MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Complaints and PALS – Annual Report 2021

Requested/ Required by: Patient Experience Committee
The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

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(Board lead for complaints)

Directorate: Clinical Governance

Specialty: Quality and Governance

Maidstone and Tunbridge Wells NHS Trust

Complaints and PALS – Annual Report 2020

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 2020-21. A review of performance in responding to complaints in 2020-21. A summary of the learning and action taken in response to complaints responded to 2020-21.
Cross references:	This report is supported by the Trust's key policies and procedures: Managing Concerns and Complaints Policy and Procedure

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	First annual Board report	June 2013
2.0	Second annual Board report	June 2014
3.0	Third annual Board report	May 2015
4.0	Fourth annual Board report	May 2016
5.0	Fifth annual Board report	May 2017
6.0	Sixth annual Board report	June 2018
7.0	Seventh annual Board report	May 2019
8.0	Eighth annual report	May 2020
9.0	Ninth annual report	May 2021

Contents:

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 focused on service users and striving for continuous improvement. The importance of using complaints to drive improvement in both patient safety and experience has never been more widely recognised and the Trust embraces the opportunity to learn from the feedback provided.

Extract from an email to the complaints team:

'It really has made me and my family feel at ease that if my grandmother was to go to hospital again, she would be looked after appropriately. In our eyes, the fact that these matters have been identified and raised with the staff, it is the best outcome we could have hoped for.'

The regulations require an annual report to be produced which:

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

The management of complaints is also a Key Line of Enquiry used by the Care Quality Commission in their assessment of the Trust.

Introduction

The year 2020-21 has been one like no other in the history of the NHS. The impact of the COVID-19 pandemic on the PALS and complaints services will be discussed in more detail later in this report. Despite the disruption of the pandemic, some service developments continued, most significantly, the migration of complaints from Datix rich client to Datixweb was completed. The Policy and Procedure for Managing Complaints and Concerns was also ratified. A deep dive into complaints about communication was completed and presented to the Patient Experience Committee in September 2020.

3. COVID-19

On 31 March 2020, NHS Improvement/England issued guidance to all NHS healthcare providers, recommending that the complaints system be 'paused' for an initial three-month period. Emphasis was placed on the need to continue to maintain any PALS (or equivalent) to ensure that any incoming complaints/concerns could be triaged on receipt, so that immediate appropriate action could be taken, should the complaint/concern identify a serious incident, safeguarding or competency issue.

All complaints open at that time were reviewed by the Complaints & PALS Manager to identify which could be completed with no or minimal input from the front facing clinical teams. Those complaints which could not be progressed without moderate/significant input from the front facing clinical teams, were 'paused' in line with the recommendations. All affected complainants were contacted and informed of the situation.

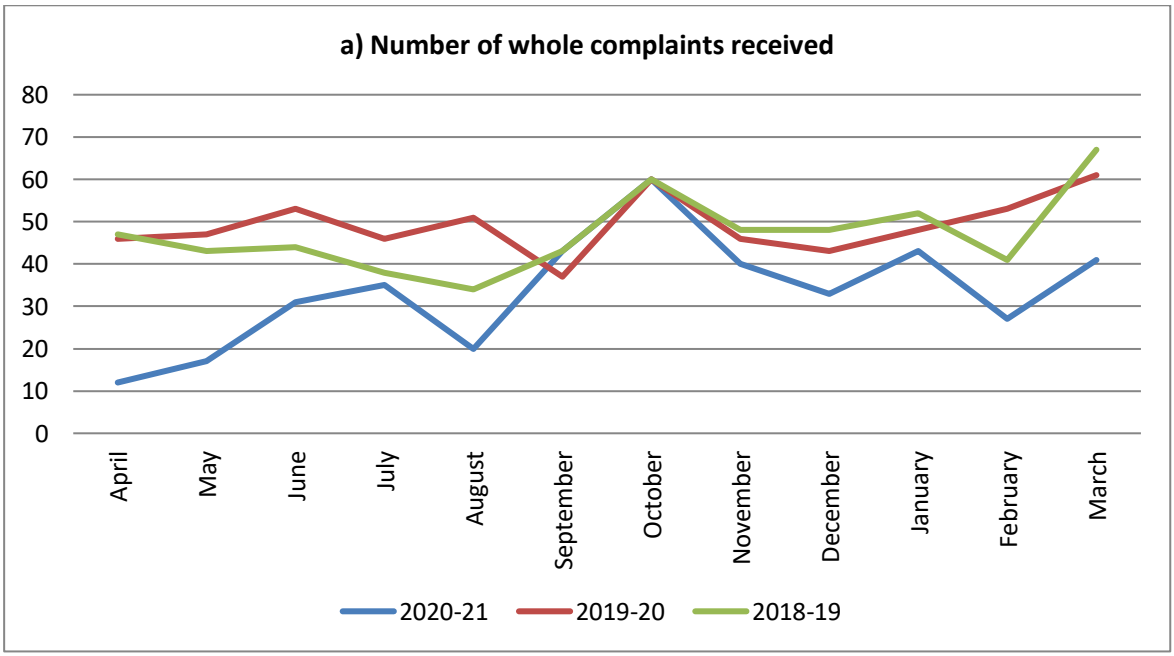
At the same time, all face to face services offered by PALS and complaints were suspended. This was to support the national lockdown, government instruction to 'stay home' and to maintain COVID-secure environments to ensure the safety of staff. The PALS offices were closed to personal callers. Any complainant awaiting a local resolution meeting was contacted and advised that this would be postponed indefinitely at that time and they were offered the opportunity to receive a further written response instead. In mid-May, the complaints staff were issued with laptops and the team were then able to organise virtual local resolution meetings using WebEx.

The 'pause' ended on 30 June 2020. All 'paused' complaints were progressed and normal systems and processes for managing complaints resumed. However, due to the need to continue to provide COVID-secure working environments and reduce unnecessary travel, the PALS offices remain closed to personal callers and local resolution meetings continued to take place on virtual platforms. Themes and trends in relation to complaints and concerns about COVID-19 were reported regularly to the Patient Experience Committee.

Members of PALS and complaints staff undertook a number of additional roles to support the Trust during the pandemic. This included shifts in the incident co-ordination centre, releasing staff to support the workforce department, participating in the One Team Runner initiative and clinically trained staff were redeployed to cover shifts in the Intensive Care Unit and support the COVID-19 vaccination roll out to staff.

4. Complaints received

For the year 2020-21, the Trust received 389 formal complaints, a decrease of 167 complaints from the previous year (556 complaints received 2019-20). This equates to only 0.057% of the total clinical activity of the Trust. The significant reduction in the number of complaints received is a direct result of the COVID-19 pandemic. Graph 4a shows more detail around the numbers of whole complaints received. As can be seen, there was a significant reduction in the number of complaints made in April 2020. As complaints can be made up to 12 months from the event occurring, it is possible that complainants made a conscious decision not to raise their complaint during this initial peak, to enable staff to prioritise the care of the sick. It is also possible that potential complainants decided not to pursue a complaint at all, influenced by the national 'wave' of sympathy shown towards the NHS as a whole. Furthermore, in response to the pandemic, the levels of non-urgent activity within the Trust were reduced, to ensure capacity to care for patients with COVID-19 and other emergencies. With any reduction in activity, it is expected that there will be a reduction in complaints.

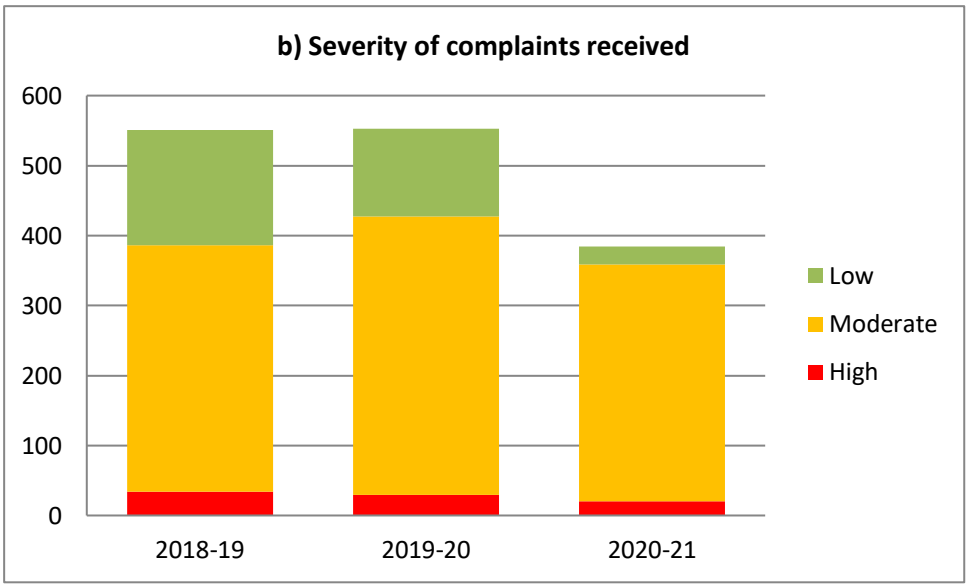


All complaints are graded on receipt as either low, moderate or high risk complaints. High risk complaints are defined as complaints where it is described that:

- by action or omission of Trust staff, the patient has been placed at risk of or suffered significant harm, up to and including death
- or where the complaint raises safeguarding concerns against the Trust
- or where the complaint presents a significant reputational risk to the Trust.

A moderate complaint involves aspects of clinical care, but where the above criteria have not been met. Low risk complaints do not involve any aspect of clinical care and do not meet the criteria above.

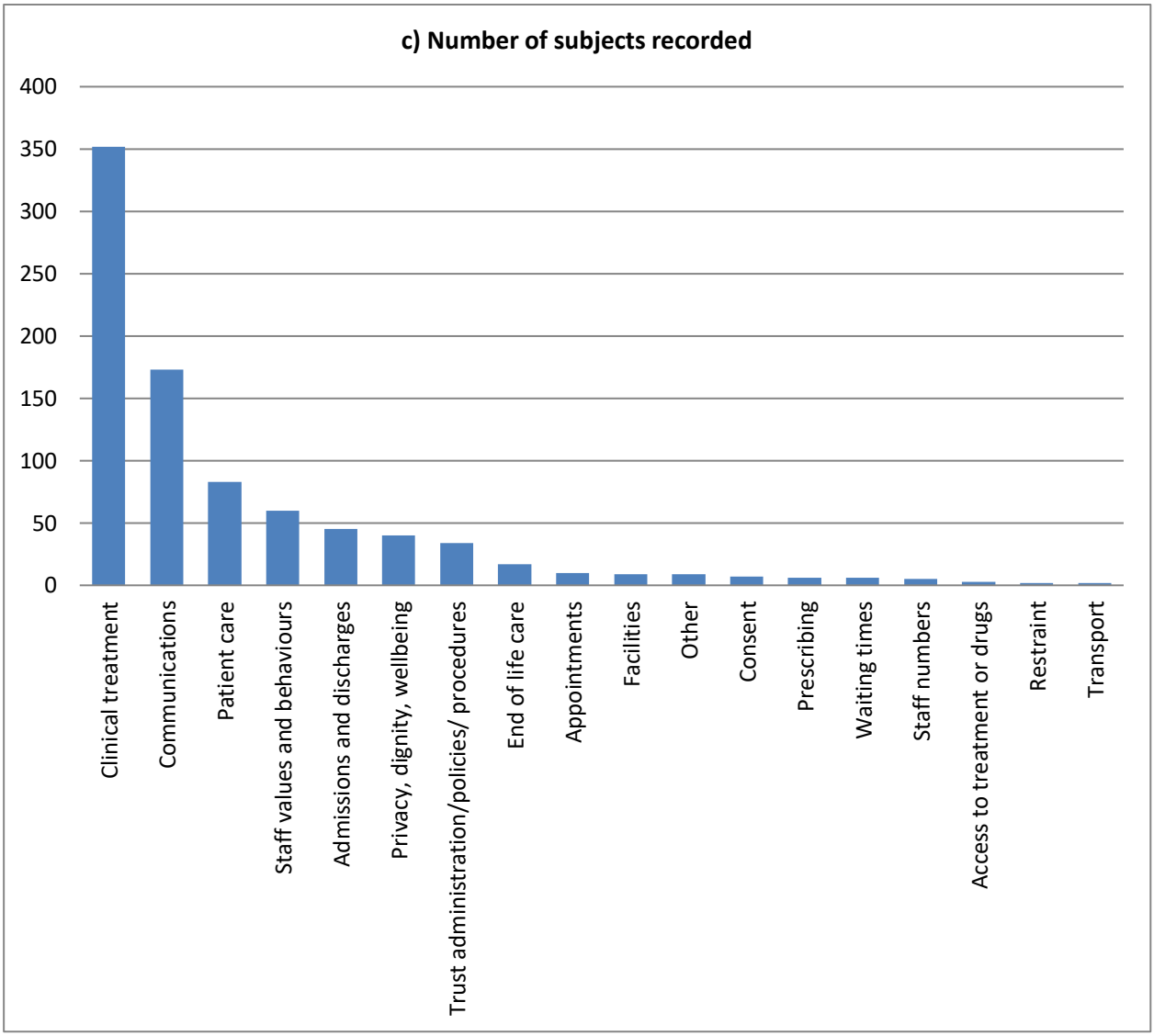
The number of complaints received graded by severity for the past three years can be seen below (3b).



Due to the significant reduction in the number of complaints received in 2020-21 as compared to previous years, the proportions have been reviewed. This shows that the proportion of high risk complaints has remained relatively static, with the most significant increase in moderate risk complaints (88% of complaints received 2020-21). It is worth noting that the scope of moderate complaints has increased, with more complaints requiring input from multiple specialties and external agencies (11.5% for 2020-21, as compared to 9.5% for the previous year). This presents challenges when trying to meet the reponse target, as there can be difficulties in all departments getting timely access to healthcare records, receiving comments from different agencies and drafting can also be more challenging due to the need to cross-reference mutiple sources of information. The proportion of low risk complaints has seen the biggest drop and this is likely the result of the reduction in non-urgent activity during the year.

5. 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 as one complaint can contain a number of subjects (e.g. one complaint detailing issues about communication, clinical treatment and waiting times would be reported as three subjects). For the year 2020-21, the Trust recorded 863 subjects raised in formal complaints, approximately two thirds of the previous year (1220 subjects recorded 2019-20). A breakdown of the subjects recorded for 2020-21 is shown in graph 4c.



This clearly illustrates that issues relating to clinical treatment were the most frequently raised subject in complaints received by the Trust in 2020-21, totalling 352. As compared as a proportion with the data from 2019-20, this has remained static (42% of subjects raised in 2019-20 related to clinical treatment; 41% of subjects raised in 2020-21 related to clinical treatment).

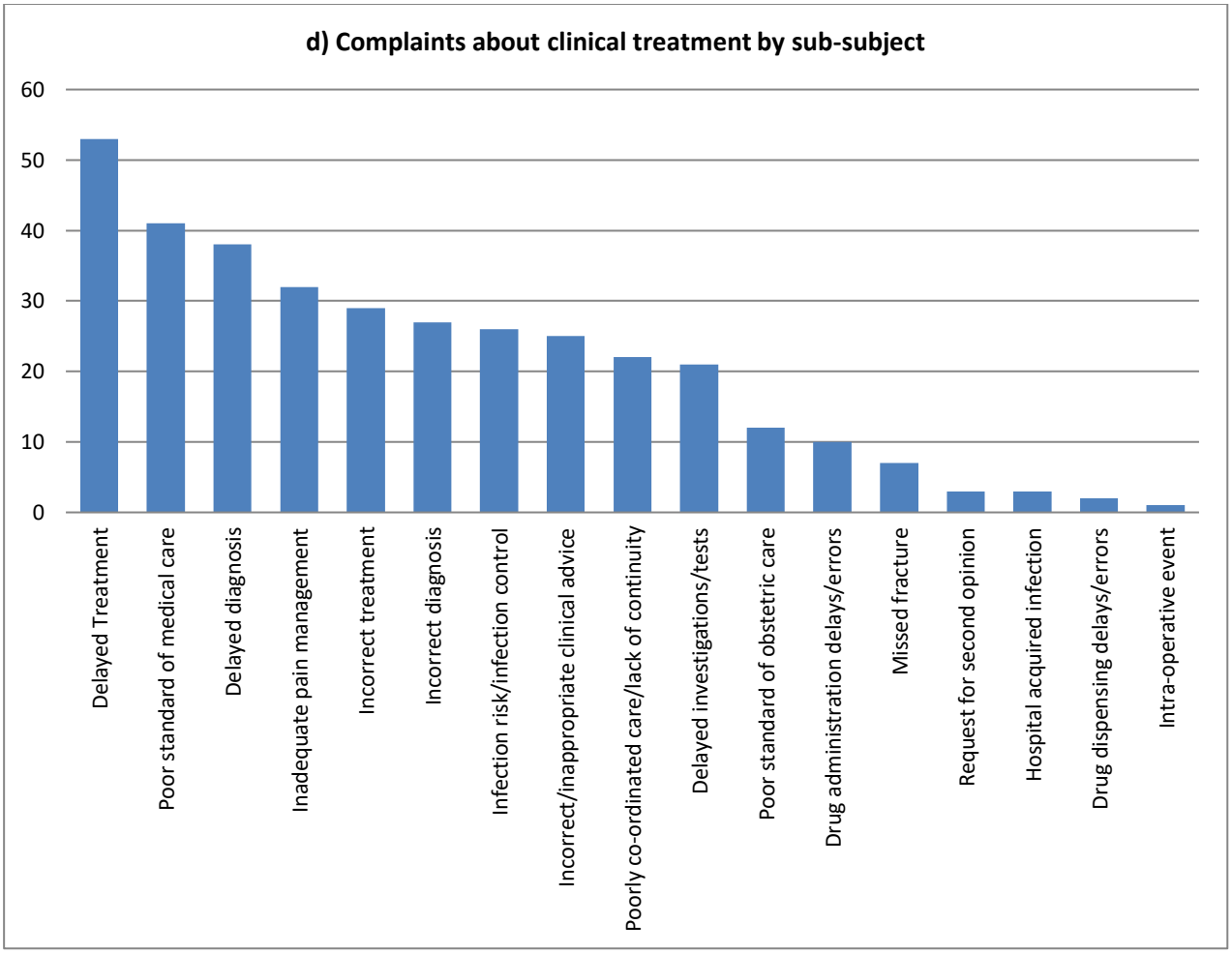
While clinical treatment significantly outweighs the other subjects. Again, when compared to the previous year, the proportion of subjects recorded about communication also remains steady at 20%.

However, the largest increase in proportion of subjects recorded relates to patient care, which has increased from 6% in 2019-20 to 10% in 2020-21. This is unsuprising given the unprecedented pressures placed on theTrust by the pandemic, during the first and particularly the second wave of COVID-19. This not only placed a burden from the perspective of the volume of patient admissions, but the Trust was also experiencing exceptional levels of staff absence (due to shielding, isolating and COVID-19 infection). This was further compounded by visiting restrictions, which undoubtedly raised anxieties for relatives, unable to be with their loved ones in hospital.

Extract from a complaint:

'My poor dad, who I may add cannot wash, dress himself was left to get on with [it] himself. On numerous occasions whilst we was [sic] on video call he would ask for a commode which he was then told do you actually need it as your [sic] wasting our time…..He was left on commode several times for 30-60mins at a time which then resulted in my father trying to attempt to clear himself up……On returning home, my father….had dry blood coming out of his mouth and nose, he had old blood and faeces in his nails, his toothbrush hadn't come out [of] the pack, he had not been shaven [sic] he had dry faeces up his back….I could go on and on.'

Each of the subject categories shown on page 7 are defined by NHS Digital. However, this data can be broken down to offer a higher level of detail, by analysing the locally determined sub-subject codes. Graph 4d) shows detail of the sub-subjects raised under clinical care.



This identifies that the most frequently raised issue in complaints about clinical treatment relates to delayed treatment, followed by poor standards of medical care and delayed diagnosis. It is relevant to note that these sub-subjects are based on the issues raised in the complaint and are therefore a reflection of the perceptions of the complainant.

Although delayed treatment remains the most frequently recorded sub-subject within clinical treatment, as a proportion, this has reduced as compared to last year (18% 2019-20; 15% 2020-21). There have also been slight reductions in complaints about delayed diagnoses and incorrect treatment, when compared to the previous year. However, as a proportion, complaints about poor standards of medical care have increased year on year (12% 2019-20; 16% 2020-21) and the most significant increase has been in the proporation of complaints about inadequate pain management

(5% 2019-20 to 9% 2020-21). Looking at the top five sub-subjects of clinical treatment, the outcomes for those cases closed at the time of writing are as follows:

Sub-subject reported	Upheld	Partially upheld	Not upheld
Delayed treatment	4	6	34
Poor standard of medical care	1	1	31
Delayed diagnosis	5	6	22
Inadequate pain management	6	5	15
Incorrect treatment	3	0	21

As this data shows, proportionally, more complaints about delayed diagnosis and inadequate pain management are upheld or partially upheld, than complaints about delayed treatment. Very few complaints relating to poor standards of medical care are upheld or partially upheld and these often come down to communication issues or failure to manage expectations.

