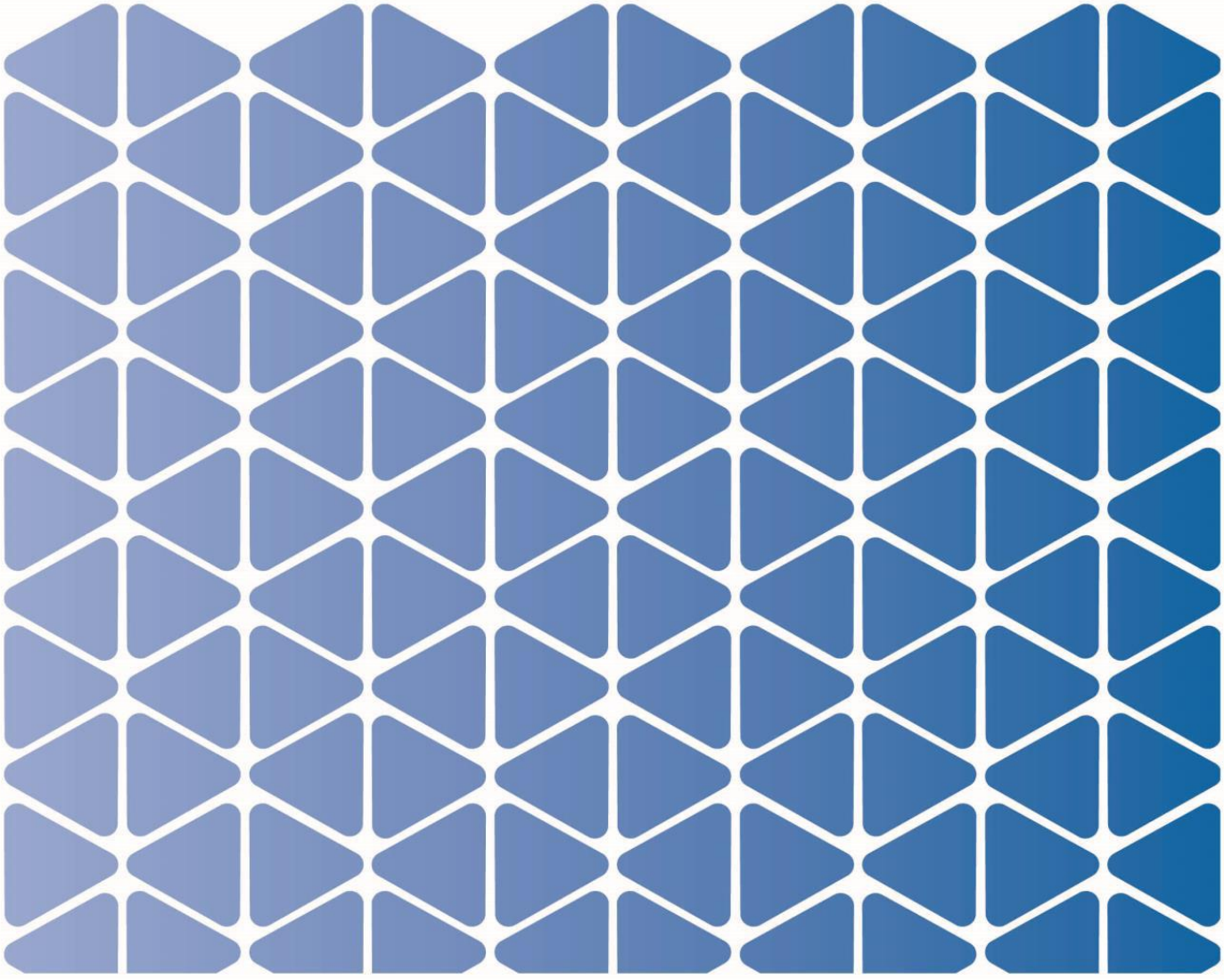
PATIENT INFORMATION

# MASTECTOMY WITH IMPLANT BASED BREAST RECONSTRUCTION



**General Surgery**
Name of procedure: Mastectomy with Implant Based Breast Reconstruction

It has been recommended that you have a breast reconstruction using a breast implant to replace some or all of the volume lost from your breast at the time of your mastectomy surgery. The aim of breast reconstruction is to produce a replacement breast with a satisfactory appearance both in and out of clothes, avoiding the need for an external prosthesis to be worn in the bra. This can be achieved by either:

a) producing a 'replica' sized and shaped breast to the one which has been lost - matching the other breast as closely as possible or
b) if it is not possible or desirable to produce a 'replica breast', then your surgeon may suggest producing the best breast possible (usually smaller and perter). In this case, you are likely to need surgery to the other breast in the future if you wish it to match.

