Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 6509

Please reply to:
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Trust Management
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20 January 2021

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Mr John Shotton.

You asked:
I would like to have details of all complaints made by patients and/or staff against the consultant Mr John Shotton at Tunbridge Wells Hospital at Pembury please.
I would like details of any and all complaints for the past 20 years please.

Trust response:

Please note:
The Trust is currently in the process of reducing the amount of complaints data held in order to comply with the Records Management Code of Practice 2020 where the retention period is 10 years after the closure of the complaint.

We do not hold data on patient complaints for a full 20 years. The earliest records we have access to date back to 2003.

The Trust has identified three complaints received linked to Mr Shotton in the time period 2003 to date and these are detailed below:.

First received	Description (Policies)	Closed	Outcome code	Outcome
12/04/2016	Delay in communicating test results and delayed investigations. Delay in diagnosis cancer.	23/06/2016	PARTUP	Apology offered for obvious and understandable distress caused. Explanation that there was no clinical indication to pursue invasive treatment sooner and in fact, the patients condition was noted to have improved by scan 3. However, with the benefit of hindsight, lump should have been removed. New FNA protocol for paediatric patients being developed. Review of test tracking is underway within H&N.

16/08/2016	Query delayed diagnosis of cancer. Were timeframe's involved in treatment appropriate. Was the loss of vision in patients eye avoidable?	13/07/2018	NOTUP	Investigation concluded that there were no delays in diagnosing the cancer and the steps taken by ED were appropriate. Independent review concurs with this view and that the loss of sight in the eye was unavoidable.
19/05/2014	Delayed diagnosis and treatment. Poor communication with patient.	18/08/2014	UPHEL	Image findings were not communicated on to anyone - discussed with doctors concerned. Clinical lead to work with radiology to identify actions required to prevent reoccurrence. All patients reviewed by ENT who are under the care of another Trust for cancer will have results sent on appropriately

Prior to 2020, there was varied compliance with linking staff named in complaints to Datix and therefore we can only provide the information where this has been captured.

If we receive a cluster of complaints about an individual consultant, these are highlighted to the relevant Clinical Director/Chief of Service and brought to the attention of the Medical Director for further review. The Medical Director will take further action (as appropriate and proportionate) with the individual consultant, to ensure that all professional standards are maintained.