Patient story

Mrs Hardy[†] was admitted as an emergency for surgery to a fracture. Pre-operatively, Mrs Hardy had been told that she would be administered a nerve block to manage her pain post-operatively, but at the last minute this plan changed and she was prescribed morphine.

Mrs Hardy received a number of doses of oramorph and was also offered paracetamol, which she declined due to nausea. Mrs Hardy described being in intense, unrelenting pain all night which was not controlled by analgesia. She asked the ward nurses for help, but felt that they did not listen to her, understand her level of pain or provide any care, compassion or solutions. They did not assess her pain level or make any efforts to improve Mrs Hardy's comfort. Mrs Hardy reported that one nurse suggested that she was in pain due to her declining the paracetamol.

Mrs Hardy asked to see a doctor. She was told the doctor had been paged, but no-one arrived. Mrs Hardy asked again about seeing the doctor a few hours later. The doctor was called again and attended. He looked at Mrs Hardy's foot and immediately cut away some of the plaster cast, which eased her pain.

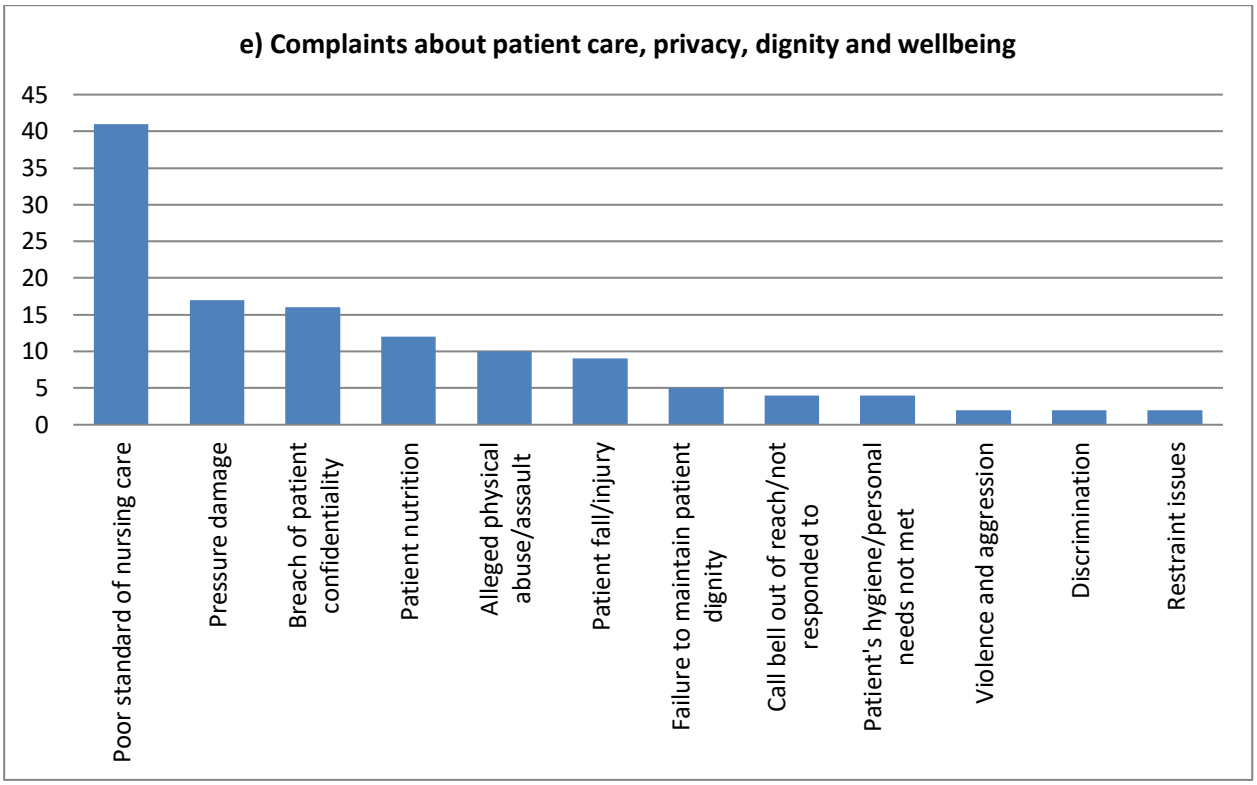
Upon investigation, it was established that the option of a nerve block was suggested to Mrs Hardy, but a final decision on this would not be made until the morning of the surgery. The consultant anaesthetist reflected on this and recognised that he needed to be more diligent in making sure that patients understood this in future.

It was clear to the ward nurses that Mrs Hardy was in considerable pain and she was offered all the pain relief options prescribed for her. As nursing staff can only administer prescribed medications, they had to contact a doctor to obtain alternatives. Unfortunately, the doctor was delayed attending to other duties and apologies were offered for this. The nursing team did not follow the correct escalation protocol and in response to the complaint, the Matron provided further education to the ward team on the process to follow. The Ward Manager also met with the individual nurses to discuss the feedback about their manner and attitude when caring for Mrs Hardy, for their personal learning.

[†] All names have been changed to protect confidentiality

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. On review of the complaints raised about these subjects, graph 4e demonstrates the most frequently reported issues.



The most frequently raised issue is poor standard of nursing care followed by pressure damage. Both of these showed marked increases from last year: poor standard of nursing care complaints increased from 33 in 2019-20 to 41 in 2020-21; pressure damage complaints increased from 4 in 2019-20 to 17 in 2020-21. Taking into account the overall reduction in numbers of complaints received between 2019-20 and 2020-21, these are areas of concern. However, as referenced earlier in this report, the impact of COVID-19 on admission rates and staffing levels is likely to be a significant factor in this. Of these complaints received and responded to at the time of writing, the outcomes are as follows:

Sub-subject reported	Upheld	Partially upheld	Not upheld
Poor standard of nursing care	9	8	19
Pressure damage	3	5	4
Breach of patient confidentiality	5	0	8
Patient nutrition	1	3	5
Alleged physical abuse/assault	2	0	4
Patient fall/injury	2	0	5
Failure to maintain patient dignity	1	3	0
Call bell out of reach/not responded to	1	1	2
Patient’s hygiene/personal needs not met	0	2	1
Violence and agression	1	0	1
Discrimination	0	0	1
Restraint issues	0	0	2

Of note, all the complaints responded to relating to failure to maintain patient dignity were either upheld or partially upheld. A further two complaints relating to alleged physical abuse/assualt were also upheld. This is a concern for the Trust, as it does not reflect the safe, caring and compassionate environment staff aim to provide. Any complaint containing allegations of abuse

are shared with the Matron for Safegaurding Adults and/or the Lead Nurse for Safegaurding Children (as relevant). This ensures that any safeguarding alerts can be registered with the Local Authority for transparency and external scrutiny.

Looking at the upheld complaints relating to allegations of physical abuse/assault, both of these related to incidents where a confused patient assaulted another patient. It was confirmed that despite staff taking all relevant measures to reduce the risks to other patients, the events described did take place. Regrettably, risks associated with nursing confused patients can never be completely eradicated, but patient on patient assaults are very rare.

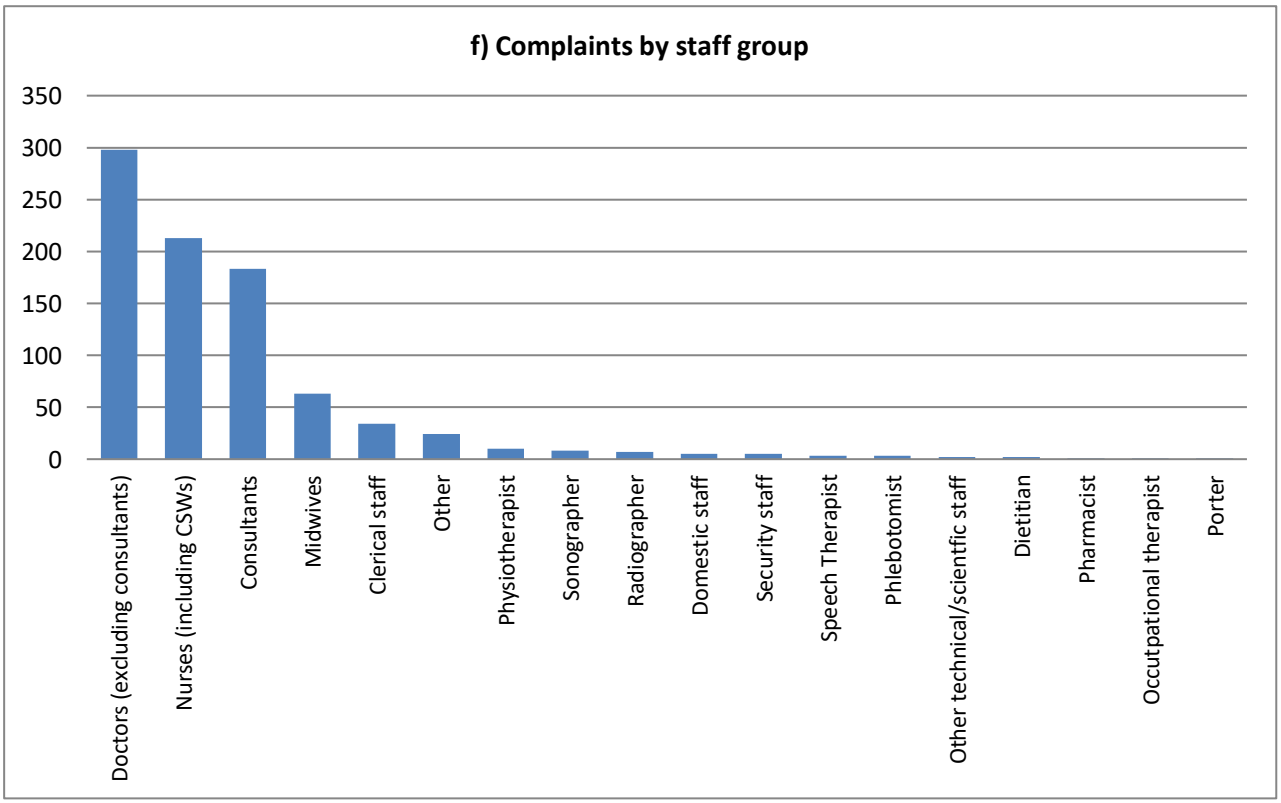
Approximately two thirds of the complaints raised regarding pressure damage were either upheld or partially upheld. The complaints team liaise closely with patient safety and the Tissue Viability Team to ensure that they are aware of any complaints received relating to pressure damage, to ensure that (where appropriate) incidents have been raised for these and to allow the Tissue Viability Team to identify any themes or trends which can inform their education programme for staff.

Extract from a complaint:

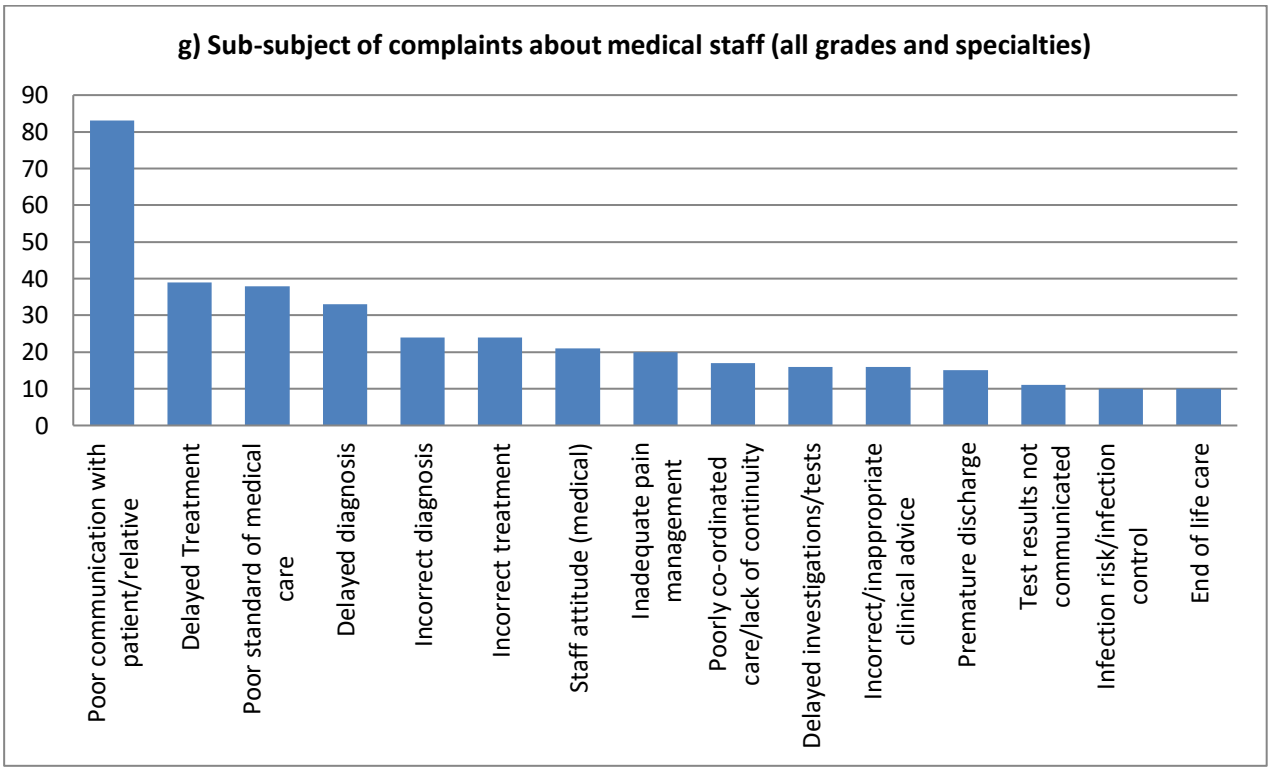
'Another CSW tried to perform an ECG for me. She didn't close the room door properly and of course did not lock the door. I was told to pull up my top and bra. I requested her to draw the curtain so that no one passed by the door or entered to [sic] the room and could see my body. However, she refused to do so and told me that she sees a number of naked patient [sic] every day, therefore she feels nothing at all.'

6. Staff groups identified in complaints

As part of the data the Trust is required to capture from formal complaints, the staff group involved is recorded. This data has been reviewed in line with the number of individual subjects raised in each complaint, therefore offering a more detailed picture. Graph 6f shows the number of subjects raised in complaints, by staff groups.



This clearly illustrates that the majority of complaints received in 2020-21 related to doctors (excluding consultants). However, as a proportion, this shows a continuing downward trend with complaints about doctors (excluding consultants) comprising 41% of complaints in 2019-20, but 33% of complaints for 2020-21. Looking at these in more detail, complaints about doctors (of all grades and specialties) is broken down in the following graph (6g).



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. As can be seen, complaints relating to communication far outweigh all other areas.

Patient story:

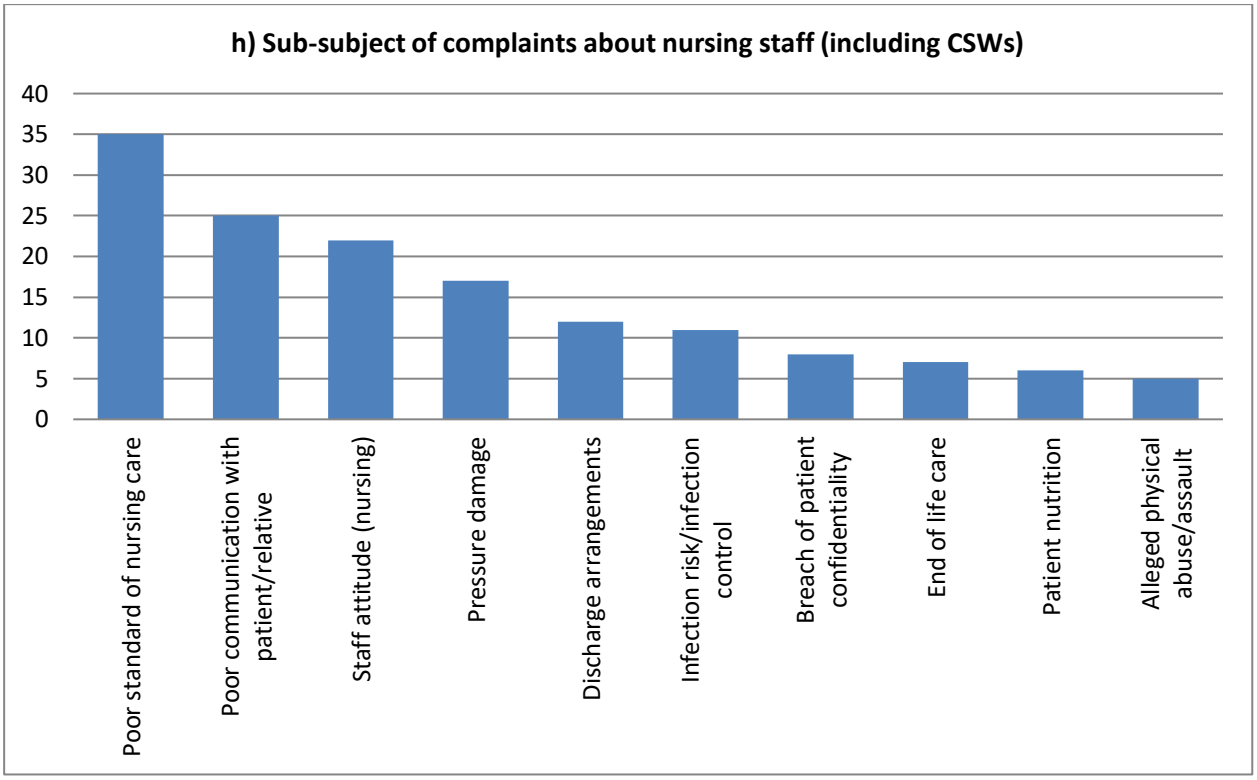
Cynthia was booked to have a colposcopy. She received some patient information in the post ahead of her appointment, which explained what to expect and what the procedure involved. However, her experience did not meet these expectations. She found the doctor to be very abrupt and cold. She did not reassure Cynthia when starting the procedure, did not explain what she was doing or that she was taking a biopsy. Cynthia expected to be able to see her cervix on the screen and be talked through what the doctor could see, but this did not happen.

After the colposcopy, Cynthia was advised by a nurse to get dressed and then return to the consulting room. While changing, Cynthia overhead the doctor telling the nurse not to redirect the patient back to her, as this was not necessary. On returning to the consulting room, the doctor gave Cynthia a leaflet and indicated that the appointment was over, with no further explanation or information.

On investigating the complaint, the doctor offered her personal apologies for Cynthia's poor experience and undertook professional reflection. The complaint would also be discussed as part of her annual appraisal. The complaint highlighted that the colposcopy clinics at Maidstone Hospital run differently to those at Tunbridge Wells Hospital, which the doctor was unaware of. As a result of the complaint, the directorate committed to standardise the two clinics to improve consistency of care and patient experience.

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 Chiefs of Service and where there is a pattern of issues identifed, this is highlighted to the Medical Director.

Graph 6h offers more detail around complaints raised relating to nursing staff and contentrates on sub-subjects with over five incidences recorded. The data captures issues raised about all grades of nursing staffing across the organisation (registered and unregistered).



Unlike previous years, the majority of complaints relating to nursing staff received in 2020-21 related to poor standard of nursing care. As a proportion this shows an increase from the previous year (3% in 2019-20; 4% in 2020-21). Complaints relating to communication remain static, at 3%. The most significant increases can be seen in complaints relating to staff attitude (nursing staff), pressure damage, infection risk/infection control and end of life care. As described earlier in this report, this correlates with the pressures arising from the pandemic, in particular the heightened anxiety for both staff and the public, coupled with staffing challenges and visiting restrictions. All complaints raising any issues relating to nursing services are routinely shared with the Divisional Directors of Nursing and Quality on receipt. Complaints raised about end of life care are made available to the Lead Nurse for Palliative Care and Associated Services for reporting to the Trust's End of Life Steering Group, and the feedback these complaints provide help shape the relevant staff training and education packages.

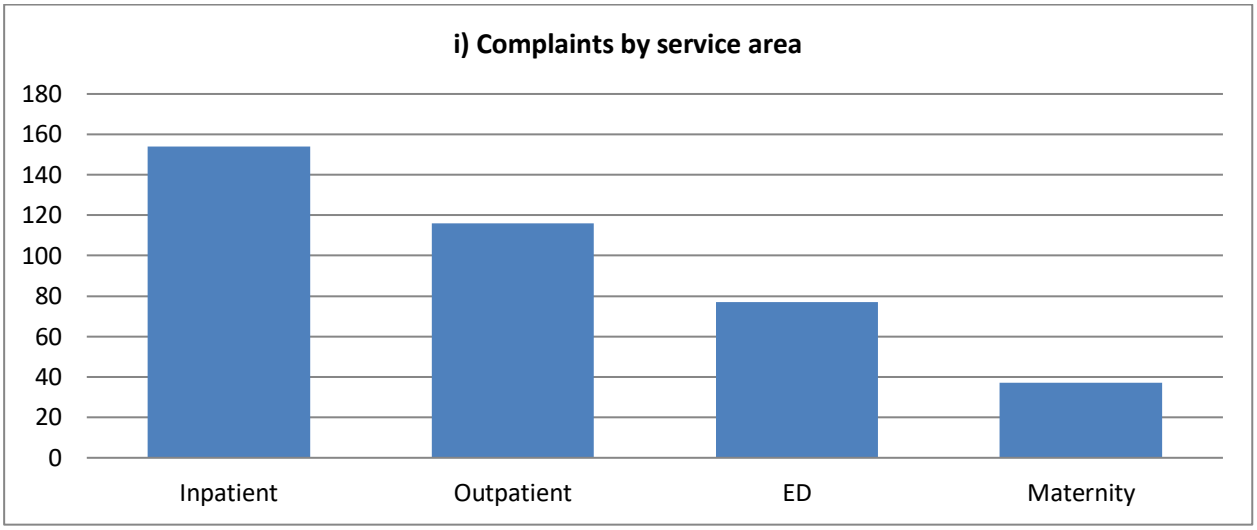
Extract from a complaint:

'I am completely traumatised having witnessed what happened to my mum on that ward and need clear explanation and clarity of the steps taken and medical decisions made which resulted in what was for her a very painful, tiring, terrifying, undignified death.'