Nationally, about a third of women having a mastectomy choose to have an immediate reconstruction and a further smaller group choose to have a delayed reconstruction.

Implant-based reconstruction is a popular choice for women following a mastectomy, often chosen because it is the least invasive reconstructive procedure. On average, we carry out 100 implant-based reconstructions in Worcestershire every year. However, although implant-based reconstruction is often considered to be a "straightforward" form of reconstruction, most patients ultimately require two to three operations to achieve their desired cosmetic outcome. As mentioned above, it's also common for women who have this type of reconstruction to require an operation on their non-affected breast, to get a good match for size and shape. Almost 4 out of 10 women have some form of additional operation to improve symmetry. Therefore, when considering breast reconstruction, it is important to understand that it is usually a multi-operation procedure.

This leaflet explains what you will experience when having an implant based breast reconstruction, along with some of the benefits and risks of the procedure. We recommend that you read this leaflet carefully. A detailed information booklet, listing all reconstruction options, will also be provided for you to read. You will also be offered a further one-to-one consultation with your breast care nurse to discuss your reconstruction options. This consultation will take place after you have been reviewed by your breast surgeon.

You and your doctor will also need to record that you agree to have the procedure by signing a consent form, which your health professional will give you. Your details and

the details of the implant inserted will also be registered on the National breast implant database. Please ask your surgical team about anything you do not fully understand or want to be explained in more detail.

**What Does the Surgery Involve?**

The surgery involves a mastectomy (removal of the breast tissue) along with insertion of a breast implant with or without an additional mesh used to support the implant as outlined below.

**Types of Mastectomy**

All mastectomies will remove 95-98% of the breast tissue. There are subtle variations in how it is done.

a) **Skin sparing mastectomy.** If an immediate breast reconstruction is planned, the breast tissue and nipple are removed, preserving most or all of the overlying breast skin. In most cases the breast skin is usually perfectly healthy and can be preserved to keep the shape of the original breast.
b) **Nipple preserving, skin sparing mastectomy** - in certain circumstances a patient may be able to keep her nipple. Your surgeon will generally have discussed this with you if it is an option, but please ask if you would like to consider this. If your nipple is preserved there is a very high chance that the nipple will be numb and lose the ability to become erect with touch or cold. Half of preserved nipples will also fade in colour. This can often be improved with nipple tattooing later.
c) **Skin reducing mastectomy** - in some cases the skin may be reshaped into a smaller breast shape.

**What implants are used?**

a) Round or shaped, fixed volume silicone implants are most commonly used. These contain 100% soft silicone gel (neither fully liquid nor solid). They are generally textured or microtextured to help the implant adhere to the tissues and prevent rotation.
b) Very occasionally, if there is a need to increase breast volume gradually after surgery, an expandable or inflatable implant (expander) may be used instead of a fixed volume implant. The expander has a port within it, or attached to it, that allows it to be inflated with saline using a simple needle and syringe. This is done over a period of time, allowing your skin and muscle to stretch gradually until the desired breast size has been reached. Inflation does not begin for a few weeks after the initial surgery and then it is done in the outpatient department and takes only a few minutes with minimal discomfort. The whole inflation or expansion process (if required) can take up to a few months of weekly or fortnightly visits to

the outpatient department and when the required volume and shape is achieved another operation will be needed to exchange the expander for a fixed volume 100% silicone implant.

