seen.	Patient did experience a long wait to be seen by the ED staff, due to some unfilled shifts. Apologies offered.
18737	LOW	GENSUR	15/05/2017	Concerns raised around attitude and communication from consultant.	Apologies offered for distress caused. Explanation provided around circumstances and reassurance that all complaints about conduct are discussed at appraisal. Pathways being reconfigured to improve emergency surgery service.
18983	LOW	MID	02/06/2017	Concerns raised with attitude of staff on EGAU and with staff member who contacted to advise will have a miscarriage. Ultrasound scan was not cancelled and patient attended unnecessarily.	Apology offered and explanation around why staff member was asking certain questions. Apology offered that ultrasound scan was not cancelled.
18992	LOW	ENT	09/06/2017	Patient's procedure for tomorrow cancelled and she is very unhappy.	Apology that procedure cancelled. Patient has procedure the following week.
18995	LOW	OPTHAL	12/06/2017	Concerns raised with attitude of CAU staff when cancelling and rebooking appointments	Apology offered and reassurance that concerns would be discussed with staff member and any identified learning actioned.
19060	LOW	GENSUR	23/06/2017	Patient unhappy that clinic letter from surgeon makes no mention of referral to gynaecology.	Consultant advises that he would normally include reference to further investigations and apologises for the omission
19019	LOW	RHEUM	28/06/2017	Concerns raised around lack of support provided when patient experienced breathlessness following a rituximab infusion. Concerns raised around environment of clinic including infection risks, lack of privacy, noise. Patient was distressed by interaction with the receptionist/ward clerk.	Due to levels of activity in the hospital, AMU had been escalated, which resulted in a delay of 15 mins in commencing patient's infusion. Apologies offered. Assurance offered regarding infection risks. Explanation provided for layout of treatment suite. Chair side lockers not available on AMU but infusions are now provided in dedicated unit with storage. Interaction with ward clerk has been addressed with her. Patient appropriately accessed helpline and GP following infusion.
19026	LOW	GENSUR	03/07/2017	Concerns raised around poor communication and lack of co-ordinated care. Inconsistent messages to patient regarding whether condition was operable or not, and attitude of Surgeon seen in outpatients..	Explanation provided of patient pathway and management plan. Not clear why patient understood condition was inoperable , but apologies offered for lack of clarity in communication. Patient will be seen by alternative surgeons in the future.

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19042	LOW	PATH	03/08/2017	Concerns raised regarding failure of staff to address and support individual patient needs. Patient with significant disabilities required blood sample, phlebotomy staff made a derogatory comment about patient and did little to facilitate obtaining a blood sample.	Apologies not enough consideration was given in the ENT clinic to patient's needs when a the blood tests was requested - issue to be discussed at clinical governance meeting. Phlebotomist explained that numbing cream wasn't available and offered a cold spray which was declined on the patient's behalf. Patient should have been directed back to clinic for cream prescription. Assurance offered that support for patients with severe learning disabilities exist in the department. Assurance offered that complaint shared with safeguarding adults matron.
19097	LOW	GENSUR	17/08/2017	Concerns raised that surgery cancelled twice, once on the day and once and the patient was not advised until attending for a pre-op. Would like to know if the service provided is normal / acceptable.	Explanation re circumstances of cancellations. On second occasion, patient shouldn't have been offered that date as consultant was on-call and therefore not able to undertake elective procedures. Patient was rebooked within the 18 week time limit.
19114	LOW	ORTHO	23/08/2017	Patient was seen in A & E and advised that she would hear from the VFC as to when to come back to the hospital regarding her fractured knuckle. Why was patient referred to Medway and therefore has not received any treatment for injury to thumb?	Initial plan was for patient to be followed up at Medway as this was closer to home. VFC staff were asked to contact family regarding this. One call was made with no answer or facility to leave a message, however, no further attempts were made. Apologies offered for this. Reassurance offered that delay in follow-up has not impacted on recovery.