Of the five complaints recorded relating to alleged physical abuse/assault, one of these has been been discussed earlier (patient on patient assualt). Of the remaining four complaints, one was not upheld, and at the time of writing two are under investigation and a third complaint investigation has been suspended pending the outcome of police enquiries.

7. Service areas identified in complaints

The distribution of complaints in relation to the service area involved is shown in graph 7i.



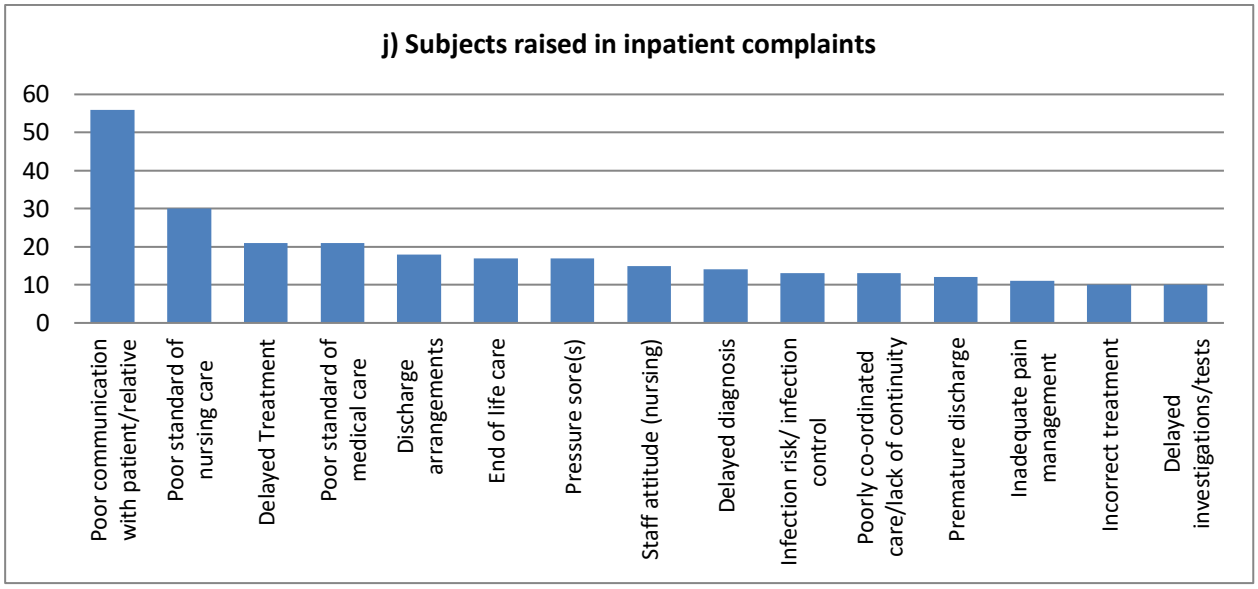
In line with last year's data, the Trust has received more complaints about inpatient services than other service areas. However, as a proportion of complaints this has reduced as compared to the previous year (46% inpatient complaints in 2019-20; 40% inpatient complaints in 2020-21). Similarly, the proportion of outpatient complaints also reduced (34% in 2019-20; 30% in 2020-21). There has been an increase in the number of outpatient complaints and a decrease in the number of inpatient complaints. The Trust recorded 91,066 inpatient episodes and 375,277 outpatient episodes in 2020-21, reflecting a higher proportion of complaints arising from inpatient services. This compares to 119,471 admissions and 557,681 outpatient episodes in 2019-20. This shift is likely to reflect the impact of COVID-19 in that non-urgent inpatient and outpatient activity was reduced during 2020-21 and fewer episodes of care should generate fewer complaints.

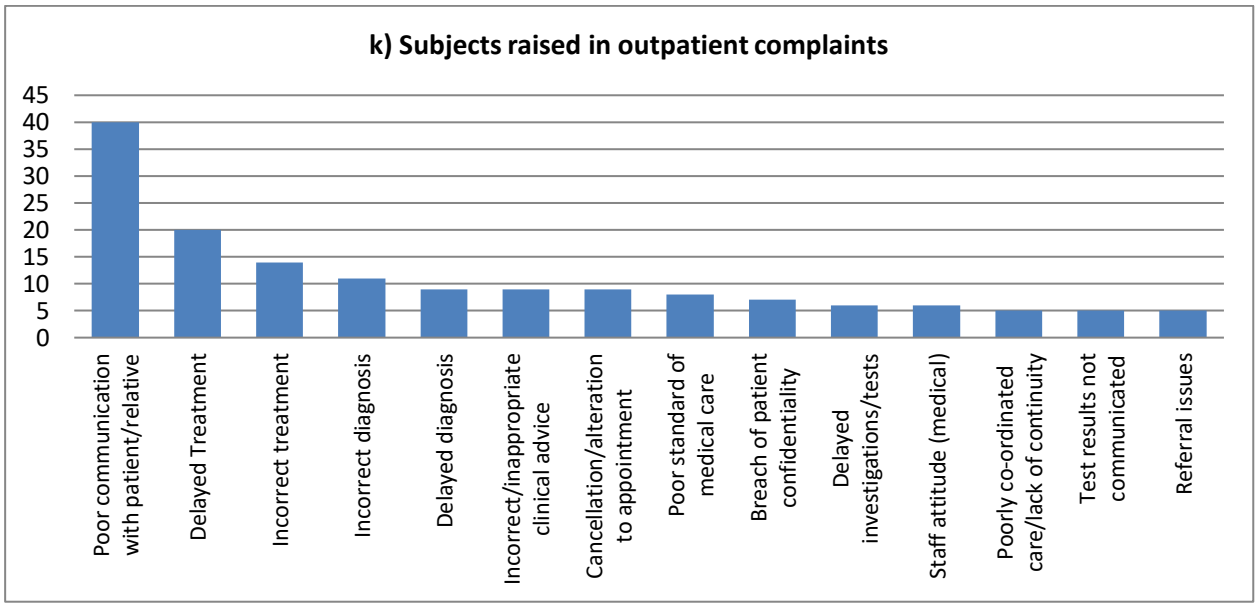
The Trust saw increases in proportion of both maternity and emergency department complaints in 2020-21, as compared to the previous year. The proportion of ED complaints increased from 16% to 20% and the proportion of maternity complaints increased from 5% to 10%. Our maternity services have seen a sustained increased in activity since November 2020 and have had to continue to operate thorughout the pandemic to meet the needs of expectant parents. Attendances to the EDs decreased to 133,378 (from 164,877 in 2019-20).

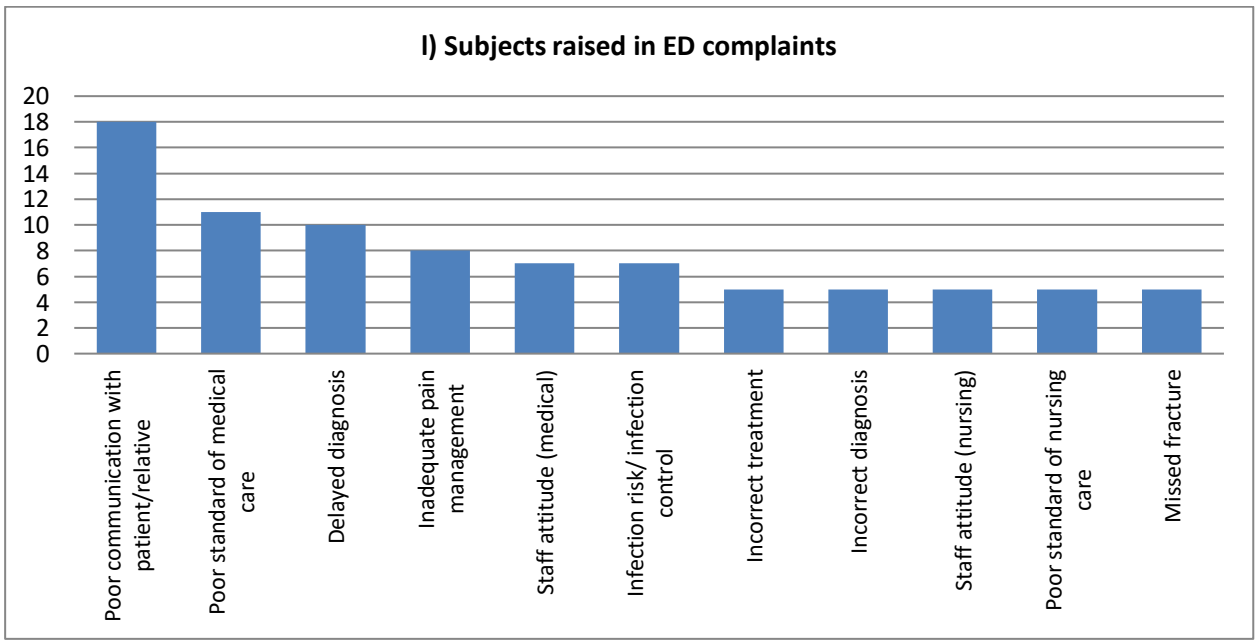
More detail on the main subjects raised in these complaints can be found in graphs 7j to 7m. The inpatient graph shows any subjects recorded at least ten times during this reporting period; the remaining graphs show any subjects recorded at least five times.

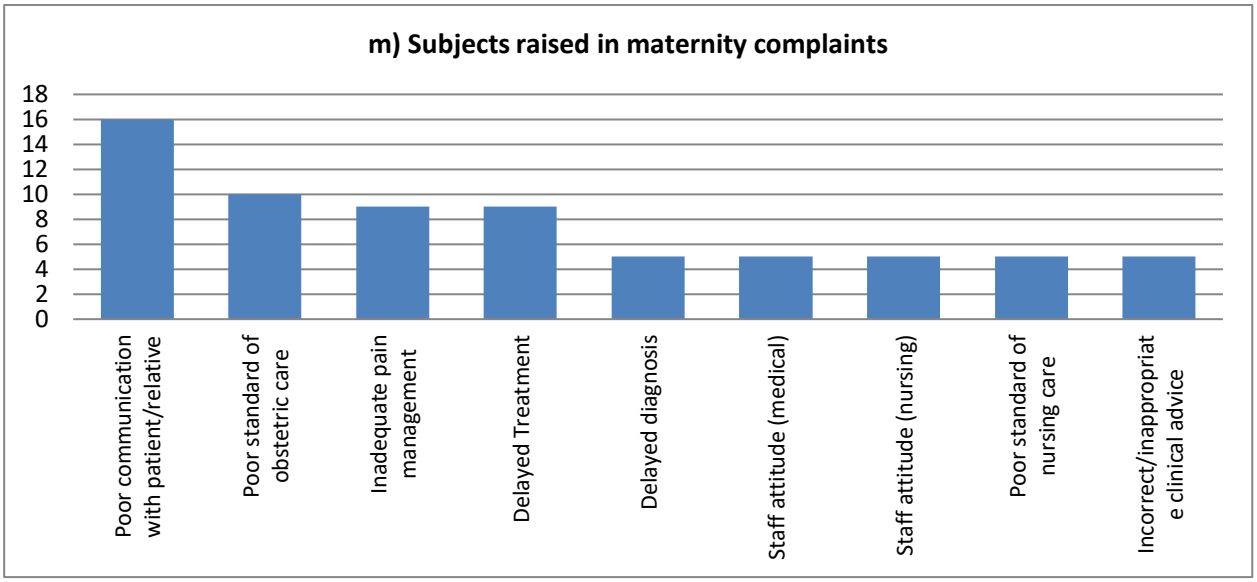
The Trust saw a significant rise in complaints about communication as compared to the previous year. Taking into account that the overall number of complaints has reduced, this is an area of concern. However, it is likely that this has been a direct impact of COVID-19, with visiting restrictions making direct communication with clinical teams more challenging. In addition, the increased reliance on telephone updates and pressures on the ward teams meant that relatives were experiencing difficulty in obtaining information on their loved ones. In terms of outpatient complaints, many services rapidly introduced telephone or virtual appointments and certainly during the transitional phase, there were some teething problems with confusion over whether appointments were taking place face to face or via another platform.

It is interesting to note that despite the reduction in clinical activity, the Trust received far fewer complaints about cancellations and waiting list delays when compared to the previous year. This reinforces that the local community recognised the exceptional circumstances of the pandemic and were affording an additional degree of understanding and tolerance for the disruption this was causing.


j) Subjects raised in inpatient complaints
60
50
40
30
20
10
0
Poor communication with patient/relative
Poor standard of nursing care
Delayed Treatment
Poor standard of medical care
Discharge arrangements
End of life care
Pressure sore(s)
Staff attitude (nursing)
Delayed diagnosis
Infection risk/ infection control
Poorly co-ordinated care/lack of continuity
Premature discharge
Inadequate pain management
Incorrect treatment
Delayed investigations/tests


k) Subjects raised in outpatient complaints
45
40
35
30
25
20
15
10
5
0
Poor communication with patient/relative
Delayed Treatment
Incorrect treatment
Incorrect diagnosis
Delayed diagnosis
Incorrect/inappropriate clinical advice
Cancellation/alteration to appointment
Poor standard of medical care
Breach of patient confidentiality
Delayed investigations/tests
Staff attitude (medical)
Poorly co-ordinated care/lack of continuity
Test results not communicated
Referral issues


l) Subjects raised in ED complaints
20
18
16
14
12
10
8
6
4
2
0
Poor communication with patient/relative
Poor standard of medical care
Delayed diagnosis
Inadequate pain management
Staff attitude (medical)
Infection risk/ infection control
Incorrect treatment
Incorrect diagnosis
Staff attitude (nursing)
Poor standard of nursing care
Missed fracture



Patient story

In December, Miss Akhtar brought her daughter, Anya, to the ED on the advice of NHS111. On assessment, Anya was diagnosed with tonsillitis and prescribed antibiotics. The doctor went to collect the antibiotics from stock and provided them to Miss Akhtar. The following morning, Miss Akhtar went to administer the antibiotics to Anya, and noticed that they were out of date, having expired in August. Miss Akhtar sought immediate advice from NHS111 who arranged alternative medication.

Apologies were offered for this error. On investigation, it was identified that the doctor had not followed his usual process of double-checking the medication with a colleague, as the ED was short-staffed that night and he was trying to avoid disturbing his colleagues who were all attending to other patients. The clinical lead for the ED discussed this complaint with the doctor for his individual learning.

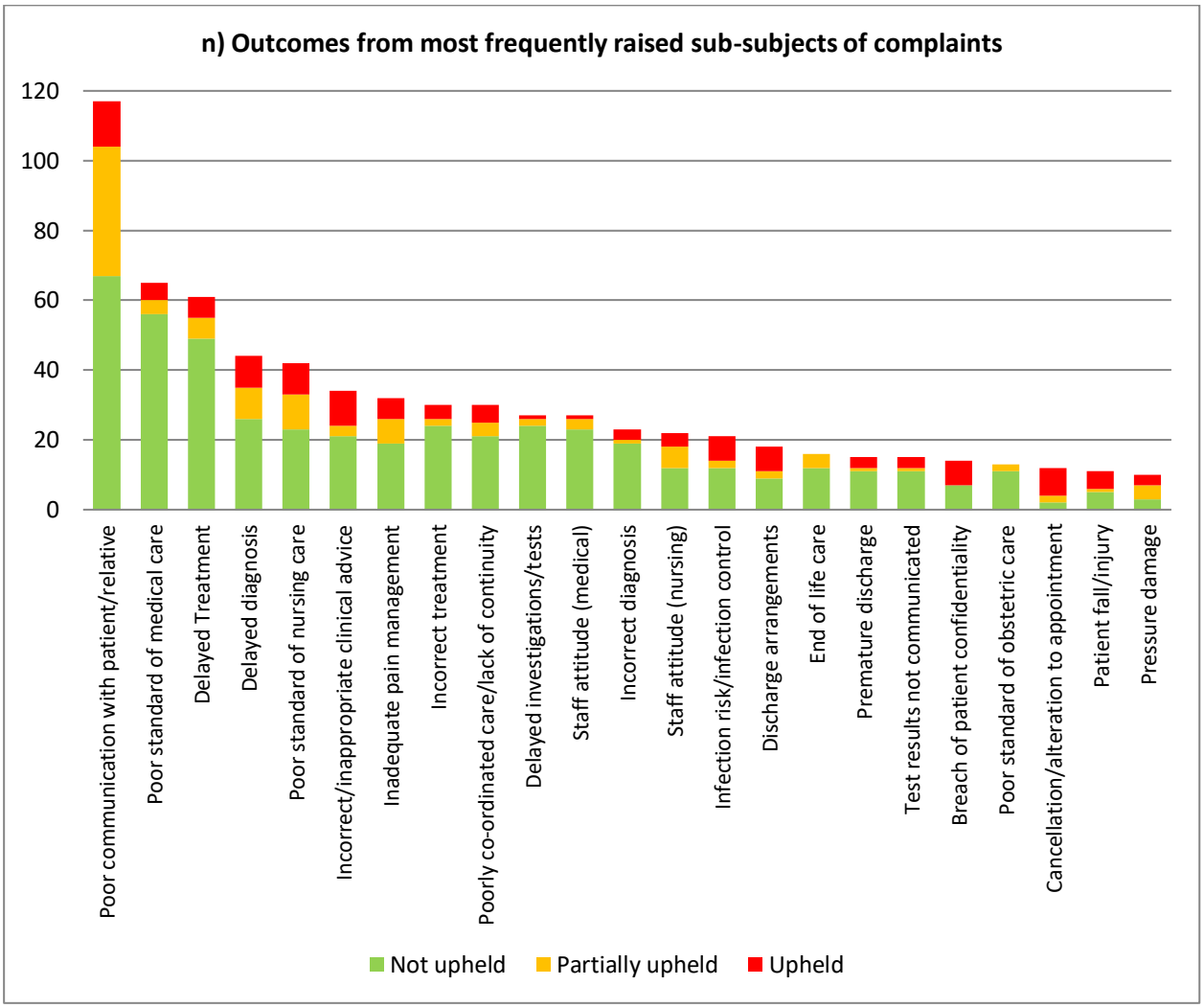
The expired medication should have been identified and removed during routine pharmacy stock checks. The deputy chief pharmacist confirmed that there are detailed procedures for staff to follow when undertaking stock checks and discussed this incident with the team for their learning. Key messages from this complaint were shared Trustwide via the governance newsletter.

8. Upheld complaints

Where complaints are found to be justified, directorate staff address the issues locally with individuals or teams as is appropriate. A summary of all the outcomes for all upheld/partially upheld 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. During 2020-21, 199 complaints were reported as upheld or partially upheld, a decrease from 2019-20 (299). The Trust offered financial remedy in 2 cases, totalling £162.58 (one payment of £12.58 for medication costs and one payment of £150.00 for injustice caused by the loss of the patient's healthcare records, which prevented the Trust from fully investigating the family's complaint).

For each individual subject raised in each complaint, the complaints team determine whether they have been upheld, partially upheld or not upheld. The following graph (8n) illustrates the outcomes of the most frequently raised (recorded at least ten times) sub-subjects in complaints responded to in 2020-21.



The numbers of upheld complaints generally remain in the minority for each sub-subject shown and it is encouraging to note that none of the complaints about end of life care or poor standards of obstetric care were fully upheld.

9. 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 provided via the Complaints, Litigation, Incidents, PALS, Audit and Mortality (CLIPAM) report and in a separate report to the Executive Management Team each month. A quarterly report is submitted 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.

The responsibility for completion of actions arising from complaint investigations and provision of evidence to support this sits with the individual directorates. More detail follows with individual divisional updates on actions taken in response to complaints to improve services.