**Where is the implant placed?**

After the breast tissue has been removed, the implant can be placed either under the skin or under the chest wall muscle, often wrapped fully or partially in a “mesh” or in a piece of your own tissue.

a) Implants under the skin – may be quicker and easier to insert and so less painful immediately after surgery, with less animation (twitching of the muscle) later, during exercise. However, the implant edge may be more visible, especially in thin ladies, and the implant may be less protected from trauma in the longer term.
b) If the top of implant is inserted under the muscle of the chest wall (pectoralis muscle), the outline of the implant may be less obvious under the skin.

**What is a “mesh” used in implant reconstruction?**

In order to restrain the movement of an implant and to provide a more definite and permanent lower edge to the reconstructed breast, a piece of mesh is often inserted over the implant or over its lower half. This can be a biological mesh or a synthetic mesh as described below. Alternatively, for women having a skin **reducing** mastectomy (to make a higher, less droopy breast) some of their own skin can often be used to support the lower half of the implant.

**What is a Biological Matrix (Or Acellular Dermal Matrix or “ADM”)?**

ADM is a natural tissue, derived from cows or pigs that has been sterilised and chemically treated so that all animal cells have been removed to leave behind only the collagen and supporting tissue components. It is like a scaffold that provides support and acts as a framework for the patient’s own tissues to grow into. Most implant reconstructions in the UK use ADMs.

If successful, once the ADM has been placed inside the body, you will incorporate the new tissue framework as if it belonged to you, with rapid new blood vessel and tissue ingrowth, so providing a supporting thicker layer over the lower half of the implant. There are no known long term problems associated with ADM use once it becomes fully incorporated into your body. However, it may be associated with a slightly increased risk of complications immediately after surgery when compared with implant reconstructions not using a mesh.

**Is there a synthetic alternative to the ADM?**
Yes, there are non-absorbable prosthetic meshes available for those who wish to avoid animal products. It can sometimes be particularly useful in ladies with a more generous breast (as it is a larger mesh).

**Benefits of the procedure**
The aim of your surgery is to retain as natural a breast size and shape as possible following a mastectomy. It is not often possible to make the reconstructed breast identical to the natural breast, and it will certainly not feel warm or as soft as the natural breast but the cosmetic results achieved from the surgery can have an extremely positive effect of a woman's confidence, self-image and self-esteem.

**Are there any risks or complications?**
Everything we do in life has risks.

a) **Risk from the anaesthetic:** In a healthy patient, the risk of problems arising from an anaesthetic is very small. However, each year in the UK a few healthy people will die or suffer serious heart, lung or brain injury following an anaesthetic. For a woman who is otherwise in good health, the risk of a serious complication due to general anaesthesia is less than 1%.
b) **Pain:** A degree of pain is likely after any surgery. We aim to manage your pain with painkillers to an acceptable level postoperatively. There is evidence to suggest that if we get on top of your pain early following your operation we can reduce the chance of it becoming a chronic problem. If the pain or numbness and tingling continues to be troublesome please let your surgeon or breast care nurse know and we can give you a medication to manage the pain.
c) **DVT/PE:** With all surgical procedures there is a risk of developing a clot in the deep veins of the leg, deep vein thrombosis (DVT). In a very small number of patients a bit of this clot breaks off and lodges in the lungs. This is a pulmonary embolus (PE) and in very extreme cases can be life-threatening. Your surgical team will prescribe you compression stockings and/or blood thinning medication after careful assessment of your individual risk.

Complications specifically related to breast surgery include problems with the following.

1) **Scarring:** There will be a scar where the breast tissue is removed. This may be at the outer curve or lower aspect of the breast but often if the nipple needs to be removed it will be across the centre of the breast and sometimes it will be an anchor shaped or inverted "T" shape scar. Your breast surgeon and breast care nurse will talk to you about what scar to expect in your particular case. If you

already have scars, these will also need to be taken into account. Remember, scars usually fade over time.