19028	LOW	HAEM	05/09/2017	Patient concerned that no written treatment plan has been provided to GP and he has been discharged from clinic. Conflicting verbal instruction given to GP regarding continuing/stopping warfarin. Clinic letter still outstanding.	Explanation and apologies given that communication with patient and their GP had not met the expected standards. Assurance given that when recommending anticoagulation, the risks and benefits were considered, and patient did not appear to have experienced any side effects of the therapy.
19174	LOW	OPTHAL	29/09/2017	Long wait for telephone to be responded to when phoning to make appointments. Also advised appointment required in 6 weeks but unable to book an appointment within this timeframe.	Apology and explanation offered. It is recognised that not all appointments can be allocated within the designated timeframes and staff have been reminded to be realistic when booking appointments.
19202	LOW	GYNAE	02/10/2017	Patient attended for planned operation which was cancelled on the day as the surgeon was not available. Questions asked about administration processes as letters indicated patient to go to Ward 33 on arrival but needed to be on SSSU.	Apology offered that list was not cancelled due to an administrative error. Apology offered that letter advised of the incorrect ward to attend on arrival and this has been rectified.
19171	LOW	MID	06/10/2017	Concerns raised the ante natal clinic short staffed and had to wait over 2 hours past appointment time to see doctor. Why did reception staff not make those waiting aware that there was a delay. Concerns that doctors were working without adequate breaks.	Explanation offered around availability of staff in this clinic. Clinic was short staffed by one, which couldn't be covered by agency as short notice. Apology offered that reception staff did not update those waiting in clinic and reception staff left before clinic had finished due to it overrunning. Assurances offered that staff are allowed to take adequate breaks.

ID	Grade	Sub Spec	Closed	Description	Outcome
19218	LOW	AE	06/11/2017	Patient's husband wishes to raise concerns about medication being left in patient's handbag when she was admitted following an overdose. Husband believes staff should have asked about medication or removed the medication from patient's possession.	Explanations provided that staff do not have the authority to search a patient's belongings for medication. Apologies given that patient was not asked by staff if she had any medication in her possession. Staff in ED have been asked to request medication from patients who present with a psychiatric condition and to document the outcome of that request.
19209	LOW	THEATR	07/11/2017	Concerns raised that it was inappropriate to undertake a pregnancy test on a patient with severe learning difficulties prior to surgery.	Explanation provided that a pregnancy test is required for all women of child bearing age regardless of disabilities. However, a best interests meeting should have been held prior to surgery to determine the best course of action. Apologies offered.
19229	LOW	GENSUR	08/11/2017	Concerns raised that could not contact the surgical CAU to follow up on when a surgical appointment would be made. Tried different numbers which were not answered or where the incorrect number. Patient had surgery at the Spire.	Apology offered for frustration caused when attempting contact. Explanation provide around how patients are listed for surgery and apology for waiting list delays. Concerns regarding calls going through to other departments raised with Switchboard manager.
19141	LOW	AE	13/11/2017	Poor communication - relatives unable to get through to ward, lack of information provided. Delays with patient transport. No-one advised that patient did not have any outdoor clothes to go home in.	Apologies given for the difficulties experienced when trying to communicate with staff and find out information about patient's condition. Apologies also given that he was not informed his mother did not have any outdoor clothes to go home in.
19252	LOW	ADMIN	27/11/2017	Concerns regarding rude and unhelpful attitude of receptionist who told patient to sit and wait for her son's name to be called for his appointment. His name did not show and this resulted in patient being late for the appointment and having to pay an unnecessary £2 parking fee.	Apologies offered for distress caused by experience. Not clear why receptionist didn't direct patient to children's department, as this was what was indicated in the appt letter. As an outcome of the complaint, supervisor has discussed expected standards of communication with the receptionist; reception team will be receiving customer care training in the new year; and details of children's appliance clinics now available to reception staff.
19240	LOW	GYNAE	28/11/2017	Patient unhappy with outpatient appointment consultation and felt that the doctor was not interested in her condition and did not listen to her. Concerns also raised that patient was put on the waiting list for a hysterectomy even though she had been advised her BMI was too high. Patient was informed after pre-assessment that doctor had completed the incorrect paperwork.	Apology offered from consultant, and assurance offered that concerns were listened to. Apology that patient was put on waiting list as this should not have been the case until BMI had reduced.