Division of Medicine and Emergency Care

The division comprises three directorates: Specialty Medicine, Actue Medicine and Geriatrics and Emergency Medicine. In 2020-21, the division responded to 189 complaints. Examples of action the division has taken in response to complaints include:

- Following a number of complaints relating to communication challenges on medical wards during periods of restricted visiting, this issue was presented at a directorate clinical governance meeting to highlight the impact that this had on families and to agree a strategy to improve this important aspect of care. As an outcome, it was agreed that a named member of the medical team on each ward would have responsibility for contacting families every afternoon, after either the daily ward or board rounds, to provide them with an update on their loved one. Additonal mobile telephones were purchased for all medical wards, linked to nursing stations, to make it easier for the nursing team to respond to incoming telephone calls.
- In response to a complaint whereby a patient presenting to the ED with chest pain experienced a delay in being triaged, Hello Nurses were introduced in the departments. As part of their role, they identify patients who require rapid assessment and expedite their clinical pathway thorugh to majors or resuscitation.
- The Acute Medicine and Geriatric Directorate recognised that there were some emerging themes being highlighted in complaints relating to the stroke service. In response to this, the division developed a Stroke Induction Day to run alongside the Trust induction package. This focuses specifically on the care of acutely unwell stroke patients, including targeted education on privacy and dignity. The Stroke Induction Day includes education on mouthcare, skin integrity, diabetes, falls prevention and the Mental Capacity Act.
- The Emergency Medicine Directorate received a complaint regarding a delay in diagnosing and treating a patient with a contact lens related corneal ulcer. Investigation of the complaint identified a missed opportunity to carry out a detailed examination of the patient's eye, using the Snellen Chart and/or fluourescein dye. The patient was not asked about their use of contact lenses and the ED eye proforma was not completed. In response to this complaint, the directorate introduced training on the management of eye emergencies, including basic eye history taking and eye examinations for doctors at the start of their ED attachment. The use of the eye proforma was discussed at the directorate's clinical governance meeting and it was agreed to deliver training on eye examinations and management of eye emergencies to the junior doctors every four months.
- A complaint was raised whereby an inpatient was incorrectly prescribed 30mg of prednisolone twice a day, instead of once a day on discharge. Following investigation of the complaint, it was agreed that the completion of electronic discharge notifications should be completed by the doctor responsible for the patient and not handed over to other doctors. A dedicated pharmacist has been assigned to the ward to strengthen medication safety. The directorate have also identified prescribing as a specific quality improvement project.

Division of Surgery

The Divison of Surgery comprises six directorates: General Surgery, Specialty Surgery, Head and Neck Services, Theatres and Critical Care, Orthopaedics and Private Patients. The Division responded to 115 complaints in 2020-21.

All formal complaints and the learning from these are discussed anonymously at the Surgical Divisional Board meeting, directorate clinical governance meetings and ward and unit meetings. Clinical, support and administrative staff have the opportunity to learn from complaints and to help change systems and processes to improve services for patients. The Division has recently implemented 'Stand Up' sessions and plan to include discussion around learning from complaints as part of these. These are drop in forums which are open to all Divisional staff.

The Division conducted a number of full root cause analyses in response to complaints during this reporting period. For example, an investigation was undertaken when a patient complained that they had been touched inappropriately during a colonoscopy. A safeguarding alert was raised with the Local Authority and consideration was given to declaring a serious incident. The investigation supported that the procedure was undertaken as expected and within standard protocols. However, there had been lapses in communication which had left the patient feeling vulnerable. It was identified that although the procedure was explained in full to the patient prior to commencing, the consultant did not ensure that sufficient explanation was reiterated throughout the procedure. This was discussed with the consultant and the wider team to ensure shared learning. In addition, as a result of the complaint, dignity shorts are now offered to all patients undergoing lower endoscopy procedures.

A further example of learning from complaints was when a patient complained about a potential complication following their cataract operation. They stated they had contacted the department as they were experiencing gastric symptoms; issues post-surgery are not uncommon and the patient was appropriately advised to speak to their GP about their gastric symptoms. However, the investigation found that staff who spoke to the patient at that time, missed the opportunity to ask more questions about the issues the patient was experiencing with their eye. As a result of the patient's complaint, the Head and Neck directorate developed triage sheets to ensure all relevant information is captured. These triage sheets are now reviewed by the senior nurse to ensure the correct course of action has been taken.

Division of Women's, Children's and Sexual Health Services

Three directorates: Women's Services, Children's Services and Sexual Health Services, make up the Division. In 2020-21, the Division responded to 69 complaints. Examples of action taken by the directorates in response to complaints includes:

- Further to a complaint from a patient who had experienced a miscarriage, the Women's Services directorate reviewed and updated a patient information leaflet. The patient's story was also built into teaching delivered to doctors working in the Early Pregnancy Assessment Clinic.
- A complaint was raised with Women's Services due to an inaccuracy in a scan report document. The patient had been upset that the form indicated that she had declined a screening test, when this was not the case. This was due to limited options in a drop down menu used to populate the report. Work was initiated with the sonographers to explore how this could be better captured in the reports going forward, to avoid causing distress.
- Following a complaint relating to medication during a post-natal episode, the Women's Services directorate issued a reminder regarding blood pressure medication care plans via their weekly maternity newsletter. In addition, the ward manager committed to a period of spot-checking medication records to ensure that all medications were being offered and documented correctly.
- The Women's Services directorate also received a complaint relating to a breach of confidentiality. As an outcome of this complaint, the department involved undertook a thorough review of their data security and implemented a number of changes to practice, including: completion of documentation in patient rooms to prevent loose sheets being mixed up; all printed/handwritten documents to be securely attached to patient records; midwifery handovers to take place in person (rather than by telephone); patient records to be stored in the patient's room at all times; if records need to be removed to be completed, only one set of records will be moved at a time; a notice was attached to the printer reminding staff to check that they have the right print out for the right patient; full implementation of the 'follow me' printing software which means only the person printing the document can retrieve the document from the printer.
- The Sexual Health Services directorate responded to a complaint regarding conflicting information provided to a patient in respect of contraception. As an outcome of the complaint, key learning around thorough documentation of risks, benefits and answers to any questions or concerns raised was discussed at the directorate's next forum meeting.

The Maidstone Birth Centre received a complaint from a woman who required referral to the consultant for assessment, but this referral had not been completed in a timely manner. In response to the complaint, the centre manager implemented a new referral system to ensure all actions are completed and monitored. As part of this, the email address for referrals was standardised and the senior midwife on each shift was given responsibility for monitoring these referral emails.
The family of a child attending for a scan raised a complaint that they were not kept informed about what was happening. In light of this, the Children's Services directorate worked with the Imaging directorate to develop a parent information leaflet around scanning children under sedation. The complainant was invited to participate in the development of this leaflet.

Division of Cancer Services

The Division of Cancer Services comprises three directorates: Oncology, Clinical Haematology and Outpatients. The Division responded to 28 complaints in 2020-21. Actions taken in response to these complaints include:

A complaint received by the Oncology directorate highlighted problems faced by locum doctors who may be unfamiliar with the clincial IT systems used, especially as the Trust provides cancer services across the region, at a number of different hospitals. As an outcome of the complaint, the directorate management team undertook a review of their local induction procedures to address any gaps.
Following a complaint relating to a breach of confidentiality, the Oncology directorate reviewed their standard operating procedures for registering patients. Key learning from this complaint was also shared Trustwide via the governance newsletter.
The family of a haematology patient raised a complaint that the patient had been discharged too soon and required rapid readmission due to clostridium difficile infection. Investigation of the complaint identified that extending the admission by 24-hours would have been prudent and this case was presented by the Chief of Service at the directorate's clinical governance meeting.

SNAPSHOT LEARNING

A patient was contacted by a member of administration staff and advised that they needed to attend the hospital urgently to commence treatment for a newly diagnosed cancer. However, when the patient attended clinic, it transpired that the results did not relate to her and she had been contacted in error.

Please remember, if you're contacting a patient by telephone, **verify their identity using date of birth, address and NHS/hospital number**. This prevents mistakes, keeps our patients safe and protects confidentiality. Thank you.

Extract from Governance Gazette, April 2020

Division of Diagnostic and Clinical Support Services

This Division is made up of five directorates: Pathology, Imaging, Therapies, Pharmacy and COVID Testing. During 202-21, the Division led on 16 formal complaints. However, due to their roles within the Trust, they often contribute to investigations of complaints led by other Divisions.

The Imaging directorate responded to a complaint relating to a delay in reporting a scan. Investigation identfiied that the scan had been moved to a virtual reporting room, but had not been followed-up to ensure the report was completed. In light of this complaint, the directorate now allocate a consultant radiologist to the virtual room with dedicated time to report on any imaging there. A dedicated secretary also monitors the scans moving through the room, with an escalation protocol for any scans waiting longer than two weeks.

The Therapies directorate identified a theme around discharge arrangements. Sometimes issues arise due to the patient wanting to go home, but the relatives have concerns that they are at risk of falls and may be unable to cope at home. The directorate identified a need to improve communication with relatives around discharge arrangements and the occupational therapists and Therapy Assisted Discharge Service (TADS) team are working on group learning and case study

review. Staff within the directorate have also attended training courses on communication and challenging conversations.

Division of Corporate Services

A number of different directorates fall within this Division, including Coporate Nursing and Governance, Estates and Facilities, Workforce and Finance. Like Diagnostics and Clinical Support Services, this Division often contributes to the investigation of complaints being led by other Divsions. The Division responded to 10 complaints during 2020-21 and due to the very small number, there were no significant changes to practice identified.

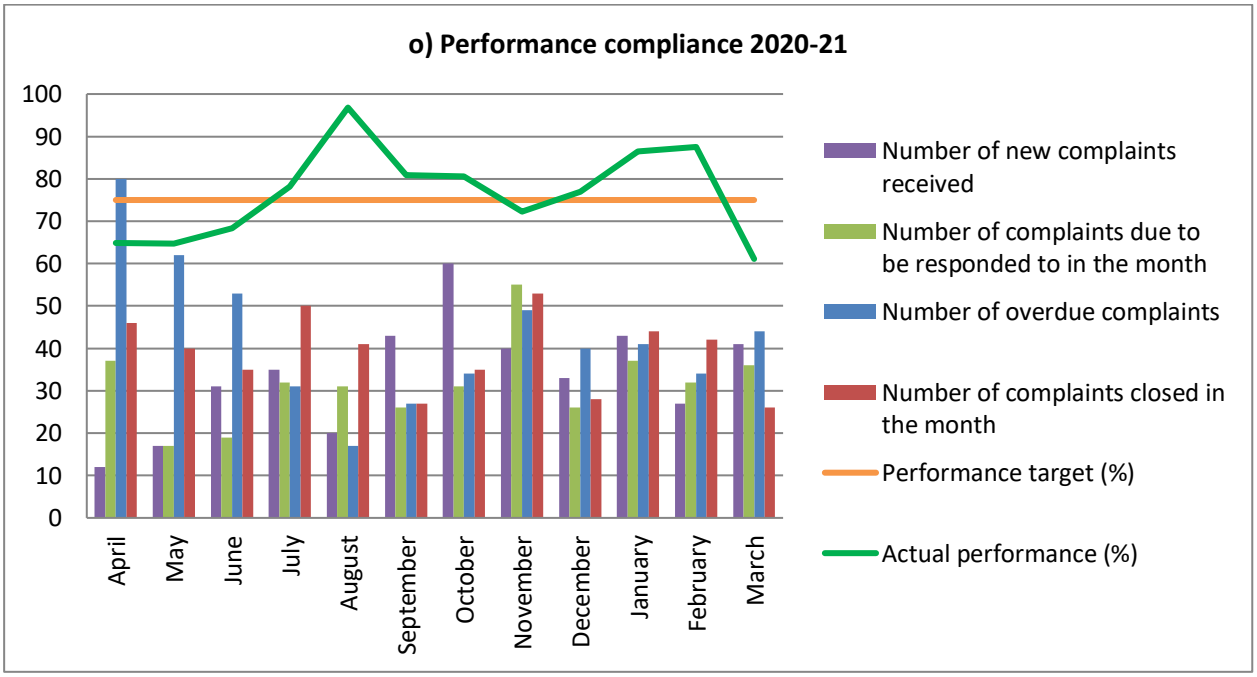
Extract from an email to the complaints team:

'I wanted to acknowledge how thorough and personal the response was – it addressed the elements of our complaint in a pragmatic and understanding way and I am pleased that the overall complaint was upheld…… The written response has gone a long way in addressing our concerns and it is encouraging to hear of the specific actions taken as a result. For that, I would like to thank the people involved in taking action so far and I hope that it leads to lasting improvements in the areas of hospital/patient/family communication.'

A summary of all upheld/partly upheld formal complaints closed in 2020-21 can be found at Appendix A.

10. Directorate performance in responding to complaints

The directorates are measured on their compliance with responding to formal complaints within 25 working days (for low and moderate risk complaints) and 60 working days (for high risk complaints or those involving third parties) of the Trust receiving the complaint. The Trust achieved 71.3% compliance for the year (64.2% in 2019-20). Monthly compliance is shown in graph 10o.



As the above chart demonstrates, following a slow start which coincided with the first wave of the COVID-19 pandemic, performance showed marked improvement and met or exceeded the target of 75%. The drop in activity between April and August allowed good progress to be made in reducing the backlog of overdue complaints inherited at the start of the year. Unfortunately,

following a peak of activity in October, when 60 new complaints were received, the number of overdue complaints began to increase again and this remains an area of focus for the team.

Detail on the complaints performance and number of overdue complaints is reported monthly by the Chief Nurse to the Exective Team Meeting for ongoing monitoring and scrutiny.

Information on percentage performance by directorate, by month can be found in the following table. The performance shown takes into account all breaches, including those which occur outside the direct control of the directorate, Division or Trust.

Directorate	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Acute Medicine & Geriatrics	100	66.7	50	100	100	100	100	100	100	66.7	33.3	80
Clinical Haematology	N/A	N/A	100	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Corporate Services	100	N/A	N/A	100	100	100	N/A	N/A	100	N/A	100	N/A
COVID Testing	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emergency Medicine	88.9	33.3	100	75	80	100	100	88.9	100	100	77.8	50
General Surgery	33.3	0	0	40	100	0	100	0	0	100	100	N/A
Head & Neck	75	N/A	100	100	100	100	100	66.7	N/A	100	100	N/A
Imaging	100	N/A	N/A	100	N/A	N/A	N/A	100	N/A	100	100	0
Medical Specialties	50	66.7	0	100	100	80	75	80	75	100	100	66.7
Oncology	100	100	100	100	100	N/A	100	66.7	N/A	75	100	0
Orthopaedics	40	100	N/A	100	100	33.3	0	60	50	100	100	N/A
Outpatients	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	66.7
Paediatrics	N/A	100	100	100	N/A	50	N/A	50	100	N/A	N/A	100
Pathology	N/A	N/A	N/A	N/A	100	N/A	N/A	N/A	N/A	N/A	N/A	0
Pharmacy	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sexual Health	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Theatres & Critical Care	100	N/A	100	N/A	N/A	N/A	100	N/A	N/A	N/A	100	100
Therapies	N/A	N/A	N/A	N/A	N/A	N/A	0	N/A	N/A	100	N/A	N/A
Surgical Specialties	33.3	N/A	N/A	0	N/A	N/A	N/A	100	0	100	100	50
Women's	0	66.7	40	75	100	100	60	83.3	66.7	66.7	100	66.7
Trust	**64.9**	**64.7**	**68.4**	**78.1**	**96.8**	**80.8**	**80.6**	**72.7**	**76.9**	**86.5**	**87.5**	**61.1**
Private Patients	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Maintaining performance compliance with response times to complaints remains a high priority for the Trust and as will be discussed later in the report, a number of initiatives have been introduced to help support this.

11. Satisfaction survey

Extract from a complainant's email to the complaints team:

'I just wanted to thank you again for all your support and understanding throughout the entire process. Your contribution to it was impeccable and I'm sure that you had a significant bearing on the outcome. You really understood what we were seeking as an outcome and ensured that our complaint was answered fully. I can't imagine that any complaint is easy to handle, but you showed real empathy in what we were going through and you helped us feel listened to.'

Every complainant is offered the opportunity to provide the Trust with feedback on their experience of making a complaint by way of an online satisfaction survey, with information on how to access this provided with the response to their complaint. In line with best practice,

respondents are asked to respond to five questions, all based on the 'My expectations' guidance produced by the Parliamentary and Health Service Ombudsman. Feedback was sought on the following:

Did you feel confident to speak up?

Was making your complaint simple?

Did you feel listened to and understood?

Did you feel that your complaint made a difference?

Would you feel confident making a complaint in the future?

Respondents are given a number of answer choices under each of the above questions and are also invited to provide an overall rating by scoring the Trust out of 5.

Disappointingly, despite a redesign of the survey and raising the profile of the survey within the complaint response letters, only 5 responses were submitted during the year, providing very limited information, which cannot be considered to be representative. Nonetheless, the feedback provided has still been reviewed to identify areas for improvement.

Question	**Score**
I knew I had a right to complain	5/5
I was made aware of how to complain (when I first started to receive services from the Trust)	0/5
I understood that I could be supported to make a complaint (e.g. advocacy services)	2/5
I knew for certain that my care would not be compromised by making a complaint	0/0
I felt that I could have raised my concerns with any of the members of staff I dealt with	0/0
I was offered support to help me make my complaint	0/0
I was able to communicate my concerns in the way that I wanted	4/5
I knew that my concerns were taken seriously the very first time I raised them	1/5
I was able to make a complaint at a time that suited me	2/5
I understood what was happening with my case	2/5
I felt that responses were personal to me and the specific nature of my complaint	3/5
I was offered the choice to keep the details of my complaint anonymous and confidential	0/5
I felt that the staff involved in handling my complaint were also empowered to resolve it	2/5
I received a resolution in a time period that was relevant to my particular case and complaint	1/4
I was told the outcome of my complaint in an appropriate manner, in and appropriate place, by an appropriate person	1/4
I felt that the outcomes I received directly addressed my complaint(s)	1/4
I feel that my views on the appropriate outcome had been taken into account	1/4
I would complain again if I felt I needed to	4/5
I felt that my complaint had been handled fairly	0/5
I would happily advise and encourage others to make a complaint if they felt they needed to	2/5

I understand how complaints help to improve services	2/5

The average overall rating given to the Trust was only 2 out of 5 (although two respondents scored the Trust 4/5). Importantly, there were a number of answer options which were not selected by any respondents including:

- I was made aware of how to complain (when I first started using Trust services)
- I knew for certain that my care would not be compromised by making a complaint
- I felt that I could have raised my concerns with any of the members of staff I dealt with
- I was offered support to help me make my complaint
- I was offered the choice to keep the details of my complaint anonymous and confidential
- I felt that my complaint had been handled fairly

This feedback would suggest that more work is needed within the clinical directorates to promote a listening and feedback culture, where the views of patients are actively welcomed and encouraged. The Trust offers reassurance around the impact of making a complaint on the delviery of care via our patient information leaflets and website. Nonetheless, it is recognised that this is a real fear for complainants, which needs further work to ensure that people feel confident to raise complaints, and ideally, as soon as things go wrong. Details of local advocacy services and contact details are made available to all complainants via the patient information leaflet on making a complaint and the Trust website. On receipt of complaints, all complainants are provided with contact details for the local independent complaints advocacy service. As part of acknowledging receipt of complaints, complainants are made aware that a record of their complaint will be held on a secure system, separate to the healthcare records. They are also made aware that an anonymous summary of their complaint may be made available to the public and are given the opportunity to opt out of this. As will be discussed later in this report, there is a need to improve the gathering of feedback on the experience of making a complaint to drive improvements.

12. External feedback

Regrettably, due to the onoging COVID-19 pandemic and associated restrictions, it was not possible for our patient representatives to reinstate their review of complaints this year, as had been hoped. It is the Trust's aim to reinstate this for next year's annual report.

TIAA published their findings following their audit of learning from never events, complaints and incidents in the Summer of 2020 and concluded that they had found reasonable assurance of learning from complaints within the organisation.

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

During 2020-21, 6 complaints were referred to the PHSO for review (an increase from 3 for the previous year). The Trust also received decisions from the PHSO on 2 complaints which they had considered. The table below shows the PHSO's decisions on the cases they considered.

	Number of cases
Upheld by the PHSO	0
Partly upheld by the PHSO	2
Not upheld by the PHSO	0
Case closed without investigation	0

The low rate of referrals and of upheld decisions would suggest that the Trust maintains high quality standards in terms of managing and responding to complaints. Shortfalls in both clinical care and complaints handling are considered by the PHSO when looking at a complaint referred

to them and where shortfalls exist which have either not been identified by the Trust during local resolution or where the PHSO feels that insufficient action has been taken to address any shortfalls, they will uphold or partly uphold the complaint and make recommendations.

The PHSO issued one final report to the Trust, in which they partly upheld the complaint. This related to a very complex case (dating back to July 2017), which had undergone an extensive period of local resolution. A letter of apology has been issued to the family and at the time of writing, a further response was being prepared to the Ombudsman outlining the actions that have already been taken in the intervening period to address the issues highlighted from their investigation.

The second final report partly upheld an oncology complaint, which had originally been investigated by the Trust in 2018. The Ombudsman found failings in communication with the patient and documentation of discussions. Learning from the Ombudsman's report was presented at the oncology clinical governance meeting by the clinical director and assurance was provided to the PHSO that the implementation of the Hybrid mail system in the interim had addressed the problem with the sending of clinical correspondence.

Key learning from both these Ombudsman's reports was shared Trustwide via the governance newsletter:

OMBUDSMAN REPORTS

The Trust has recently received two reports from the Parliamentary and Health Service Ombudsman, setting out their findings following investigation of two complaints against the Trust. In both cases, the complaints were partially upheld and recommendations have been made which the directorates involved are working on.