2) **Partial or full skin flap loss (necrosis):** This is a rare but serious complication (less than 2 in every 100 women) which may result in the implant and affected skin having to be removed. It is more common in smokers, the obese (body mass index over 30) and diabetics. If the circulation to the skin over the reconstruction is compromised, then some or all of the skin may not be healthy enough to survive. Although it may heal gradually with appropriate nursing care and dressings, in more serious cases the skin cannot be saved. In those cases, the skin must be removed. If the implant becomes infected or exposed, it is not usually possible to save it with antibiotics and in most cases the implant and overlying skin will need to be removed.
3) **Bleeding:** 2-4% of women having breast surgery (with or without reconstruction) will have a secondary bleed, normally within 24 hours of their operation. This is generally obvious as there is a tender swelling which comes up rapidly with very obvious associated bruising. This collection of blood under the wound is called a haematoma. If you think you may have a haematoma please call your GP or breast care nurse and arrange for an urgent review as most patients developing this complication will need to have another small operation performed within the next few hours or days to stop the bleeding, wash out the clot and prevent any pressure on the overlying skin.
4) **Bruising:** More minor bruising is very common after surgery and will usually resolve after a few weeks.
5) Altered Breast sensation. Your reconstructed breast is likely to feel numb due to damage to the nerve supply when the breast tissue is removed. This may never recover completely.
6) **Seroma:** It is to be expected that you develop a small to moderate amount of tissue fluid (seroma) under the wound after your surgery. This may take up to 6 weeks to settle down and can often be left alone if it is not too uncomfortable.
7) **Infection:** Minor wound infections are often seen but should be reviewed and treated quickly with appropriate antibiotics. If you get an infection around your implant you will need a course of anti-biotics and in the worst-case scenario, with a deep-seated infection, your implant may have to be removed as it is hard to eradicate infection around a foreign body. Infection is more common in smokers, diabetics and in those who are overweight (with a body mass index over 30).
8) **Minor skin burn**. Due to heat conduction used to stop bleeding during surgery.
9) **Capsular contracture:** Scar tissue forming around the implant may change its shape making it hard or uncomfortable. This can happen even several years after surgery and can sometimes be treated by removing the implant and replacing it with a new one. However, the risk of further contracture is then

approximately 50%. The risk of capsular contracture increases if you have radiotherapy to that area either before or after the reconstruction and if you are a smoker.

10) **Implant Displacement:** Occasionally the implant can move slightly within the breast cavity causing discomfort and/or distortion of your breast shape. In order to minimise the risk of early implant displacement, it is important to follow the advice given regarding exercise after this type of surgery and not to lift your arm above shoulder height for two weeks following surgery.
11) **Implant loss and delay in other treatment:** Ultimately wound breakdown or infection can lead to implant loss in 5-15% of patients having an implant based reconstruction. Smokers, diabetics and overweight individuals (body mass index more than 30) are at a greater risk. All significant healing issues will also prevent chemotherapy or radiotherapy getting underway so if you have risk factors for reconstruction and will need these other treatments you should consider the pros and cons of having a delayed reconstruction after your other treatments are finished.
12) **Lifespan:** Most implants last for about 10 years and therefore, may need replacing at some time in the future. It is also important to remember that implants will not droop with ageing as normal breast tissue often does. There is no guarantee that the NHS will cover the cost of implant replacement surgery in the future.
13) **Asymmetry:** No surgery can guarantee a complete match between your breasts. It is not possible to predict how the breast will change shape in the longer term. Shape, volume and nipple position may alter due to the effects of aging of the tissues and changes in your body weight.
14) **Implant rippling; visibility**: More common in slim women.
15) **Implant animation:** Sometimes the implants can move with contraction of the chest wall (pectoral) muscles. This is commonly seen to a mild degree but is rarely a problem.
16) Very rare risk of breast implant associated anaplastic large cell lymphoma (BIA-ALCL) (1:24,000)- see below.

Most people will not experience any serious complications from their surgery. However, the risks increase for elderly people, those who are overweight (body mass index over 30), in smokers and in people who already have heart, lung or other medical conditions such as diabetes or kidney failure. You will be cared for by a skilled team of doctors, nurses and other health-care workers who are involved in this type of surgery every day. If problems arise, we will be able to assess them and deal with them appropriately.