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19262	LOW	AE	29/11/2017	Patient referred to ED by his GP after blood tests which revealed he had kidney and liver failure. ED doctor asked the patient "what makes you think that this hospital should be treating you". Patient very unhappy with doctor's attitude and comments. Patient was subsequently admitted to ICU. Patient believes there was a reluctance to treatment him as he was considered to be a drunk. Patient unhappy that DNR also completed with consultation with his family.	Apologies for poor communication from locum ED dr. Issues regarding his conduct had been discussed with him when he was working for the Trust. He is no longer working for us and his agency has been informed of concerns. DNAR decision was appropriate but there is no evidence to show this was discussed with the family. Apologies offered for this, CD will remind the ITU doctors about their responsibilities in this respect. Assurance offered that DNAR status did not mean patient was not receiving active treatment, to which he responded well.
19260	LOW	RHEUM	29/11/2017	Concerns that consultant refused to see the patient at a new outpatient appointment because she was late due to difficulties she had in parking and difficulties she has in walking. Patient was referred back to her GP even though she is in pain. Patient unhappy with consultant's attitude and also delays in new outpatient appointment.	Explanation around reason patient could not be seen that day. Apologies for comment made by consultant - unacceptable and complaint will be discussed as part of annual appraisal. Apologies for frustration with roadworks and parking.
19266	LOW	CHRPA	04/12/2017	Patient needle phobic and asked for sedation prior to the procedure. Cannula inserted without sedation and then patient advised no sedation would be given.	Sedation is not used for this procedure due to the risks it poses to the patient. Investigation has been unable to determine why patient was advised sedation would be used. Apologies that pain and anxiety was not well managed for this patient. All patients are provided with an information leaflet pre-procedure which explains what will happen. Anaesthetic cream wasn't given before the cannula was sited as staff were unaware that patient was needle-phobic and cream takes 40mins to take effect.
19235	LOW	THEATR	04/12/2017	Concerns that elderly patient's bronchoscopy was cancelled the day before his appointment, but patient was then contacted the following day to ask where he was for his appointment. Additional distress caused to patient when he was already worried about attending for appointment.	Procedure was cancelled as consultant did not have sufficient capacity. Bronchoscopies are managed on two systems and the cancellation was only updated on one of these. Secretary reminded of the need to ensure that both systems are amended/updated when changes made.
19268	LOW	MAINT	04/12/2017	Concerns regarding inadequate working toilet facilities for patient undergoing daily radiotherapy treatment.	Explanations and apologies given that toilet facilities were not working when patient was attending for daily radiotherapy treatment. Information given that there had been a problem with the pumping station (which was outside of our control), a broken toilet seat which was replaced shortly after his meeting with staff. A staff toilet was also re-designated for use by patients and visitors to improve access to the facilities.

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19300	LOW	AE	08/12/2017	Long waiting time for young child to be seen in ED. Department did not appear busy. Complainant is querying why paediatric ED closes at 10pm. Vomit on floor of waiting area was not cleaned up.	Apology offered for poor experience. Outside of paediatric ED service, children are seen in the main department. Patient's condition was not urgent and improved whilst waiting to be seen by the doctor. Patient left department before being seen by the doctor, even though this was within the four hour target window. Apologies that vomit was not attended to - matron will discuss with nursing team and domestic staff.
19277	LOW	AE	12/12/2017	Concerns regarding poor and uncaring attitude of triage nurse. Patient states that she was made to feel like she was wasting the hospital's time attending ED.	Apologies and explanations offered to patient. ED Nurse has considered patient's feedback and will use this to inform her future practice, with a view to avoiding another patient having a similar experience. A triage audit is also being undertaken on the nurse to highlight any areas that require development.
19275	LOW	AE	13/12/2017	Concerns raised that patient attended with foreign body in eye, only had an eye test and was asked to leave and an appointment would be provided in 24 hours. Patient was given cream with nothing on the outside and no instructions.	Investigation concluded that examination and treatment was appropriate for the injury sustained, and that instructions were given on how to use the cream, however the communication with the patient could have been better. The consultant has discussed the concerns with the doctor involved.