One of the common elements in both reports relates to documentation. In one case, we were unable to evidence some key elements of a discussion which took place in the outpatient clinic about the potential risks and benefits of a surgical treatment plan versus an oncological treatment plan. Although the clinician was clear this conversation had taken place, there was insufficient information captured in the healthcare records to support this.

The second complaint related to an inpatient admission to one of our wards. One of the issues identified by the Ombudsman was a lack of clarity about whether or not the patient was in pain. The pain scores recorded on nervecentre indicated that the patient was not in pain, however, entries in the healthcare records suggested that the patient had been in pain during the same period. As a result, the Ombudsman couldn't reach a conclusion about whether we managed any pain appropriately or not. We were also unable to provide evidence of an oral care plan for the patient and there was a lack of documentation to reflect whether the physiotherapists recommendation for use of a neck brace was implemented by ward staff or not.

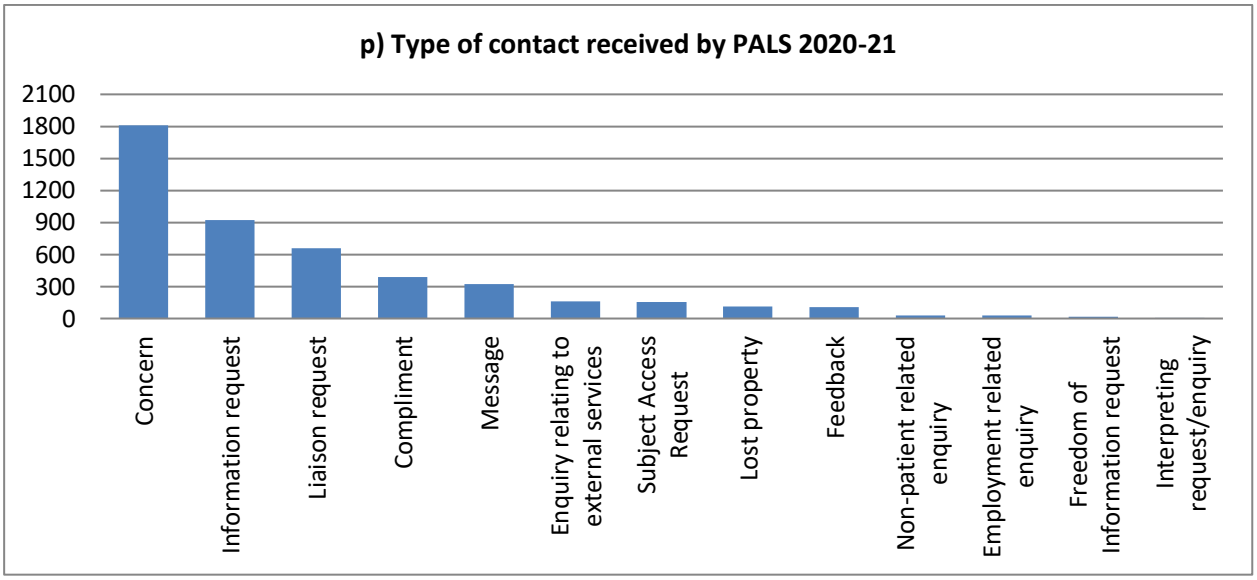
We can all take learning from these cases around record keeping. **Please remember, if it isn't recorded, as far as evidencing our practice goes, it didn't happen.**

Extract from Governance Gazette, December 2020

14. PALS contacts

For the year 2020-21, the Trust received 4,712 PALS contacts, a decrease of 1,110 on the previous year (5,822 received 2019-20). This is unsurprising as a significant proportion of PALS work relates to elective care, which was reduced during the year due to the COVID-19 pandemic.

The PALS receives different types of contacts for different purposes including: general enquiries, concerns and compliments (including NHS Choices feedback). Chart 14p offers more detail on the nature of the contacts received.



As this chart shows, the main function of PALS remains in supporting patients/service users with resolving concerns. Data on emerging themes and trends captured by PALS is regularly reported to the CLIPAM 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.

15. 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. As with complaints, it is possible for one concern to raise a number of issues and data on each issue raised is recorded.

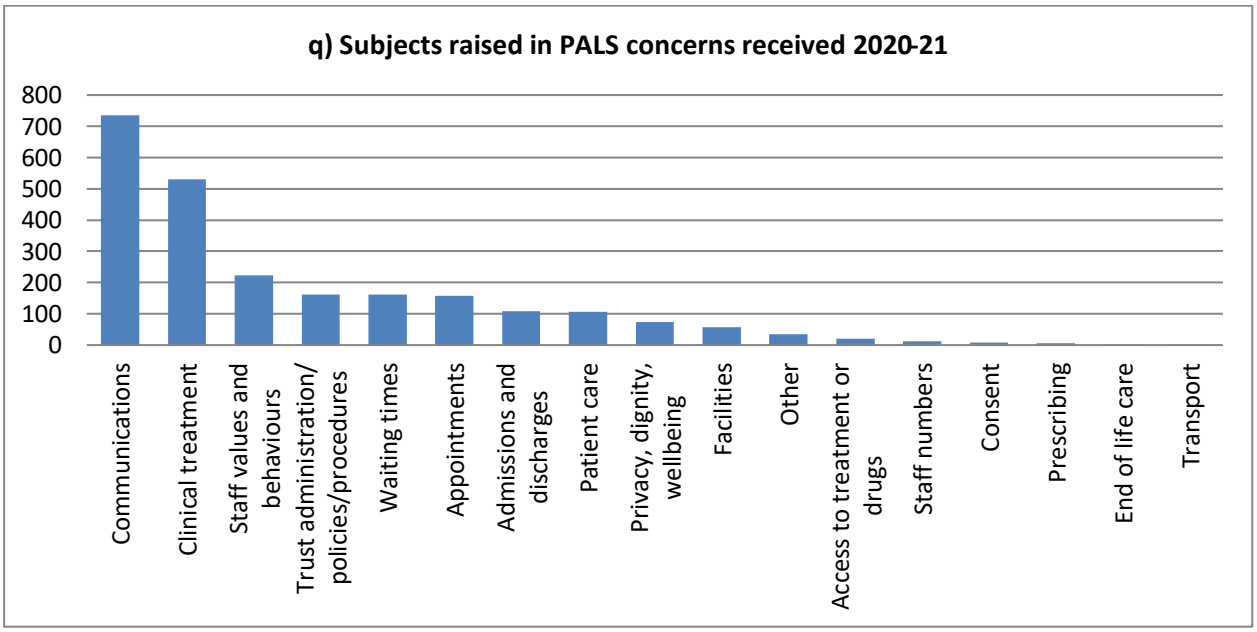
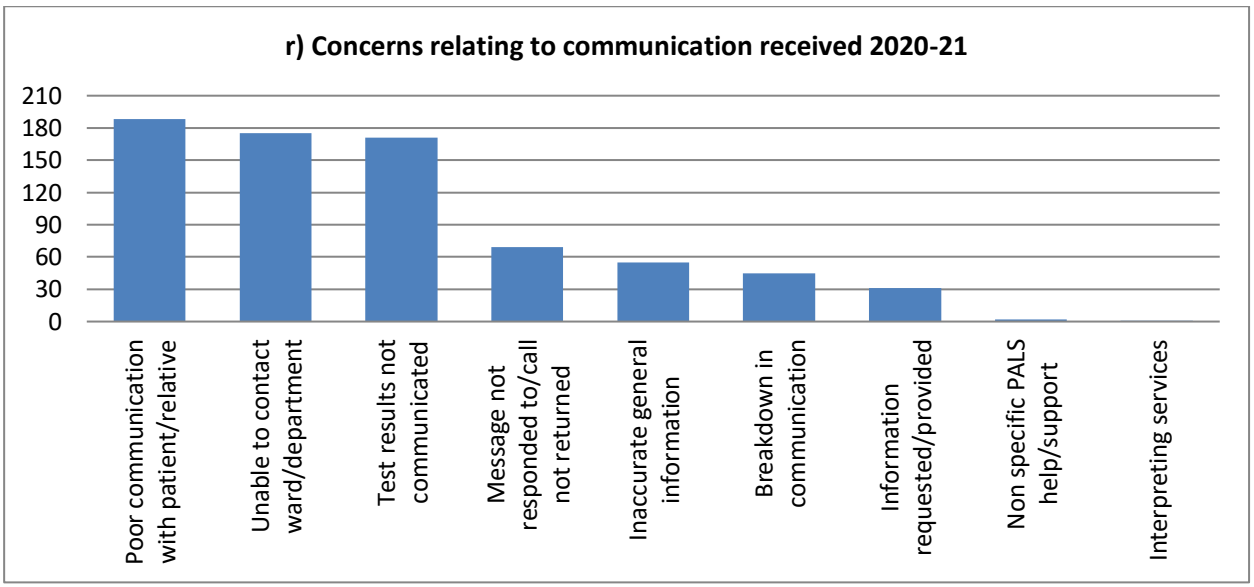


Chart 15q clearly illustrates that the main subject of concern raised with PALS relates to communications. A breakdown of concerns about communication is shown in graph 15r.

Concerns about clinical care decreased, but the most significant drop was unsurprisingly in relation to appointments, due to the suspension of non-urgent work for periods during the year.

Example of PALS casework:

During 2020, PALS identified an emerging issue around referrals for MRI scans. They were contacted by a number of rheumatology patients who had been referred for MRI scans, but who had not received any further contact with regards to when their scan would take place. Enquiries made by the PALS team identified that the MRI department was not receiving the paper referral forms. Following discussions between PALS and the rheumatology assistant general manager, the rheumatology directorate introduced an electronic referral system. This worked well and following its introduction, PALS did not receive any similar enquiries.



Poor communication with patients/relatives remains the subject most frequently raised in concerns. It is important not to underestimate the impact of poor communication on patients and the level of distress this can cause, as illustrated below:

Extract from a patient's email to PALS:

'As a family we have had one telephone conversation with the registrar since Dad's admission explaining that he had a blockage in his bowel and he would be starved to give his system a rest he would be given antibiotic and pain relief. If this did not work he would….be given a dye containing laxative that would flush him out. If this did not work he would then be considered for surgery. Since then we have had no further updates despite numerous telephone calls to the ward. Whilst I appreciate that yes, we are in the middle of a pandemic and resources are full to bursting one telephone call from a professional who knows Dad's treatment plan would avoid the constant calls to the ward with no answers being given. We have been made to feel as though we are a nuisance when calling and one nurse was extremely rude to my Sister which was very upsetting.'

There was an increase in the number of contacts received by PALS during the year, in respect of relatives being unable to contact wards. This was a direct impact of visiting restrictions, which resulted in increased reliance on telephone communication to seek updates on patients and to

allow relatives to speak with their loved ones. Coupled with the staffing pressures described earlier in this report, it was acknowledged that the volume of calls to the wards could not be managed, but understandably, this was highly frustrating for relatives. The Trust responded to this by introducing a new initiative, One Team Runners. This involved redeploying staff volunteers from other departments throughout the Trust to wards, to support the clinical staff by undertaking non-clinical duties, including answering telephones.

This data also illustrates an increase in concerns about test results not being communicated. This is likely a result of decreased outpatient activity, where non-urgent activity was postponed in some areas to release staff to care for COVID-19 patients. This resulted in some longer waiting times for appointments.

16. PALS satisfaction survey

Any service user contacting PALS by email is provided with a link to complete an online survey. During 2020-21, 44 responses were received. Key findings include:

- The majority of respondents had heard about PALS via the Trust's website; a further 18% of respondents had used the service before.
- The most common reason for contacting PALS was to raise a concern or complaint (42.5% - an increase on the previous year) followed by needing help (32%).
- 57.5% of respondents indicated that they got the resolution they were looking for; 17.5% felt their enquiry was partly resolved; 25% responded that they had not got the resolution they were seeking.
- Feedback relating to respondents' experience of the PALS staff was invited. 73% reported that the staff were polite; 57% described the staff as understanding and 51% felt the staff were friendly. There had been a drop in scores around how knowledgeable the staff were, which is likely due to the appointment of two new members of staff in early 2020, who would have been builiding their knowledge during the year. Perceptions of staff can be influenced by the outcome of the contact and it is possible that in situations where the PALS team were unable to offer the outcome being sought, this may have led the service user to perceive the individual as unfriendly.
- 82.5% of respondents would use PALS again or recommend to a friend; 10% responded maybe and 7.5% would not. All these scores show improvement from the previous year.
- Respondents were asked who they would have contacted instead of PALS. The common responses were either unsure/no-one or the complaints department. This illustrates the value of PALS in providing a point of contact for people using Trust services and how the service can prevent the need for someone to make a formal complaint.

In addition to the above, respondents were invited to give an overall score from 1 to 5. The average score recorded for PALS remained at 4.2.

Extract from email sent to PALS:

'Just a quick email to thank you for being so fast to act today and contact me and communicate the situation to the ward and to get me into the hospital to be allowed to be with my wife. She had her scan which confirmed she has miscarried….It was important for her and myself to be with her today so she was not alone.'

17. Innovations and service developments

The COVID-19 pandemic meant that service development and innovations were limited, as priority was given to managing the immediate impacts and provide support to the wider Trust in meeting the challenges this presented. A number of ambitions outlined in the complaints annual

report 2020 had to be paused or postponed. Nonetheless, work was progressed wherever possible.

The Policy and Procdure for Managing Complaints and Concerns (which had been reviewed and updated in line with its schedule in 2019-20), underwent virtual ratification.

As mentioned earlier in the report, the complaints service migrated from a rich client database to Datixweb. Unfortunately, due to prioritisation of the pandemic, work remains outstanding to develop and optimise the dashboard function offered by Datixweb, which will enable users to see live data on complaints and PALS concerns. The dashboards can be designed at a Trustwide level, divisional or directorate level, or individual ward/department level. This should help support compliance with performance targets as well as allowing triangulation of data and theming and trending by service leads/managers. This work will be resumed in 2021-22.

In respect of complaints performance, daily complaint huddles were introduced to review all immediate and approaching deadlines to faciliate reallocation of tasks (where needed) to enable performance targets to be prioritised. This was further enhanced by revised weekly divsional update reports, supported by regular meetings between complaints staff and key directorate/divisional staff to review progress on all open complaints. A new weekly huddle was developed between the complaints managers and the patient safety team to improve communication around complaints which are also the subject of serious incident investigations or patient safety root cause analysis investigations, to minimise delays but also to improve co-ordination and continuity between the departments, which allows the complaints team to keep complainants better informed.

Work commenced on redesigning the documentation used to support complaint investigations, with increased focus on understanding the cause of any shortfalls or errors in practice, including human factors, and identifying meaningful, quality actions to prevent reccurrence. The action memorandum has been revised to reflect this. This will be further supported by the use of the action module on Datixweb, to capture all actions arising from complaint investigations, send automated notifications to the action owners and allow monitoring to ensure completion of actions. Unfortunately, the system upgrade required to enable this functionality was not effective and actions to complete this work are still being pursued by the Datix administrator.

In recognition of the low response rates to the complaints satisfaction survey, the Deputy PALS and Complaints Manager, will be leading on a project with Trust volunteers to understand the limitations and reasons for the poor return rates and following this, will co-design a new strategy for collecting feedback on the experience of making a complaint. This will be reported to the Patient Experience Committee.

The new NHS Complaints Standards pilot was launched in March 2021. This new guidance sets out national, system-wide expectations for the effective management of complaints, from staff training and education through to sharing the learning and action from complaints with the communities we serve. The Standards are being piloted by a number of Trusts and are due to be introduced nationwide in 2022. In readiness for this, the Complaints and PALS Manager will be undertaking a gap analysis and reporting the findings to the Patient Experience Committee. Early discussions have taken place to scope out the introduction of a new level of external scrutiny to complaint responses, by recruting a team of volunteers to approve and countersign formal complaint responses. This proposal is awaiting assessment alongside the NHS Complaints Standards to ensure this aligns. A role profile has been developed for volunteers taking on this duty and this initiative has received positive support from the Chief Nurse and the Patient Experience Lead.

Following initial work to improve the capture of data arising from complaints which feeds into medical staffing appraisals, a revised proposal has been developed and at the time of writing, is awaiting sign off from the Medical Director and Appraisal Lead Consultant.

The introduction of virtual local resolution meetings was successful and the complaints team will retain this option going forwards. However, it is recognised that this forum is not optimal for all complainants and the option to reinstate face to face meetings at the end of the Government roadmap is welcomed.

The length of the lockdown restrictions was unexpected and as a result, the PALS offices have remained closed to personal callers. In line with the Government roadmap, the Complaints and PALS Manager will be leading on a demand and capacity exercise to review the sustainability of any long terms changes in how PALS is delivered.

In order to support directorate focus on managing PALS concerns as a priority, the Business Intelligence Unit has been approached and asked to consider formal reporting of a key performance indicator on the Trust's monthly intergated performance report. At the time of writing, as decision on this is pending.

The Deputy Complaints and PALS Manager developed a strategy for raising the profile of PALS, but the implementation had to be paused in view of the limitations posed by the COVID-19 pandemic. This is due to be progressed in 2021-22.

18. Summary and conclusions

Despite the disruption of the COVID-19 pandemic, the PALS and complaints services have continued to perform, delivering invaluable support to patients and relatives. The year has seen improvement in complaints performance and strengthening of internal communication channels to help maintain this. PALS have also sustained good performance in meeting their local KPIs, especially around response times and ongoing monitoring of this at Executive level would be welcomed. The Trust continues to demonstrate high quality complaints management, as evidenced by the Parliamentary and Health Services Ombudsman activity.

It is disappointing that progress in recording and monitoring actions remains outstanding due to technical issues outside the direct control of the services. Further work is still 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. Despite the level of assurance provided by the TIAA audit, this continues to remain the greatest present challenge to the Trust in terms of complaints management and will require a co-ordinated approach across the Trust to deliver.

The launch of the NHS Complaints Standards presents an exciting opportunity to re-evaluate the Trust's current approach to complaints management to ensure it is delivering best practice for all service users.

APPENDIX A

Learning from upheld/partly upheld complaints closed 2020-21

ID	Grade	Specialty	Closed	Description	Outcome
20616	HIGH	GENSUR	15/10/2020	Concerns raised that head injury was not monitored effectively when identified.	In respect of monitoring head injury, medical care was found to be coordinated appropriately but there were deficits in effective communication with the family on when patient would be transferred. Actions identified as a result of Serious Incident investigation.
20540	HIGH	MIDWIF	14/04/2020	Concerns raised the jaundice was not acted upon soon enough which has resulted in long term effects for the baby.	Investigation concluded that baby should have been referred for blood testing and apology offered that this action was not taken. Discussed with staff member for learning and consideration being given to community bilirubinometers.
20642	HIGH	GYNAE	03/09/2020	Concerns raised that treatment and advice in gynaecology was inappropriate and patient was discharged home and suffered miscarriage. On return to hospital, experienced delays in treatment received.	Clinical management of presentation was correct. However, patient should have been advised that further tissue may be lost after she went home. Patient was on emergency surgery list which is managed in order of clinical priority. Actions identified as a result of Serious Incident investigation.
20393	HIGH	GAST	20/05/2020	Concerns raised about the nursing care of the patient, in particular skin care, wound care and management of her diabetes.	The Root Cause Analysis investigation showed that there were examples of lapses of care as well as good practice. Improvements have been implemented where lapses were evident. Staff have been provided with training to ensure they understand the Waterlow scoring and when to escalate. Diabetes was managed appropriately.
20857	HIGH	AE	04/12/2020	Concerns raised about a misdiagnosis in ED resulting in sight loss and pain.	Serious Incident investigation concludes that diagnosis could have been made had the ED proforma been used to remind the doctor to assess contact lens care, and if the snellen chart and fluorescein staining had been used. Number of actions to include raising awareness through clinical governance for the use of the eye proforma and to review the requirement of the use of the eye proforma on examination of patients.
20886	HIGH	RESPIR	24/11/2020	Concerns raised about the behaviour of a confused patient who slapped the complainant's relative who was dying on the ward.	Complaint is upheld. While the correct risk assessments and actions were in place, this was regrettably an unfortunate unforeseen incident.
20169	HIGH	COLOR	08/06/2020	Concerns raised that lesion in colon was missed on previous imaging. Numerous concerns raised with attendances to hospital, including nursing care, delays in procedure being undertaken, why blockage was not identified sooner, why further tests were not undertaken.	Apology offered that lesion was missed which resulted in a delay to treatment. On the whole the treatment and management of this patient during his admissions was appropriate. The blockage was identified and managed appropriately given his symptoms and when his condition started to deteriorate further investigations were undertaken. Actions identified as a result of Serious Incident investigation
21061	MOD	AE	04/01/2021	Concerns raised about the poor attitude of the ED staff.	The staff members involved in the patient's care have been spoken to about the way they were perceived. They have been reminded of the importance of always being polite, compassionate and courteous.
20963	MOD	ENT	09/11/2020	Complaint concerning telephone appointment not being received with a follow-up letter stating will be removed from list if appointment is not kept, however no call received on two occasions. Very concerned about condition as has been waiting for 5 months to be seen.	Apology offered. Administration error and lack of clarification by consultant led to telephone appointments not taking place. Consultant reminded to ask staff nurses if assistance is needed with obtaining a correct telephone number. Training being implemented to ensure that staff are aware of how to update patient records. In light of complaint time slots for telephone appointments to be reviewed.