**Breast Implant Associated Anaplastic Large Cell Lymphoma ( BIA- ALCL)**

BIA- ALCL is a rare type of cancer that affects women who have had breast implants inserted for either cosmetic reasons or following breast reconstruction. It seems to affect about 1 in 24,000 women with breast implants. It usually involves a swelling of the breast, typically developing years after the operation to insert the breast implant. This swelling is due to an accumulation of fluid (seroma) around the implant. BIA-ALCL has been seen as early as 1 year after surgery or as late as 37 years after the operation. Less commonly, BIA-ALCL can take the form of a lump in the breast or a lump in the armpit. If you notice any of these problems (swelling or a lump), or have any other concerns with your implants, you should seek medical attention.

**How is BIA-ALCL diagnosed?**

If you develop swelling in your breast around an implant you will be referred to a specialist breast surgeon who will arrange for an ultrasound scan of your breast to see if this is due to a fluid collection. Most fluid collections are not ALCL, but arise as a result of trauma, implant wear and tear or infection. However, if fluid is present it will be removed under ultrasound guidance, with a small needle, by a radiologist, and sent to the laboratory for analysis. Other investigations such as MRI and CT-scans may sometimes be required as well.

**How is BIA- ALCL treated?**

Most cases of BIA-ALCL are cured by surgical removal of the implant and the capsule surrounding the implant.

**Should women with implants be screened for ALCL?**

Regular screening is not recommended for BIA-ALCL. If you notice enlargement or swelling of one or both reconstructed breasts, or a lump, you should seek medical advice as soon as possible.

**Breast Implant Illness (BII)**

Is a term sometimes used by people to describe a variety of health problems they associate with their breast implants, most of which are common in the general population who do not have breast implants. Symptoms often described are, “brain fog”, fatigue, anxiety and joint pain and are not limited to a particular manufacturer or type of implant. Currently we do not know if there is a link between breast implants and the reported health problems. If you have any concerns please speak to your breast consultant.

**Are there any alternatives?**

When mastectomy is necessary, the option of breast reconstruction will be discussed with you. Some patients may not be suitable for an immediate breast reconstruction.

This may be because of the type of cancer they have developed or because of other health conditions. Others may choose to complete their cancer treatment first and have a breast reconstruction at a later date - this is known as delayed breast reconstruction. If immediate breast reconstruction is not done, a patient will be offered a simple mastectomy or if appropriate, medical cancer treatment. You will also have been provided with information on other types of reconstruction. Let us know if you would like further information.

**Preparing for Surgery**

Before you come into hospital there are some things you can do to prepare yourself for your operation and reduce the chance of difficulties with the anaesthetic.

a) If you smoke it may not be appropriate for you to have an immediate reconstruction but if your surgeon does consider it safe to proceed, you are advised to give up for at least six weeks before the operation and several weeks after. Smoking reduces the amount of oxygen in your blood and increases the risks of breathing problems during and after an operation. It also increases the risk of complications with your wound and the healing process and specifically increases the risk of complications with breast reconstructive surgery. Using a vaporiser instead of smoking may help the lung and breathing issues but does not significantly reduce the risk of post-operative wound problems.

b) If you are overweight, many of the risks of anaesthesia are increased. Reducing your weight will help, although this may not be possible if you are having an urgent operation for cancer.

c) If you have loose or broken teeth or crowns that are not secure, you may want to visit your dentist for treatment. The anaesthetist will usually want to put a tube in your throat to help you breathe. If your teeth are not secure, they may be damaged.

d) Please stop taking the contraceptive pill one month before surgery. This is to reduce the risk of a blood clot (deep vein thrombosis) but remember to use alternative means of contraception.

e) Continue to take any other normal medicines up to and including the day of your surgery. If we do not want you to take your normal medication, your surgeon or anaesthetist will explain what you should do.

f) It is important to let us know, before you are admitted, if you are taking any anticoagulant (blood thinning) drugs (for example, warfarin, aspirin or clopidogrel or rivaroxaban). These will need to be stopped but other drugs may need to be used instead. This should all be explained to you in the pre-operative assessment clinic if not before.

g) If you are taking Tamoxifen tablets please stop these four (4) weeks before your surgery and recommence 4 weeks later.

## Your pre-operative assessment

Before you are admitted for your operation, you may be required to attend for a pre-operative assessment, to ensure that you are fit for surgery. It is important that you attend for this appointment to avoid delaying your surgery.