19185	LOW	ORTHO	14/12/2017	Feels that process to diagnose cause of pain has been lengthy and resulted in no outcome or immediate treatment.	Initially added to the incorrect consultants waiting list but cannot say whether this caused a delay in diagnosis and treatment as each consultant has differing waiting lists. However there were no further delays once reviewed in clinic.
19231	LOW	MRI	04/01/2018	Various concerns raised regarding accessibility of MRI scan and co-ordination of care between King's and Maidstone Hospital. ** please do not publish summary of complaint **	Explanations provided that MRI scan requested in error for this year when it was meant to be carried out next year. Apologies also offered for the error. Detailed explanation provided of patient's co-ordination of care between this hospital and King's College Hospital. King's had tried to contact patient on several occasions but patient did not return calls.
19310	LOW	LEGAL	11/01/2018	Concerns around conflicting information provided by legal department and unwillingness to release information to patient when requested.	Explanation and apologies offered for mishandling of case and breakdown in communications. Legal Services manager has discussed the case with the staff in the department and an SOP has been created for the handling of third party claims which includes a check list of what documents can be supplied and clear communication pathway.
19313	LOW	MID	11/01/2018	Concern raised that had to wait 5 days for an emergency scan at TWH when having pain and bleeding. Comments required from CCG regarding scanning capacity within West Kent.	Apology offered for delay in scan, there are no national guidelines around the timing of emergency scans, however, we would expect this within 48 hours. Assurance offered that Trust is working on improving scanning pathways for women.

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19302	LOW	OPTHAL	12/01/2018	Explanation required for why appointments have been made with the incorrect doctor, why the 18 week timeframe has not been met, why it takes over 30 minutes to answer the telephone in the CAU and why an appointment letter has not been received. Patient would like a consultation with the surgeon prior to the surgery taking place.	Directorate contacted patient by telephone to discuss concerns and apology offered for the frustration caused. Explanation provided about the process for the surgery and apology offered that timeframe had not been met and for the delay in answering the telephone.
19312	LOW	GENSUR	15/01/2018	Difficulties experienced when trying to telephone the hospital using the number quoted on the appointment letter. Patient wanted to cancel surgery appointments and rebook for new year. Sent recorded delivery letter on 25 November which has not been responded to. Despite advising wanted appointment for new year, received a telephone message advising had been rebooked for 19 December.	Apology offered regarding the telephone system. Investigation concludes that patient cancelled surgery at MTW as wanted to have it at Medway. Unfortunately Medway do not undertake the surgery so he was returned to the MTW waiting list. Letter sent recorded delivery was received, however it is not clear when this was sent to CAU as has not been date stamped. Likely this letter crossed with the telephone discussion staff were having with Mr Smetten to arrange his surgery.
19335	LOW	FINSER	29/01/2018	Concerns regarding delays in cheque for £1250 compensation payment being sent to him from Finance Department. Patient was also reimbursed three times and had to make arrangements to pay the money back to the Trust. Patient is claiming further compensation for additional distress caused.	Apologies and explanation provided to patient regarding delays and problems experienced with payment being sent to him several times. This was an isolated incident that should not happen again in the future.
19353	LOW	AE	08/02/2018	Patient unhappy that he was taken to the ward and sat in a room with a lot of other patients and left there all day, lack of privacy for him and other patients. Patient also unhappy that he was not offered food by nursing staff and the toilets were not working on the unit. Concerns also raised that patient had to sleep in an examination room in ED as there were no beds available and patient was uncomfortable and cold. Patient unhappy with nurse's uncaring attitude as she gave the patient cereal in a sick bowl and he was given a fork to eat it with.	Explanation provided that patient was taken to the ambulatory dedicated area. Apologies offered that food was not offered to patient and nursing staff have been reminded of the need to offer food and beverages to patients. Explanation provided that toilets were working but one toilet was closed to use as other patients were in the same area. Explanation provided that department was full to capacity and a trolley was provided to patient to sleep on, apologies given for discomfort caused. Apologies also given for patient's poor experience when he was given breakfast, nursing staff have been reminded of the need to ensure appropriate cutlery is provided to patients.