ID	Grade	Specialty	Closed	Description	Outcome
20914	MOD	AE	17/02/2021	Concerns raised that patient should not have been discharged as he was unwell and he should have been admitted to monitor the subsequent infection that was found at the site of his pacemaker. Dr was found to lack compassion and did not listen to patient.	Medical care has been reviewed and the decision to discharge patient was appropriate. Nursing staff did not make Dr aware of patient's subsequent confusion and this was a missed opportunity to reassess patient prior to discharge. As a result the complaint will be used (anonymously) at the department's clinical governance meeting to highlight the need for robust communication between staff.
21077	MOD	GENONC	11/02/2021	Concerns raised that Locum Consultant had not read and prepared for consultation with patient. Nor did they follow up with a telephone call as promised.	Apology offered. Locum new to the Trust and was learning the systems etc. Complaint has identified the need to ensure a robust induction for new doctor and Locum Consultant and adjusted their practice based on the concerns in the complaint.
20752	MOD	AE	07/04/2020	Concerns raised about the wait to be triaged when suffering from cardiac chest pains.	Apologies offered for the delay. ED are working on improving triage with 'hello nurse' and utilisation of emergency nurse practitioners to triage certain patients to reduce waiting times for others. Staff reminded of the escalation protocol to follow.
21119	MOD	GENMED	18/03/2021	Concerns raised about the lack of communication with the family when the patient was dying, and a missed opportunity to be with him. Concerns also raised about inaccuracies on the death certificate.	Investigation finding shows poor communication with family due to staff shortages and operational pressures due to COVID-19. The Division has implemented an number of improvements, these are scheduling a set time to update families and the introduction of the One Team Runner. Apologies given for the date of birth inaccuracy on the death certificate and staff reminded to attend to detail.
21096	MOD	ORTHO	04/02/2021	Concern that referral was not fit for purpose and despite requesting, a further referral has not been made.	Apology offered and assurance that referral has been redone. Action in place for registrar to be present in ad hoc clinics to ensure referrals are done at the time, with input from the consultant.
20991	MOD	GYNAE	19/11/2020	Concerns raised in respect of misdiagnosing pregnancy very soon after miscarriage. Additionally patient states she was not told to refrain from sexual intercourse and to use contraception to avoid another pregnancy.	Assurance offered that diagnosis was correct. However communication could have been better. Action to take the case to the Early Pregnancy Assessment Clinic teaching session as a source of learning for the team. Doctors have received feedback. Apology offered that advice not provided, leaflet providing this advised to be reviewed and made available to sonographer to provide to women who do not need any further management.
20759	MOD	GENONC	15/04/2020	Concerns raised about a breach of confidentiality.	Apologies offered. Staff members did not verify patient's identity to check they were talking to correct patient. Need for verification discussed with team and shared via governance gazette. Department also reviewing standard operating procedure for registration process.
21074	MOD	GAST	18/01/2021	Concerns raised regarding lost property. Concerns also raised about telephone communication that lacked compassion when the family called for an update.	Property was mislaid, and only one ring has been located. The ward did not record or store the jewellery in the correct place. They are aware of the correct policy and procedure now. Apologies given for the poor communication experienced.
20921	MOD	AE	13/10/2020	Concerns raised about the care and treatment provided in ED following knee injury and the long wait for the MRI and the results.	Appropriate clinical assessment undertaken however patient should have been provided with a knee brace. There were no delays in the waiting for MRI and scan results.
20912	MOD	AE	05/10/2020	Concerns raised about the care received in the ED with regard to the application of the brace, pain control and follow up care.	The investigation has shown that we should have kept the patient in overnight to control her pain and ensure the right size brace was fitted from the store in the morning. Learning shared with doctor and discussed within department huddles. Follow up MRI was booked within target timeframe.

ID	Grade	Specialty	Closed	Description	Outcome
21088	MOD	RESPIR	26/02/2021	Concerns raised about not being contacted in good time prior to the patient's death. Concerns also raised about not being able to video chat with the patient.	Our investigation showed that there was at least daily contact with the daughter in the days leading up to the patient's death, but we did not update her during the final hours prior to death. Improvement actions are in place with a daily rota to update families as well as the use of the One Team Runner initiative to improve this aspect. Attempts were made to assist the patient with her iPad which were not successful.
20810	MOD	ORTHO	24/08/2020	Questions asked about the treatment of this patient and whether there were delays in diagnosis and treatment.	Detailed explanation of care provided. Mass was identified early on but it proved difficult to identify the cause. Apologies offered that it wasn't made clear that MTW would not have control over how quickly tertiary centre responded to urgent referral. Issue highlighted with directorate and staff and via Governance newsletter.
20956	MOD	AE	02/11/2020	Concerns raised that the patient's fractured nose was missed.	Although the fracture came to light later, appropriate examination was undertaken and the fracture was not obvious on first presentation.
20897	MOD	OBSTET	29/09/2020	At 12 week scan patient was advised that as she had had the Harmony test she would not be allowed to have the combined screening. Scan report states patient refused the combined screening test, this is inaccurate. Response provided through PALS is unacceptable as combined screening test measuring PAPP-A were not carried. Concerned low PAPP- A is associated with low birth weight, early birth and miscarriage. Concerned something may have been missed by sonographer that may impact on fetus growth as test not undertaken. Seeking explanation as to why combined screening test was refused.	The Harmony test is currently the most accurate first trimester screening test available and is more sensitive to picking up the risk of chromosomal abnormality than the combined screening test. This is the reason patient was not offered the combined screening test. Nonetheless, when a patient still requests the screening to be done, even after the rationale being given, then this should be done. As a point of learning the directorate have ensured that all sonographers know this to be the case for future parents. Apology offered that we stated patient had refused the screening when this was not the case. The reviewed report documents that she declined screening, this does not reflect patient's situation, as due to the drop down menu it was not possible to record rationale accurately.
20879	MOD	RESPIR	12/02/2021	Concerns raised about the inadequate communication of patient's condition with the family whilst visiting restrictions were in place. Concerns also raised about the compassion and subsequent handling of his death.	Learning has been shared via the clinical governance meeting around more regular updates for families, especially when there are visiting restrictions in place. Learning has also been shared regarding communication with bereaved families.
20833	MOD	ORTHO	23/07/2020	Concerns raised that insulin was not given prior to surgery despite diabetic patients increasing blood sugar levels. Concerns with management of pain and diabetes on the ward. Concern that patient was discharged with limited mobility and that patient transport was not arranged as indicated by physiotherapy team.	Incorrect advice was given as patient should have taken insulin prior to attending for surgery. This incorrect advice has been discussed with the staff member involved for their learning. Assurance offered around management of pain and diabetes on ward. Patient transport was arranged as indicated.
20851	MOD	RESPIR	17/12/2020	Concerns raised about the medical and nursing care of the patient. Concerns focus on delirium assessment, nutrition, dignity and also mobility. Concerns also raised about a breach of confidentiality.	Complaint partially upheld. Patient was not appropriately dressed. Point learning staff reminded to ensure they follow the 'End PJ Paralysis' Fluid charts were not consistently completed, staff completed a focused piece of work on completion of charts. Investigation highlighted training need for new staff on mobilising and repositioning patient, this was delivered by stroke clinical nurse specialist and physiotherapists. There was some learning for the staff around mental capacity assessment which is being taken through via the stroke development programme. Apologies given for the breach of confidentiality that was dealt with at the time.

ID	Grade	Specialty	Closed	Description	Outcome
20867	MOD	ELDER	28/09/2020	Concerns raised regarding discharge arrangements. Concerns also raised regarding handover to the family and communication. Concerns about the patient's care raised.	Complaint upheld. Actions undertaken are improvements to the bedside handover meetings and Board rounds where the team proactively check the discharge plans and paperwork. Spot audits are in place to check completion of the discharge checklist and catheter saving lives care plan
20898	MOD	ORTHO	23/11/2020	Patient experienced complication during bunionette surgery, resulting in a need for more intervention. Concerns raised about lack of clinical review post-operatively.	Apology provided for consultant's manner in how she came across however she wanted to convey her concerns about bilateral surgical procedures each foot. Apology given that consent form did not specifically list risk of fracture occurring during any surgical procedure which involves the cutting of bone. Complaint will be discussed anonymously at the Trust's consent working group. Investigation findings show there was breakdown in communication and consultant was not contacted. Apology given for the impact this had on patient. As a point of learning the junior team have been reminded to escalate any concerns to the on call orthopaedic consultant. Apology provided for not completing Electronic Discharge Notice Complaint discussed with registrars highlighting the importance of the completion of this form and the impact this can have on patients.
20960	MOD	ORTHO	10/12/2020	Complaint made with regards to cancellation of hip replacement surgery due to issues with CPAP machine. Explanation re issue with CPAP machine provided by manager, however unhappy that patient was advised 12 hours before procedure of cancellation, particularly as service has been aware of the need to use CPAP machine from the outset. Seeking assurance that the issue of the CPAP machine will be addressed as a matter of urgency. Seeking compensation for hotel costs incurred due to need to self-isolate for procedure that was cancelled.	Patient should not have been referred to the Horder Centre given his need for a CPAP machine. This has been raised with outsourcing team and have asked them to review the pathway for patients in this group. Patient was incorrectly booked for surgery in Maidstone as the CPAP machined generate a vapour which presents a risk in terms of COVID-19. As a point of learning staff in the clinical administration unit are to identify any patients who use CPAP and not to book them for Maidstone.
20713	MOD	BREAS	15/04/2020	Concerns raised that information provided by specialist nurse was incorrect and caused additional anxiety. Telephone messages not responded to, delaying treatment. Confusion around why patient was referred to an alternative consultant.	Apology offered for confusing information. Explanation provided that tests and investigations can be subject to change depending on results of other tests. Apology offered for delayed response to telephone message left. Assurance offered that the delay in starting treatment has not impacted negatively and explanation provided as to why patient was seen by another consultant.
20863	MOD	AE	16/10/2020	Concerns raised about the lack of care by mental health services and the long wait to be seen by them.	Explanation provided in respect of delay in completing the psychiatric assessment by KMPT. Apologies offered for delay in transfer to a bed, due to level of activity in the ED.
20853	MOD	ORTHO	04/02/2021	49 questions raised regarding management of patient. Concerns raised around lack of care and treatment of presenting injuries, poor communication with family following patient safety incident. Patient was not given adequate pain relief. Concerns about inappropriate discharge and lack of support provided post-discharge.	Answers provided to all questions raised. Patient had capacity and was compliant with care. Risk assessment concluded that preventing patient from going out to have a cigarette was more likely to cause a problem than not taking her out for a cigarette. Patient was not expected to harm herself. Since incident, staff no longer take patients out to that area of the site to reduce risk of this happening again. All discharge planning was done in conjunction with patient who understood risks involved.
21038	MOD	AE	07/01/2021	Concerns raised about the decisions to discharge patient from ED on two occasions. Concerns raised about the visiting restrictions and not being able to support a person who is vulnerable with information. Concerns also raised about the drugs prescribed and their reaction to the patient's existing therapies.	There was no error in the prescribing and administration of medication. Patient did not require impatient admission when discharged from ED on two occasions, but he should not have been discharged overnight. This case is being discussed with the ED team when they next have their team meeting post COVID 19.

ID	Grade	Specialty	Closed	Description	Outcome
20808	MOD	COLOR	07/08/2020	Concerns raised with a potential delay in appointment and the removal of a collection via ultra sound scan following surgery. Concerns about nursing care.	Assurance offered that there were no delays in treatment provided and acknowledgement that this did not happen in timeframe patient expected. Apology for some aspects of nursing care which did not meet expected standard. This has been addressed by the ward manager. Concerns raised have been shared and discussed with the nursing team who have been reminded of the expected standards.
20923	MOD	GENONC	06/10/2020	Concerns raised regarding care, treatment, delays experienced.	There was a delay in being seen due to capacity issues, that has now been resolved, but there was no delay in chemotherapy. Patient's condition deteriorated so she was not fit for treatment.
20755	MOD	AE	10/06/2020	Concern regarding the length of time to receive treatment in ED and the attitude of the staff.	The length of time it took to receive the treatment in ED was as per protocol. The nurse involved has been spoken to about the way she was perceived.
20778	MOD	GENMED	16/06/2020	Concerns regarding poor nursing care resulting in pressure damage and bruising.	Our investigation showed that appropriate care was delivered and that the patient declined some care which resulted in pressure damage.
20907	MOD	GENSUR	06/10/2020	Concerns raised regarding delay with CT scan, resulting in delayed diagnosis of ruptured appendix. Following surgery, patient was not prescribed the correct type of diet causing ongoing bowel symptoms.	The delays were due to the outsourcing of the scan for reporting. Apologies given for not explaining the diet that caused discomfort which was to be expected given the type of surgery.
20888	MOD	GAST	19/11/2020	Concerns raised about the lack of consultation, treatment, care and support provided to patient. No support provided following discharge. Advised by funeral directors about bruising to face, would like to understand how this happened.	There is a range of learning following this case. Communication with the family should have been far more effective. Both nursing and medical teams have reflected on this theme and are discussing improvements at the medicine clinical governance meeting.
20847	MOD	ELDER	20/07/2020	Concerns raised about the behaviour of another patient in the bay. Complainant was frightened by the actions of another patient and had to have additional blood tests for possible blood borne infection risk.	Complaint upheld. Unfortunately a confused patient approached the complainant unsupervised due to staff being called to another person. In light of this complaint staff have been reminded never to leave a confused patient unattended in a bay. This has been shared at the handovers so that all staff are aware.
20633	MOD	HAEM	16/12/2020	Concerns raised about a delay in treatment and the communication of the patient's prognosis by the consultant on the ward.	Unfortunately the patient's poor condition was the reason why his treatment could not be started. Ideally communication should have taken place in a private place. The team have reflected on this.
21020	MOD	GAST	29/01/2021	Concerns raised about the initial discharge home. Further concerns raised regarding lack of communication with the family, poor nursing care and delays in care.	The initial discharge home was deemed as appropriate following the investigation. Communication was poor with the family and the staff have made changes to address this for future patients. There were examples of poor staff attitude and nursing care that has been dealt with by the ward manager. There was no evidence of delayed treatment. The family met with the consultants and sister to resolve their concerns on the ward, which then they felt improved.
20706	MOD	GENMED	06/07/2020	Concerns raised about patient's clinical and nursing care, including anticoagulation.	Patient did not receive anti coagulation medication as this was not available on the ward, alternative medication was prescribed and administered. Reminders to staff to maintain patient's modesty and dignity at all times.
20978	MOD	NEUR	10/11/2020	Concerns raised about poor communication with the patient.	Apologies given. This was purely human error on the part of the consultant who has reflected on how this occurred for future practice.
20981	MOD	RESPIR	13/11/2020	Concerns raised regarding the patient's consultation with doctor, the clinical treatment and diagnosis offered. Patient did not feel they were listened to.	Apologies given from the consultant regarding the consultation. The investigation revealed a misunderstanding between the two parties. The consultant has reflected on his practice for the future with telephone consultations.

ID	Grade	Specialty	Closed	Description	Outcome
20743	MOD	GENMED	09/04/2020	Concerns raised regarding the communication between Maidstone Hospital and Kings College London in relation to an appointment at Kings where the patient was turned away as she had arrived on a stretcher.	Apology offered. No information provided to ward staff in respect of restrictions to attend outpatient appointment. Learning shared via newsletter to contact other hospitals to check for any limitations if this situation arises again.
21127	MOD	ORTHO	24/02/2021	Concern raised that diagnosis of infection in knee was delayed and patient has lost faith in consultant.	Apology offered. Sample sent to laboratory without any identifiable information and therefore results unknown. Team have been reminded of the correct process. Patient care has been transferred to another consultant.
20926	MOD	MIDWIF	19/10/2020	Concerns raised with regards to post-natal care received.	Delivery care was of a good standard but there were gaps in post natal care. Ward staff have reminded of the need to regularly check on all women and ensure that they are aware that they can summon help using the buzzer and that women are aware that they can request analgesia outside of medication round times.
20826	MOD	GENSUR	09/07/2020	Concerns raised with the manner and attitude of the treating consultant	Apology offered for manner of doctor who has been asked to reflect on the comments made and assurance that complaints are discussed as part of doctors annual appraisal cycle.
20727	MOD	OPTHAL	08/04/2020	Patient's relative was not allowed to accompany patient with poor eyesight into eye day unit. Concern raised that patient could not see the form she was given to sign. Additional concerns raised in respect of experiencing poor communication during procedure. Abrasion caused to the eye by the surgery.	Apology offered, and assurance that value of relatives attending is known and relative should have had access to the unit. Explanation provided that consent form is signed prior to procedure, and re-signed depending on time between consent being taken and scheduling of surgery. Apology offered for poor communication and assurance that all information is provided prior to the surgery by way of information leaflets. Assurance offered that abrasion was not caused during the procedure.
20686	MOD	GYNAE	09/06/2020	Concerns raised that operation notes were not available at follow up outpatient appointment, which was not received within timeframe indicated, resulting in patient having to contact PALS to assist in making the appointment. Patient was not advised after her surgery of the outcome. Patient has now been advised there is nothing further that can be done and has been referred back to her GP.	Apology offered that operation notes were not available for follow up appointment and assurance that these notes are available and have not been misplaced. Apology provided that follow up was not arranged within timeframe and outcome of surgery provided.
20903	MOD	GENMED	17/02/2021	Concerns raised about the plans to discharge the patient when she was dying.	There was a communication misunderstanding between the junior doctor and actual plan of care. This was rectified by the Palliative Care Nurse. Complaint was discussed with doctor for his learning.
20945	MOD	ENT	02/11/2020	Concerns raised regarding the wait for an ENT appointment and the unsuitability of telephone appointment offered. Patient does not believe the consultant can look into her infected ear over the telephone. Further concerns raised regarding booking office staff who was described as being offhand. Specifically seeking to have appointment changed to an actual face to face appointment.	All initial appointments are being conducted over telephone unless it is a referral onto the cancer 2 week pathway. Patients will be seen face to face if consultant feels this is needed. Patient reviewed by consultant ENT surgeon over the telephone and at that time did not report having any ear symptoms. Face to face appointment offered. Concerns about clerical staff attitude not upheld.
20430	MOD	HAEM	20/05/2020	Concerns raised about care of the patient's PICC line. Concerns also raised about the communication between the nurses and doctors and the written communication sent to the patient's home when she was not there for 5 weeks.	A Root Cause Analysis investigation was undertaken following the infection and actions identified. A new process has been put in place to check postal details on admission and discharge.
20819	MOD	DOM	26/08/2020	Concerns raised about the poor cleanliness of the department and poor infection prevention and control procedures by the staff.	The Estates and Facilities department has strengthened their checking processes for ensuring areas remain clean, especially where there is a high footfall.
20852	MOD	ELDER	07/08/2020	Concerns raised about the discharge of the patient who arrived home in a poor condition.	The ward discharged the patient in a hospital gown as the patient refused to get dressed. They also provided her with an incontinence pad that became dislodged on the journey. There was a breakdown in communication mix up that has been fed back to the staff member for their learning.

ID	Grade	Specialty	Closed	Description	Outcome
20786	MOD	GAST	31/07/2020	Concerns raised about a delay in diagnosis and communicating and acting on MRI results. Concerns also raised regarding the lack of communication with the patient.	The investigation showed that there were avoidable delays in upgrading the patient to the cancer pathway. This has been reported as an exception report with actions in place to tighten up the process. Communication about this was also poor. Staff have been made aware of the need to keep a patient updated.
20875	MOD	STROKE	02/09/2020	Concerns raised in respect of TTO's and an overdose of anticoagulation medication.	An error was made in the prescription and the correct process was not followed. This has been discussed at length with the consultant and fully investigated as an incident. The learning will feature in the updated milestones for the stroke pathway.
21000	MOD	STROKE	04/01/2021	Concerns regarding communication, nursing care and end of life care.	Our investigation showed omissions in care and communication. The stroke consultants have changed their practice and proactively update families now. The ward staff have undergone retraining on end of life care and communication.
21150	MOD	MIDWIF	08/03/2021	Concerns raised with care provided on postnatal unit. Patient went several days without regular blood pressure medication and did not received regular pain medication following C-section. Poor communication about condition of baby and blood sugars not checked regularly. Incorrect information given regarding iron tablets.	Apology that blood pressure medication was not given for several days and this has been discussed with the postnatal team for learning. A reminder about the care plan for blood pressure medication following delivery will also be included in the weekly maternity newsletter. Apology offered that pain was not managed effectively however drug chart shows that regular pain medications being given. Apology offered that blood sugars were not recorded appropriately. Apology offered that iron tablets were offered erroneously. As learning, the concerns will be discussed anonymously, with the postnatal team and spot checks will be undertaken on documentation to ensure that diabetic charts are being completed (if required), that observations are being undertaken within guidance, and that any self-medication is documented on drug charts.
21078	MOD	GENONC	15/01/2021	Concerns raised about lack of communication from doctor after agreeing to call with updates.	Apologies given, although the consultant did not promise to call the patient as he was an inpatient at the time and under a different consultant.
21134	MOD	GAST	11/03/2021	Concerns raised about poor nursing care on the ward and experiencing delays in receiving care.	Our investigation showed that there were some lapses in nursing care as described by the family. The ward involved has developed a ward based improvement plan in response and provided some additional teaching and training for staff.
20924	MOD	MIDWIF	16/10/2020	Concerns raised over breach of patient data and confidentiality.	Printed documents relating to another patient found in complainants records. Other patient advised of breach and apology provided. Response provided outlines steps taken to prevent reoccurrence. Apology provided to complainant for the distress caused.
20382	MOD	ANAES	18/11/2020	Concerns regarding the insertion of the patient's portacath position and also infection.	Apologies offered. The investigation revealed that the port should have been removed earlier due to infection. The need for early referral to the vascular access team was discussed with the ward staff for learning. The port was not placed in the wrong position.
21062	MOD	OUTP	07/01/2021	Concerns raised regarding the attitude of the receiving nurse and then the way the COVID-19 swab was taken.	Due to the staff member leaving we were unable to investigate the behaviours, however, we upheld the complaint and have offered redress for the cost of the prescription she had to obtain. New and strengthened procedures and training have been put in place in the COVID pod.
20722	MOD	ELDER	01/05/2020	Concerns raised about medical and nursing care on the ward.	Apologies offered as there was no evidence of mouth care provided. Mouth care education and training delivered on the ward. Other aspects of care were in line with best practice.