Not all patients require a detailed pre-operative assessment and a health questionnaire is used to determine which patients require a full assessment. The health questionnaire may be on paper or on a tablet/computer. The information required includes all medical conditions, regular medications, allergies to medications and your previous anaesthetic history. The information you give will be reviewed by the pre-operative assessment team. If you require further assessment you will be given an appointment to attend the pre-operative assessment clinic.

At the clinic, the nursing staff will confirm the medical information you have previously given and some further tests may be required, such as a blood test, X-ray, heart or lung test. If a more detailed assessment or discussion is required you may see an anaesthetist prior to your admission for surgery. This may require an additional appointment.

If you are taking prescribed medicines please bring a copy of your repeat prescription to your appointment and a copy of the operation consent form (if you were provided with a copy at your out-patient appointment).

Following your assessment, the staff will provide you with written information regarding preparation for your surgery and a point of contact. It is important that you follow the fasting instructions given on your admission letter.

## On the day of your operation

It is important that you carefully follow the instructions we give you about eating and drinking which will be detailed on your admission letter. You must not eat anything for at least 6 hours before your operation. This is to make sure your stomach is empty when you have your anaesthetic, because any food or liquid in your stomach could come up into the back of your throat and go into your lungs while you are being anaesthetised. Please refrain from chewing gum. Please note **Drinks containing fats (e.g. tea or coffee with milk), chewing gum and sweets all count as food.**

You can drink water or a drink without fats in it (e.g. black coffee) until 2 hours before your operation. You may also have small sips of water to take tablets.

We will need to know if you don’t feel well and have a cough, a cold or any other illness when you are due to come into hospital for your operation. Depending on your

illness and how urgent your surgery is, we may need to delay your operation as it may be better for you to recover from this illness before your surgery.

**Being admitted to the ward**

You will usually be admitted on the day of your surgery. You will be welcomed on to the ward and your details checked. We will fasten an armband containing your hospital information to your wrist. You will usually be asked to continue with your normal medication during your stay in hospital, so please bring it with you.

**Your anaesthetic**

Your surgery will usually be carried out under a general anaesthetic. This means that you will be asleep during your operation and you will feel nothing.

**Your pre-surgery visit by the anaesthetist**

The anaesthetist will come to see you and check again the information you supplied at your pre-operative assessment. They will also be interested in any problems you with moving your neck or opening your mouth; and any loose teeth, caps, crowns or bridges. Your anaesthetist will discuss with you the different methods of anaesthesia they can use. After talking about the benefits, risks and your preferences, you can then decide together what is best for you.

**Your anaesthetic**

When it is time for your operation, a member of staff will take you from the ward to the operating theatre. They will take you into the anaesthetic room and the anaesthetist will get you ready for your anaesthetic. To monitor you during your operation, your anaesthetist will attach you to a machine to watch your heart, your blood pressure and the oxygen level in your blood.

**General anaesthetic**

General anaesthesia usually starts with an injection of medicine into a vein. A fine tube (cannula) will be placed in a vein in your arm or hand and the medicines will be injected through the tube. Sometimes you will be asked to breathe a mixture of gases and oxygen through a mask to give the same effect. Once you are anaesthetised, the anaesthetist will place a tube down your airway and use a machine to ‘breathe’ for you. You will be unconscious for the whole of the operation and we will continuously monitor you. Your anaesthetist will give you painkilling drugs and fluids during your operation. At the end of the operation, the anaesthetist will stop giving you the anaesthetic drugs. Once you are waking up normally, they will take you to the recovery room.

**What to expect after surgery?**
We commonly use local anaesthetic injections around the ribs and into the chest wall at the time of your surgery. This can give good long lasting pain relief in the first 6 hours after your operation. We may also give you tablets, suppositories or injections to make sure you have enough pain relief.

**Pain relief after surgery**
Once you are comfortable and have recovered safely from your anaesthetic, we will take you back to the ward. The ward staff will continue to monitor you and assess your pain relief. It is important that you report any pain you have as soon as you experience it.