19361	LOW	ENT	09/02/2018	ENT clinic cancelled and patient did not receive a cancellation letter.	Apology offered and explanation that iMail system did not send the cancellation letters which was compounded by the kiosk system not filtering out the cancelled clinics when patients book in at TWH. Work is ongoing to remedy these issues.
19362	LOW	UROL	12/02/2018	Concerns raised that patient was unable to contact CAU to postpone a urology clinic appointment	Apology offered for long delays on telephone system and explanation around the actions the directorate are taking to mitigate these issues, including recruitment and use of bank staff, a telephone rota, and looking a different telephone system options. No action plan required,

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19285	LOW	RESPIR	14/02/2018	GP practice sent the same referral letter to the respiratory department three times. On each occasion, hospital staff said it hadn't been received. Patient's calls to PALS were not responded to.	Explanation given that it is difficult to explain why the referral letter was not received by the hospital. Staff have been reminded of the need to contact GP surgeries and request a copy of the referral letter if this has not been received. Explanation given that no calls were received by the PALS department.
19270	LOW	GENSUR	19/02/2018	Patient advised in private consultation that has epigastric hernia and was referred to the NHS. Reviewed in outpatients and had ultrasound scans. Surgery performed but no hernia found.	Clinical diagnosis of hernia was made, but when patient was operated on, no hernia was found. Apologies that diagnosis was incorrect and that patient underwent surgery inappropriately.
19382	LOW	OPTHAL	26/02/2018	Long waiting times of telephones for an ophthalmology appointment to be booked. Several calls to the department to find out when appointment will be.	Explanation provided around how choose and book system works and apology offered that this was not explained when contacting the CAU. AGM to discuss with staff.
19326	LOW	OPTHAL	05/03/2018	Concerns raised with booking of ophthalmology appointments and whether this impacted adversely on patient's sight.	Explanation and apology offered for the frustration caused when trying to book an appointment. COO set up a group to manage and rectify the situation. AGM has discussed concerns with staff involved.
19421	LOW	ENT	06/03/2018	Concern raised that attended for an appointment, booked in and waited to be called, only to be advised an hour later that his appointment has been cancelled. Feels signage to outpatients one is poor.	Apology offered and assurance offered that this is a known problem which is under investigation Signage has been checked.
19365	LOW	ELDER	09/03/2018	Concerns that elderly patient's hearing aids went missing whilst she was a patient on the ward. Replacement costs of £1325.00 being requested. Daughter's telephone calls to ward also not returned.	Apologies given that hearing aids went missing and that calls were not returned. Staff will be reminded of the need to document a patient's property and if this goes missing and what action has been taken. Staff have also been reminded of the need to return calls as soon as they possibly can.
19451	LOW	OPTHAL	21/03/2018	Patient unable to contact CAU to cancel appointment.	Apology offered for long waiting to answer the telephone. Explanation provided around actions being taken to resolve this issue.
19424	LOW	GENSUR	22/03/2018	Patient waited over 2 hours on the phone to CAU to change his appointment and wants to be compensated for his phone bill.	Apology offered and directorate to reimburse the cost of the telephone call
19411	LOW	GENSUR	29/03/2018	Long wait for gall bladder surgery and poor communication as when came in for surgery was for a stent and not removal of gall bladder. Lost dentures in the ED.	Explanation provided that following being listed for gall bladder surgery, patient attended with heart problems and it was also identified that he had a bilary stricture and therefore removal of the gall bladder ws not appropriate. Apology offered that patient did not understand the purpose of the stent. Apology offered for the inconvenience that the patient did not have dentures with them, however property disclaimer does not indicate that patient had dentures whilst in the ED.

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19243	LOW	MID	05/06/2018	Concern regarding hospital process of newborn baby being registered on hospital systems in the mother's name, rather than the father's name, particularly after requests made that the baby's name be changed.	Explanation offered around rationale for naming convention - newborn babies are registered under their mother's surname for security reasons. Trust policy to send babies records to mother's GP for safety reasons. Apologies for the difficulties this caused. Babies' names are not changed on the hospital systems unless the baby represents to the hospital, then staff will update the system with the baby's registered name.

Maidstone and Tunbridge Wells NHS Trust