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20870	MOD	AE	02/11/2020	Concerns raised about the way the patient was treated when they attended the Emergency Department. They felt dismissed and labelled as 'just a psych patient'.	Complaint has been partially upheld. Investigation findings show care provided was appropriate. In respect of patient feeling dismissed, the doctor caring for the patient has accepted the patient's feedback for their reflection and learning.
21165	MOD	GYNAE	17/03/2021	Concerns raised in respect of consultant's attitude and treatment which was described as cold and unprofessional.	Discussion taken place with doctor who has reflected on this patient's experience.
20730	MOD	AE	17/04/2020	Concerns raised about a delay in treatment for iritis.	There was a 4 day wait to be seen, that given the presentation would not have meant earlier prioritisation. However, given this, capacity in the clinic is being addressed with more staff being trained to see patients.
20928	MOD	AE	07/10/2020	Concerns raised about the cannulation technique of the ED doctor and the risk of cross infection due to the doctor cutting himself and exposing the patient to his blood.	Apologies offered. Incident to be discussed at appraisal. Dr to redo cannulation training. Assurance offered that Dr is negative for any blood borne viruses.
20709	MOD	CARDIO	28/07/2020	Concerns raised about a faulty loop recorder device which has not stored any information since 2017.	Loop recorder should have had its memory cleared which resulted in no further data being stored for 4 months. No harm to the patient. Reminder to staff to ensure this does not happen again.
20930	MOD	MIDWIF	16/10/2020	Concerns raised in respect of being eligible to give birth at the birthing centre. Patient has been waiting for confirmation of this and despite chasing repeatedly the service was advised there was no consultation booked and no record of assessment. Patient feels the birthing centre is disorganised and not friendly or good at communicating.	Patient received poor standard of communication, as a result patient's suitability to use the birth centre was not assessed and she missed out on the opportunity to use this facility. Following learning has been introduced: - A system to ensure that referrals are checked by the team daily and followed up to ensure they have been completed. - The need to ensure that more junior staff who are less familiar with working at the birth centre are fully supported. - All birth centre staff have been made aware of the centre email address. An aide memoire to has been added the office telephone with the email address clearly identified. -The team has been reminded of their professional responsibility to ensure that all messages and calls from women are documented on their electronic healthcare records. -All team members will use the generic email for referrals and the senior midwife on duty each shift will be responsible for checking the inbox and electronic calendar to ensure that referrals are followed up. Additionally, all referrals regarding women's suitability must now be copied to the ward manager, to facilitate timely discussion with consultant as part of the multi-disciplinary team.
20481	MOD	STROKE	12/05/2020	Concerns raised about the arrangements for appointments with the consultant and a subsequent delay in diagnosis and correct treatment.	Although there was a delay, this was no longer than any other patient, despite outsourcing of the MRI service to mitigate. Apologies given. The consultant apologised for not keeping the patient updated in a timely way.
21049	MOD	AE	17/03/2021	Concerns raised regarding the care of a scalding burn. Concerns also raised by the way the family were treated in light of a potential safeguarding concern.	Our investigation showed that best practice guidelines were not followed. Learning around the correct treatment has been shared with the ED. Concerns around the attitude of staff and the safeguarding alert were not upheld, although apologies given and staff reminded to always remain professional when having sensitive discussions with families with this regard.
20962	MOD	MRI	09/11/2020	Concerns raised about the poor response times from switchboard, the possible mix up of the patient's records and the wait for an MRI appointment.	There were no delays in the patient receiving the scan, but there were difficulties in getting through to the right department. A new information system is being introduced in March 2021 that will streamline communication.

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21029	MOD	AE	10/12/2020	Concerns raised about the delay for a decision to be admitted, the poor infection prevention and control practices and the attitude of the staff.	The investigation revealed poor infection prevention and control practices in the Clinical Decision Unit. The practitioners involved are fully aware of their mistakes and have addressed their practice. Apologies given.
20673	MOD	PAEDS	25/06/2020	Concerns raised regarding the doctor's manner during clinic consultation, that patient has not been referred appropriately and that child is not being managed effectively due to his gender history.	Apology offered and assurance given that management has been appropriate. Assurance that doctor has completed the required training. Apology offered for the poor experience.
21035	MOD	OBSTET	13/01/2021	Concerns about antenatal consultation and about the contents recorded in health care records.	Apology given for the inaccurate record keeping and assurance that this will be amended once maternity notes are available.
20877	MOD	RESPIR	08/09/2020	Concerns raised about the attitude of the doctor and the patient's referral to mental health services when she was needing respiratory care.	The medical care was appropriate, but there were communication issues that the team have taken away to reflect on. Better information giving is an essential lesson for the ward's medical and nursing team, especially with anxious patients.
20622	MOD	AE	02/07/2020	Concerns raised about the care and management of the patient's knee wound.	The investigation showed that the knees should have been dressed differently. Training and competence assessment is in place for those nurses who suture and new staff are being actively supported until deemed competent.
20444	MOD	STROKE	16/06/2020	Concerns raised regarding the care and management of patient's diabetes.	A number of omissions and error were highlighted in the investigation. Policy review has been undertaken and focused teaching, training, both face to face and online has been implemented. Monitoring using wifi technology is being introduced to alert patients who are not stable to the CNS team. An educator role is being developed.
20736	MOD	CARDIO	22/07/2020	Concerns raised about the diagnosis at death of the patient as the family were not aware of the medical history and the death was quite sudden.	£150 financial redress offered for injustice caused by loss of medical records. Patient was admitted for treatment for chest infection and heart problems. Treatment was commenced on admission. Explanation of circumstances of death provided.
20869	MOD	AE	27/08/2020	Concerns raised about a delayed diagnosis and treatment in ED leading to continued physical difficulties now, despite surgery.	There was a delayed diagnosis in ED. A specific training programme on hand injuries has been put in place for the junior doctors.
21097	MOD	ULTIMA	04/02/2021	Concerns raised about a possible delay in diagnosis. Concern that appointment letters not received on time during winter period. Concern that patient was nursed in an a ward that was not ENT specialists. Poor bedside manner of nursing staff. Discharge arrangements.	Assurance offered that the type of cancer is very slow progressing and most are benign therefore immediate biopsy is not clinically indicated. Delay in diagnosis did not impact on the outcome as the cancer is slow progressing. Apology that letter did not arrive on time. Assurance that telephone contact was attempted but to no avail, however, telephone contact could have been attempted the following day and this has been shared with the team for learning. Explanation provided that, in the current times, nurses are being moved to different wards and therefore may be outside of their normal specialty. Apology offered for manner of nurse, and incorrect information provided. This has been discussed with the nurse for learning and reflection.
20822	MOD	GAST	14/07/2020	Concerns raised that call bell was not responded to resulting in the patient being in considerable pain. Relatives stayed with patient and slept on floor as no chair being offered. Patient left on commode for long periods, and also in the dark.	The patient did not have her pain controlled. There were delays in providing pain relief medication. Staff have been asked to prioritise pain relief administration. Staff have also been made aware of the need to attend more carefully to a patient and family's comfort and communication needs.
20734	MOD	ORTHO	21/04/2020	Concern raised that patient has been waiting for urgent surgery since August 2019.	Apology for long wait for surgery due to lengthy orthopaedic waiting times. Explanation as to initiatives in place to help reduce the waiting lists.
20835	MOD	ULTIMA	20/07/2020	Concerns raised about receiving the results of an ultrasound that belonged to a different patient.	Human error caused the wrong report to be uploaded and sent to the GP. The sonographer has now changed their practice so that they do each report after the scan rather than batching the reports at the end of the list.

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20779	MOD	STROKE	17/07/2020	Concerns raised about the nursing care of the patient. This included his safety in the ward due to an aggressive confused patient, dietary advice not being followed and the development of pressure ulcers.	Apology offered that patient was verbally and physically abused by a patient with dementia. Due to clinical needs both patients needed to placed near nursing station for close monitoring. Reminders to staff regarding nutritional care and referring in a timely way to the tissue viability team have been added to the daily handovers. Skin integrity is now discussed at every shift handover as routine. The SALT are reviewing the literature for practice updates on a regular basis and undertaking 6 monthly audits of compliance to their care planning.
21058	MOD	GENMED	12/01/2021	Concerns raised about four ward moves in 24 hours plus becoming COVID-19 positive	The reason the patient was moved four times during the COVID-19 outbreak was to protect him from contracting the virus from those testing positive around him. One move was for a few hours for deep cleaning the area. Although patient tested positive for the virus, this did not adversely impact on his care.
20858	MOD	ELDER	20/08/2020	Concerns raised about another patient approaching the patient. Concerns also raised about being told to wet herself.	Another patient did approach the patient. Apologies given for distress caused. Apology offered to the patient at the time for comment made regarding continence. Ward manager is monitoring patient feedback to ensure this is not repeated.
20916	MOD	AE	12/10/2020	Concerns raised about the patient's arm wounds not being assessed, sutured and dressed in ED.	Due to breakdown in communication between staff wounds had not been assessed. Staff have been reminded to thoroughly assess a person who attends with self-harm injuries.
20986	MOD	RHEUM	24/03/2021	Concerns raised about outpatient appointments and the way the patient was spoken to.	Although the doctor's recollection of the consultation differed from that of the patient, they have apologised for the way they came across and have offered to reflect on this with the medical director as part of their appraisal.
20995	MOD	PAEDS	01/02/2021	Concerns raised in respect of telephone consultation. Dr asked to call patient' father as mother was unable to take call during working. This request was not carried out and patient is now discharged. Complainant is very angry as patient has been waiting for a year to be seen. Has also requested a change of doctor and an immediate appointment offered.	Apology offered that incorrect telephone number called. Doctor was using the number recorded. Directorate to look at ways of capturing correct telephone numbers to minimise any future risks.
20694	MOD	GENMED	04/05/2020	Concerns raised that a patient was sectioned without being informed.	The team failed to inform the father of the section being put in place. Apologies given, and the doctor has reflected on their practice for the future.
20967	MOD	GENONC	09/11/2020	Concerns raised about the lack of communication with the patient after numerous calls and messages having been left.	Messages were not returned and the patient waited 6 weeks before an appointment. Staff have been reminded about the importance of answering and passing messages on in a timely fashion. A new telephone system will be installed in the new year to help track and monitor calls.
20911	MOD	CHEMO	23/03/2021	Concerns raised about chemotherapy prescriptions not being signed or written on time for the patient's treatment.	Delays in prescribing were evident due to an administration delay that has been rectified. There were also staffing shortages that have now been addressed and recruitment has taken place.
20728	MOD	ELDER	24/04/2020	Concerns raised about the care of the patient and the poor communication between the family and the staff.	The medical care of the patient was of a good standard. There were some nursing issues that the charge nurse has taken back to his team for their learning. Communication arrangements have also been strengthened as a result of this complaint. Apologies offered to the daughter.
20739	MOD	GAST	20/04/2020	Concerns raised about the care and treatment of the patient, including standards of food, environment and an alleged breach of confidentiality.	Apologies given and explanations offered for the care and treatment the patient received. Further apology offered for distressed caused when staff asked to see documentation provided by psychiatric liaison team. Intention was not to invade privacy but for assurance that it was safe to discharge.

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20946	MOD	OBSTET	02/11/2020	Concerns raised with regards to breach of patient confidentiality, difficulties in taking blood, attitude of staff and images identifying gender of baby recorded on mobile phone when this was not wanted.	Investigation confirms information governance breach. The other patient involved has been contacted and informed of the information governance breach, full disclosure of the nature of the information that had been shared in error has been provided and an apology has been offered. Apology offered for poor communication experienced.
20677	MOD	AE	29/06/2020	Concerns raised that orthopaedic boot was fitted incorrectly in ED. Patient was not given any training or supervision to administer injections.	The investigation showed that the boot was correctly fitted but the patient did not receive the training and supervision they required for administering their injections. The Emergency Nurse Practitioner team have been reminded to make sure they do this.
20920	MOD	AE	15/10/2020	Concerns raised about the attitude of a doctor in ED. Concerns also raised about the poor pain management and the long wait.	Apology provided for the length of wait and explanation provided that patients are seen based on clinical priority and how this can give the impression patients are seen ahead of them. Pain relief was subsequently provided. The doctor involved is reflecting on his approach especially when the department is busy.
20816	MOD	STROKE	24/07/2020	Patient's wife raises concerns that patient was discharged from the ED inappropriately and that he told a doctor he wasn't feeling well before he left. Patient was readmitted the same day having suffered a stroke.	The patient should have been admitted. The doctor involved has discussed his decision making with the stroke consultants and has learned that he needs to have a lower threshold for admission and seeking specialist help.
20881	MOD	AE	02/09/2020	Concerns raised about the care and management of a fractured knuckle.	The triage nurse should have referred the patient to the fracture clinic. Other medical care was in line with best practice. The Emergency Nurse Practitioner who saw the patient has discussed the case with her line manager for reflection and learning. The case has also been shared with the wider team.
20598	MOD	GENSUR	26/06/2020	Patient underwent an elective cholecystectomy and has had a longer than expected admission during which time communication was poor with the family, including mixed messages, contradictions between nursing staff and doctors and repeated failure to contact family despite assurances.	Apology that recovery took longer than anticipated. Assurance that communication was had with the patient who had full capacity. Acknowledgement that communication between teams was poor at times and this has been taken forward.
20965	MOD	RESPIR	13/01/2021	Concerns about low staffing levels at the weekends impacting on the patient's care and comfort.	There were difficulties in contacting senior staff and improvements identified for escalations over the weekend. Staff shortages were not upheld.
20944	MOD	RESPIR	02/11/2020	Daughter is concerned that patient has developed a sore on her bottom and a nurse on the ward suggested that the patient had this before she was admitted to hospital. Daughter feels this is negligence and is concerned for her mother as she has Alzheimer's Dementia and has problems expressing herself.	The investigation revealed that a pressure ulcer did not develop, but the patient did suffer a fungal infection that made her skin score. This was assessed and treated appropriately.
21001	MOD	MRI	24/11/2020	Concerns raised about delays in receiving test results and also calls not answered nor responded to.	Secretariat now forward their telephone if they are not in the office or leave the office to ensure calls are answered. Radiology have created a virtual escalation room which each of the radiologists has dedicated time to monitor in order to ensure no scans go unreported.
20775	MOD	ELDER	22/05/2020	Concerns raised about the time taken to respond to the patient and also the loss of dentures.	There was a delay in responding to the patient due to staff shortages. These were rectified at the following shift. There were no care issues but the dentures have been mislaid. Procedures with property are being reviewed.
21122	MOD	AE	22/02/2021	Concerns raised about a missed ruptured tendon. Request also made for the refund of taxi fare.	The diagnosis was made at the virtual fracture clinic three weeks later. Although this constitutes a delay, it is part of the normal patient pathway out of ED to the VFC where an orthopaedic surgeon undertakes further tests and makes the definitive diagnosis. There were no omissions in care in ED. The patient has been advised to seek redress for his fare through legal.
21065	MOD	CT	18/12/2020	Concerns raised about requesting consent from a patient who is unable to provide consent. Clarification around the consent process has been requested.	Apology offered for error which should have been identified by booking staff at time of making appointment. This has been discussed with the radiology team to minimise any future risk.

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20913	MOD	OT	30/10/2020	Concerns raised about the timeliness of home equipment and the attitude of the therapist. Concerns also raised about the care on the ward.	In respect of care on the ward there were some delays in mobilising the patient due to her wheelchair not being available. Delays in equipment due to the specialist nature occurred but were unavoidable.
20735	MOD	AE	14/04/2020	Concerns raised about the care and treatment received in the Emergency Department.	Clinical care was of best practice. Communication with the patient could have been more sensitive and timely.
21085	MOD	GAST	16/02/2021	Concerns raised regarding pressure damage that developed on the ward and the attitude of the staff. Concerns also raised that the patient was discharged too early.	The patient's pressure damage worsened due to her incontinence and the patient received the correct treatment for this. There was no evidence that she was discharged too early. Incidental learning became evident around making improvements with communication throughout the pandemic.
20845	MOD	ELDER	06/08/2020	Concerns raised about communication with the family. Concerns raised about the patient's discharge.	Some learning has been extracted with regard to the discharge of the patient where policy was not followed. Communication with the daughter did take place, although there were times when a nurse did not communicate well. Matron has put in place practice development support for the staff as well as spot checks and 6 monthly audits. Ward manager undertaking spot checks on discharge planning to ensure all relevant communication has been completed.
20834	MOD	MIDWIF	29/09/2020	Concern raised that blood results were not acted upon therefore incorrect advice was given to patient. Concern that advice given when contacting maternity triage was not appropriate given the circumstances.	Apologies offered that PAPP A test result not shared until 20 weeks scan - however, this was because no action was needed until that point. Acknowledgement of how difficult it was to retain lots of information. Apologies for lack of care shown when patient called triage in labour. Patient was misinformed by staff member. Unfortunately, due to absence of record keeping, it's not clear who this was.
20765	MOD	MIDWIF	26/05/2020	Concerns raised that tongue tie was not identified and when it was, the appropriate referral was not made.	Apology that computer error occurred during referral process resulting in tongue tie team not receiving the referral. As soon as this was identified, further referral made, however this coincided with COVID-19 lockdown and therefore procedure could not be booked. The computer error is resolved.
20645	MOD	ELDER	28/05/2020	Concerns raised about the nursing and end of life care patient received.	There was some learning for the nursing staff in relation to supervising the patient and responding to their nursing needs. This has been taken forward by the ward manager.
20861	MOD	ELDER	26/08/2020	Concerns raised about end of life care and the communication of this with the family. Concerns also raised about pressure area care and nutrition.	Overall the care of this patient was of the expected standard. There was learning extracted around improved communication with families about clinical care, particularly during the restricted visiting and pandemic and when a patient moves wards.
20631	MOD	AE	22/09/2020	Concerns raised about early discharge and misdiagnosis of pelvic fracture.	Apologies offered that subtle pubic rami fracture not detected. Fracture was stable and would have been managed conservatively, so there was no clinical impact on the patient. Patient should have had their mobility assessed prior to discharge. Matron has highlighted this with staff for their learning.
20741	MOD	ELDER	11/11/2020	Concerns raised about the nursing care of the patient.	Apologies given to the family. Staff have been reminded of the importance in ensuring a person is not left in a wet bed and to escalate when conversations become challenging with families on the telephone.
20927	MOD	AE	10/11/2020	Concerns raised in respect of care and treatment received following ED attendance for heavy bleeding at 16 weeks pregnancy and subsequent miscarriage. Reception staff refused to help saying it is was not down to them. Feels that both patient and partner were treated without care and dignity.	There were no failures in this patient's care, but regrettably she attended on a very busy evening where the staff were unable to provide the level of attention and reassurance she required.

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20971	MOD	AE	11/11/2020	Concerns raised about the wait to see a doctor who did not attend to the patient to advise on investigation findings.	Whilst it was the case that the patient did not receive her results, she did choose, for understandable reasons to discharge herself. Apologies given.
21057	MOD	AE	14/01/2021	Concerns raised regarding the patient's wounds not being cleaned and dressed and for being discharged with a cannula still in situ.	Our investigation showed that the doctor did not fully assess patient's wounds and should have undertaken a more detailed line of questioning and assessment. This has been fed back to them for their learning. Apology offered that staff failed to remove cannula.
20729	MOD	AE	14/05/2020	Concerns raised about being sent home from ED on three occasions and then requiring ITU admission later.	The patient's diagnosis was missed. The Clinical Lead has spoken in detail to the doctors involved and added the case to be used anonymously for training purposes.
20664	MOD	RESPIR	29/05/2020	Concerns raised about the patient's care, his fall and head injury and perceived delays in his treatment between MTW and Kings College Hospital London.	There were delays in the treatment between MTW and King's due to inaccurate information being relayed This underwent a Root Course Analysis investigation with actions on cross checking the referral information and healthcare records prior to sending to the tertiary centre. The fall was also investigated using Root Course Analysis methodology and points of learning were extracted and implemented.
20896	MOD	ENT	08/12/2020	Concerns raised over attending hospital appointment to find doctor had not turned up. Patient was able to see another doctor, however he did not have the necessary information for the consultation.	Due to administration error appointment was not cancelled as consultant was on leave. Apology offered.
20785	MOD	GENONC	14/07/2020	Concerns raised regarding delays in care and also the quality of the letter the patient received.	Changes in the whole administration system have taken place to prevent delays occurring in the future.
20806	MOD	AE	26/06/2020	Patient raises concerns that his foot injury was misdiagnosed in the Emergency Department. Unable to manage his pain, he returned to the ED the next day and discovered his injury did in fact require surgery for a severed tendon. Concerns also raised about the COVID-19 pathway for non COVID patients and the lack of advice given.	The foot injury was misdiagnosed. The doctor involved has been through the case for their learning with the consultant. The concern about COVID-19 was explained to the patient but not upheld.
21131	MOD	OBSTET	01/03/2021	Concerns raised in respect of postnatal care received resulting in poor patient experience. Complainant advises that patient did not receive timely pain relief, patient was left isolated in side room, not checked upon and needs were not considered by staff. Complainant alleges staff had poor attitude and were insensitive in their interaction with patient.	Apology offered that pain relief was, on occasion, late as patient was not on the ward at the time. Explanation provided that patient administered pain relief is being implemented to help new parents administer their own pain medications when visiting baby's on the neonatal unit. Investigation supports that patient was checked frequently, however, apology offered that new parents did not feel supported.
20949	MOD	ENT	06/11/2020	Concerns raised regarding cancellation of ENT appointment. Following MRI scan patient was advised she needed to be seen face to face within 2-3 weeks. Appointment secured was in 6 weeks, was assured this was appropriate. This appointment was cancelled as it was booked into the wrong clinic, patient needed an appointment in the endoscopy clinic. No appointments available for this clinic, so patient's name was added to waiting list. Letter had been sent advising of this which patient did not receive. As patient has not consented to endoscopy she believes she does not need to be seen in an alternative clinic.	Consultant made the decision that it was clinically appropriate to review patient in six weeks. This was a clinical decision, not one taken by the booking clerk. This was not explained to patient. In situations where clinicians have made changes to the appointment timeframes, the directorate will call those patients to advise of the change and address any additional concerns. Patient was booked on to the wrong clinic in error, which meant the appointment had to be rescheduled. This has been highlighted with the booking team for their awareness and they have been asked to remain vigilant when arranging appointments. Patient was not made aware of the cancellation. Apology provided. To prevent any future occurrence and to improve patient experience, staff will

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					ensure any appointment cancellations for the service are followed up with a telephone call.
21030	MOD	AE	14/12/2020	Concerns raised that the patient was erroneously discharged home from ED	Apology offered and assurance that once this had been identified measures put in place to ensure patient safety.
21007	MOD	PAEDS	27/11/2020	Concerns raised over a lack of communication, compassion and empathy by staff when patient attended for CT scan. Information about what was going to happen pre, during and post procedure was not explained. CT scan had to be abandoned as sedation has worn off.	Apology offered. Recognition that information around scanning with sedation in children is limited and information leaflet being developed in conjunction with radiology to manage expectations. Assurance offered that sedation was well managed and that child did not required one to one nursing as was being monitored electronically.
20760	MOD	AE	21/08/2020	Concerns raised about the care and treatment in the Emergency Department and also the attitude of the doctor.	Apologies offered that hip and foot fractures were missed when patient attended the ED. Foot was x-rayed and subtle fracture was not identified by doctor. Clinical lead has discussed with individual doctor. On examination, no clinical indication to x-ray hip. Apology for comments made by doctor. Clinical Lead will follow this up after COVID-19. Case to be presented at clinical governance meeting.
21106	MOD	AE	04/02/2021	Concerns raised about being dispensed out of date antibiotics.	The mother was dispensed with out of date medication. The doctor did not follow procedure due to the busyness of the ED and the pharmacy department had not undertaken their normal checks. Both have changed their practice to in line with policy.
21003	MOD	GENMED	10/12/2020	Concerns raised about the infection prevention and control procedures and decisions with bed management.	Communication to the family and the transport team needed to be timelier. Due to the heat of the moment, the nurse recognises that she may not have donned a mask when greeting the patient, crew and family. She is aware of the correct protocol.
20693	MOD	GENSUR	21/04/2020	Concerns raised with care provided on ward including loss of hearing aid, discharged without EDN and medications and discharged at short notice.	Apology for loss of hearing aid. Assurance offered that discharge and timing was appropriate given the nature of securing Hilton first places. Apology that discharge took place without EDN, which was sent the same evening. Sister has explained the correct process to the nurse and is monitoring her practice to identify any areas of practice requiring training and support.
20777	MOD	OBSTET	21/04/2020	Concerns raised that father of baby was not permitted to leave the post-natal ward and return. He says this is in contradiction to the signage on the ward and that on the Internet site.	Apology offered and explanation that this was a difficult time with changes being made frequently prior to hospital lockdown.
20742	MOD	COLOR	06/07/2020	Concern that tumour was missed on previous colonoscopy. Attitude of consultant and poor communication of CT scan. Conflicting information in clinic letters.	Apology offered, this was a very rare, difficult to diagnose tumour. The correct actions were taken with regards to the investigations required. Apology for attitude of consultant who has had sight of the complaint. Assurance offered that information in clinic letters was not conflicting.

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20901	MOD	AE	30/09/2020	Concerns raised about poor pain control and assessment in the Emergency Department. Concerns also raised about the attitude of the doctor.	Apologies given for the attitude of the doctor who is reflecting on their communication. Patient had already been prescribed co-codamal for pain management and further pain assessment suggested additional pain killers to the ones already prescribed were not required. Reminders have been given to the staff when a patient needs to use a wheelchair to mobilise.
20476	MOD	ELDER	23/09/2020	Concerns raised regarding the care of the patient with regard to falls, staffing levels, clinical care and discharge arrangements.	Answers provided to a range of questions. Apologies offered that patient sustained a fall, appropriate measures were in place to reduce the risks and staffing levels were correct. Explanations provided around medical care and decisions to discharge. Learning identified within Serious Incident investigation for fall.
20321	MOD	HAEM	02/10/2020	Concerns raised about the family not knowing the diagnosis of their mother. This is important for them as this will enable closure following her death. They are concerned that there was a delay in her receiving her biopsy and that the results were not shared with them.	The family met with the clinical team to discuss the care of the patient and reasons for the delay in diagnosis. Further nursing care issues were dealt with by the matron with the staff on the ward.
20711	MOD	ORTHO	15/04/2020	Concerns that several appointments have been cancelled without notification and question asked as to why are cancellation being made for an urgent operation.	Apology that cancellation letters not sent due to restructure of department and assurance that this has been discussed with the booking team. Explanation that patient added to waiting list for routine appointment.
20933	MOD	ENT	16/10/2020	Concerns raised about availability of ENT appointments.	Due to COVID-19 appointments were disrupted. Apologies given and an appointment has been made.
21104	MOD	AE	05/02/2021	Concerns raised about not being listened to and not being assessed in a timely way when the patient had had a stroke.	Apologies were given to the patient for him feeling as though he was not listened to. This was an extremely busy night in the ED with short staffed, double the number of ambulance conveyances due to taking a divert from Medway and the volume of patients. He did experience a delay in diagnosis due to him discharging himself before being seen by a doctor (other than triage which was normal).
21031	MOD	GENMED	25/01/2021	Concerns raised about poor communication with the family during the patient's admission. Concerns also raised about his nursing care.	There were communication difficulties throughout this patient's stay with the daughter. Apologies given and improvement actions have been put in place. There were no concerns identified in the investigation in relation to the nursing care the patient received.
20703	MOD	GAST	15/04/2020	Concerns raised about the clinical care of the patient's condition and the communication with the consultant.	There were no issues with the clinical care, but there were delays to be seen by a gastroenterology consultant and the person involved has reflected on their communication for their learning and future practice.
20712	MOD	AE	06/04/2020	Concerns raised about delays to be seen in a child with possible testicular torsion.	The delay was at triage assessment. The nurse involved has been assessed for learning needs and how to assess testicular pain has been shared with staff.
20636	MOD	STROKE	19/02/2021	Concerns raised about general care issues on the ward and the discharge process.	The investigation did not reveal any care issues, although the arrangements of the equipment for transfer from the ambulance at home should have been better organised. Staff have been made aware of this.
20990	MOD	STROKE	20/11/2020	Concerns raised about the management of the patient's diabetes on the ward as well as the arrangement of his MRI at other hospitals.	Apologies given. Learning has been identified around the error in prescribing insulin and omission of warfarin. Apology offered for not arranging MRI scan. Normally GP will arrange MRI scan at another hospital, Unfortunately the doctor assured the patient that the required test had been requested, however there is no documentation to support this in patient's healthcare records. Junior doctors

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					to be reminded of the importance of documenting all reviews and discussion and clarity around pathways for requesting investigations.
21026	MOD	COLOR	08/01/2021	Concerns raised in respect of preparation for colonoscopy. Patient is seeking to have preparation and procedure as an inpatient as he anxious of using public transport if he has the procedure as an outpatient.	Apology offered for delay in colonoscopy. MDT review suggested colonoscopy as outpatient 6 weeks post discharge. Explanation provided that this can be booked as an inpatient but wait will be long given the current bed pressures.
20820	MOD	AE	08/07/2020	Concerns raised the patient was not protected from COVID-19 whilst waiting in the ED. Pain was not managed and attempts at inserting cannula even though it is known that this should be done by an anaesthetist. Concerns that pain was not well managed and the behaviour of the doctors.	The protection of patients with COVID-19 was adhered to. Apologies given for poor pain management. The nurse has learned to administer the correct pain relief in future. Apologies given for the poor experience although this was not upheld.
20795	MOD	CARDIO	11/08/2020	Concerns raised about admitting a shielding person into a bay with other patients who had not been COVID-19 tested. Concerns also raised about the discharge process and TTO's.	Patient was placed in a bay with one other patient who was at the other end of the bay and was safe. The discharge process was safe. TTO medication was correct.
21032	MOD	AE	11/12/2020	Concerns raised about the varying possible diagnoses and how these were communicated as well as the delays in the process.	Improvements were identified as necessary in explaining to the patient their pulmonary embolism pathway. Plus a doctor failed to re-refer the patient for the correct scan in a timely way.
21033	MOD	GENMED	11/12/2020	Concerns raised that the death of the patient was erroneously reported to the cousin when in fact the patient was still alive.	The investigation showed that there was an error in the documentation of the next of kin, and that the nurse did not check details as per policy with the relative when she called them. They are undergoing retraining for information governance and end of life care.
21087	MOD	AE	27/01/2021	Concerns raised about poor pain management in ED and the delay in being transferred to Tunbridge Wells Hospital and seen.	Apologies given. There were delays in providing pain management to the patient due to the busyness of the ED. There were also delays in providing transport due to the volume of workload the transport service was experiencing. Both events relate directly to the COVID-19 pressures and receiving a divert from a neighbouring Trust as mutual aid.
20800	MOD	AE	26/05/2020	Concerns raised about a missed fracture.	There was no clinical evidence of any bony injury to prompt an x-ray. Patient was later found to have a buckle fracture (partial fracture) which did not require treatment. Case discussed with doctor for learning.
21125	MOD	GYNAE	23/02/2021	Concerns raised with long wait to be seen on Emergency Gynaecological Assessment Unit , environment of Emergency Gynaecological Assessment Unit partner not being allowed to accompany her and poor communication.	Apology for long wait and explanation as to how service works with those at higher clinical risk being prioritised. Assurance that environment has now been changed to try and make this a more user friendly. Apology that partner could not attend due to current restrictions. Apology that support information was not provided which has been discussed with the team.
21112	MOD	AE	12/02/2021	Concerns with the way needle phobia was managed in ED and cannula inserted without patient permission.	Although the staff did obtain verbal consent to take blood, they did not make clear that this was to also place a cannula at the same time. In future they will ensure robust consent is taken and documented in future. Communication difficulties were present with the patient being aggressive verbally and the staff struggling to help him relax. Senior support will be sought in future.

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20527	MOD	PAEDS	14/01/2021	Concerns regarding the care and management of the patient's PEG tube and subsequent infection and complications caused by it not working properly.	Investigations have found that patient was let down due to the lack of a clearly defined clinical protocol. Attempts were made by community services for tube replacements but these were not recognised by the paediatric department as a formal referral. Root Cause Analysis investigations identified actions to address omissions in care.
21124	MOD	AE	23/02/2021	Concerns raised about not knowing what care and treatment took place in Maidstone ED prior to transfer to William Harvey Hospital Ashford.	Our investigation showed that we omitted to update the family on the patients clinical care plan and transfer to William Harvey Hospital Ashford. The team are working on improvements in this regard during the COVID-19 pandemic.
20665	MOD	HAEM	03/06/2020	Concerns raised about bed moves late in the night and being 'boarded' at 2 am. Concerns also raised about the discharge arrangements of the patient who went home with c-diff.	Staff have been reminded to ensure they escalate any delay in transferring a patient so that it can be addressed. The issue of early discharge has been discussed with the team involved in the patient's care for learning.
20570	MOD	GENONC	09/07/2020	Concerns raised about delays in scan results and delays in treatment.	The delays in place at the time of the patient's treatment are now resolved with staff having been recruited to increase capacity and prevent delays.
20812	MOD	AE	13/07/2020	Concerns raised about the attitude of the nurse and doctor caring for the patient.	Both staff do not recall the events as described in the complaint. That said both have reflected on how they were perceived and the impression given.
21081	MOD	RESPIR	11/12/2020	Concerns raised about the side effects of medication which remain after taking medication for two weeks, with no support from nurse and doctor.	Although no delay in treatment and monitoring, it is true to say there were delays in the nurse clinic due to COVID-19 impact. The nurses apologised for this and have reviewed the patient's care plan and fed back to him.
20797	MOD	AE	26/05/2020	Concerns raised about care during a blood sample and also lack of privacy when being examined.	An education and training programmer has been put in place for the clinical support workers. This covers care of a patient during and following a blood test as well as learning around maintaining privacy. Note keeping has also been addressed as this was found lacking.
20749	MOD	UROL	23/12/2020	Concerns raised that the information contained within the cystoscopy report is not correct and pertains to a different patient.	Apology offered for this error and assurance offered that this has been discussed with the wider team as a point of learning. Report to be corrected and re-issued.
20751	MOD	OVERS	16/04/2020	Concerns raised about the clinical care in ED and being charged as an overseas visitor.	The invoice remained payable. Correct treatment was given although there was an error made with the CT scan contrast delivery. The radiographer has been spoken to and has learned from the error.
20128	LOW	GENONC	16/04/2020	Query in respect to why has outpatient appointment been changed to a different date, doctor and location?	Appointment was moved back by one day due to a change in the structure of the oncology service. Assurance provided that change was made with patient's best interest in mind.
20866	LOW	AE	17/08/2020	Concerns raised about being given someone else's health care records to take home.	Staff have been given refresher information governance training and the member of staff spoken to individually. Reminders have been shared as part of the shift briefing about checking prior to handing over notes to patients.
20601	LOW	OPTHAL	06/04/2020	Concerns raised in attempting to obtain a letter stating patient has poor eyesight, to receive disabled persons bus pass, due to difficulties in contacting the correct department. Phone number listed on website is not answered.	Explanation provided that clinic letter indicates that patient slightly above threshold for registration as being partially sighted and therefore referred to KAB. Apology for delays in answering telephone.
20774	LOW	ORTHO	30/04/2020	Concerns raised over delay in referral for CT scan appointment.	Apology that delay occurred as it was not clear which type of CT scan was required and the one required is undertaken by MRI scanning not CT scanning which caused a delay. Concerns raised shared with imaging team for learning.

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20723	LOW	OPTHAL	08/04/2020	Concerns that consultant did not attend for appointment and patient not advised in timely way.	Apology offered, consultant thought annual leave had been booked. Assurance offered that staff on site attempted to find cause for lack of attendance prior to updating patients.
20782	LOW	OBSTET	19/05/2020	Concern raised that those waiting were not advised of delays in clinic. Concern that blood tests were misplaced and referral to another department not made. Concern that appointments have not been booked in line with patient's request.	Apology that those waiting were not updated to delays as this should happen. Apology that blood tests misplaced, this is very unusual and cannot ascertain why this happened. On review of records there is no indication as to why a referral to gastroenterology is required. Apology that reception staff could not book appointments in clinic and assurance offered that we will try to book scans and outpatient clinic appointments on the same day, however this is not always possible and more so now amid the COVID-19 outbreak.
20788	LOW	GENONC	05/05/2020	Concerns raised about a breach in confidentiality.	The member of staff has reviewed how she made the mistake. A double checking procedure is now in place to prevent recurrence.
20676	LOW	MEDREC	07/08/2020	Concerns about the state of medical records sent to the person and the quality of the documentation.	Learning for the Subject Access Request department was evident around the quality of disclosure and the completeness of the records. These actions are being taken forward by the manager.
20939	LOW	STROKE	30/09/2020	Concerns raised around conduct of member of nursing staff toward a hospital visitor.	Apology offered by nurse, who has completed professional reflection.
21027	LOW	SEC	09/12/2020	Concerns raised about the way the patient was spoken to by the security guards in reception.	The staff member was spoken to and management action in progress.
20582	LOW	OPTHAL	30/04/2020	Concerns with treatment received for left eye and delays and changes to appointment for treatment with right eye. Question asked around why treatment has been moved from Tunbridge Wells Hospital to Maidstone and why environment injection undertaken is different between sites.	Apology offered for cancellation and changes to appointments. Explanation around why treatment moved between sites and why environment is different between sites.
21105	LOW	OVERS	10/02/2021	Concern raised that overseas visitor charges should not have been applied to this patients admission via ED to Clinical Decision Unit, in 2018.	Investigation concluded that charges should not have been applied and therefore invoice withdrawn. Measures now in place to check all patients prior to invoices being sent.
20415	LOW	AE	12/05/2020	Concerns raised regarding a HIV test that was undertaken without the knowledge or consent of the patient. Concerns also raised about staff attitude.	The staff member involved was not contactable, it was therefore not possible to confirm if consent was sought. There was no evidence of poor staff attitude.
20725	LOW	OPTHAL	30/04/2020	Concern that clinic letter sent to incorrect GP	Apology offered, incorrect GP details stored on system. Assurance that these have been changed and that when new computer system implemented in ED, problems such as these should not occur.
20762	LOW	GENSUR	19/05/2020	Concern raised that patients vegan status was not respected on the ward	Explanation provided as to how meals are managed on Short Stay Surgical Unit. Apology provided that at the time when patient required a meal, nothing other than that which was stored on the ward was available as the canteen was closed.
20594	LOW	PAEDS	03/12/2020	Concerns raised about possible factual inaccuracies in a letter from a consultant.	The inaccuracies were due to a delay in communication from social services to inform the Trust of the changes with the child's status. Apologies given and the corrections made.
20507	LOW	GYNAE	09/06/2020	Concerns raised regarding fertility treatment, delays therein and incorrect, inconsistent advice.	Apology for delay in appointment due to human error. Explanation that there was some confusion around whether patient was being seen in recurrent miscarriage service or fertility service. Assurance offered that information provided was appropriate and accurate.
21051	LOW	OPTHAL	17/12/2020	Concerns raised that patient received a letter for laser treatment when this had already been undertaken. Patient upset by the anxiety and stress this caused.	Apology offered. Patient underwent procedure during previous clinic appointment but doctor did not outcome appointment correctly thereby waiting list team not updated. All doctors now trained on new electronic outcome system which will minimise any future risk.

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20997	LOW	ORTHO	05/02/2021	Concerns raised about the wait to be seen in outpatient clinical and for the delay with hospital transport.	Apology offered for the wait to be seen. Delayed in x-ray due to current restrictions. No delay with patient transport, transport booked and arrived within 2 hours.
21011	LOW	AE	01/12/2020	Concerns regarding the loss of a wedding ring.	Apology offered that despite extensive search, wedding ring could not be round. No evidence in healthcare records to reflect ring was cut off in ED. Action to remind staff in ED to complete property checklist and document if jewellery is removed.
20838	LOW	AE	20/07/2020	Concerns raised about inaccurate information regarding patient's ED attendance.	Discharge summary has been amended to accurately reflect the attendance and copies sent to the client and GP. Staff have been reminded of the importance of attention to detail and accurate record keeping.
20704	LOW	CT	02/04/2020	Concerns regarding a breach in confidentiality due to personal address details not being updated.	Personal addresses were not updated as they should have been. Staff have been reminded to double check personal details at every attendance.
20717	LOW	GYNAE	22/04/2020	Concern that patient booked into incorrect clinic which meant a wasted journey to hospital	Apology offered that booked into incorrect clinic due to changes in clinic templates.
20964	LOW	ELDER	17/11/2020	Concerns raised about the accuracy of the patient's EDN and concerns raised in trying to contact the hospital.	The EDN has been reissued and corrected. The doctors involved have been spoken to and reminded to make sure they pay attention to accuracy.