Side effects of having an anaesthetic include drowsiness, nausea (feeling sick), muscle pain, sore throat and headache. After your surgery, you will need to rest until the effects of the anaesthetic have worn off. You will have a drip in your arm to keep you well-hydrated.

We will encourage you to get out of bed and move around as soon as possible, as this helps prevent chest infections and blood clots. You will usually continue to have blood thinning injections every day whilst you are in hospital to help prevent blood clots. You should continue to wear the white thromboembolic deterrent (TED) stockings at home until you are fully mobile.

Your surgical team will assess your progress and answer any questions you have about the operation.

**Leaving hospital**

**Length of stay**
Please expect one overnight stay after your operation.

**Bra**
You will require a well-fitting supportive bra (no underwire) to wear day and night for support for 6 weeks following your surgery. It is suggested that your bra is one full cup and 1 width larger than expected to allow for swelling after your surgery. You will need to bring your bra into hospital with you. Please do not spend too much money on bras as it can be hard to estimate the correct size.

An alternative for women whose breasts are expected to be different in size for a period of time, is a stretchy crop top. Your breast care nurse can advise you on bras.

**Medication when you leave hospital**
Before you leave hospital, the pharmacy will give you any extra medication that you need to take when you are at home. It is useful to be prepared in advance by stocking up on paracetamol and ibuprofen if you can normally take these drugs without problems.

**Recovery**
How long it takes for you to fully recover from your surgery varies from person to person. It can take up to six weeks. After you return home, you will need to take it easy and should expect to get tired to begin with.

**Stitches**
Your wound will be closed with dissolvable stitches and covered with paper stitches (steri- strips). Please keep the steri-strips in place until your out-patient's appointment (7 to 10 days later). Your nurse or doctor will remove them then.

**Drain**
You may have a small plastic tube (drain) coming out of a small hole in the skin near the operation site. This will usually drain fluid (which is part of the healing process) into a vacuum sealed bottle. We will remove this tube when you no longer need it. This may be anywhere between 24 hours and 1 week. It is likely to stay in longer if you are having an ADM as part of your reconstruction. You are likely to continue on oral antibiotics while you have the drain in. You can go home with the drain in and a district nurse will be booked to come out to you and check on it.

**Personal hygiene**
You will need to keep your wound dry until your out-patient appointment when your dressings and/or drain will be removed.

**Infection**
Please contact your GP or Breast Care Nurse if you notice any signs of infection such as, redness, wound discharge or have a temperature.

**Exercise**
It is important to rest as much as possible for the first few weeks following surgery and limit your arm movements to shoulder height only for two weeks.

**Sex**
You can continue your usual sexual activity as soon as you feel comfortable.

**Driving**
You should not drive until you feel confident that you could perform an emergency stop without discomfort – probably at least four weeks after your operation. It is your responsibility to check with your insurance company that you are fully insured after your operation.

**Work**
How long you will need to be away from work varies depending on: how quickly you recover; whether or not your work is physical and whether you need any extra treatment after surgery. You may be able to return to work in 4-6 weeks if you do not need any further treatment and if you do not have any complications after your surgery. Please ask us if you need a medical sick (FIT) note for the time you are in hospital and for the first two weeks after you leave.

**Emotional support**
It is not uncommon to feel a bit 'down' after any operation so do ask your doctor or breast care nurse if you feel you need more psychological support. Some find treatment for cancer a frightening experience so please tell your nurse or doctor about any concerns that you have.

**Outpatient appointment**
Before you are discharged we will give you a follow-up appointment to come to the outpatient department, or we will send it to you in the post.

**Contact details**
If you have any specific concerns that you feel have not been answered and need explaining, please contact the following.

**Worcestershire Breast Unit –** 01905 760261 (ext. 36711)
Rachel King rachel.king18@nhs.net
Emma Chater e.chater@nhs.net
Liz Jarman elizabethjarman@nhs.net
Fiona Brooke-Bills f.brooke-bills@nhs.net
(Support worker – non clinical)
**Alexandra Hospital –** 01527 503030 (ext. 44625)
Julie Weston sheila.weston@nhs.net
Joanne Buckell joanne.buckell@nhs.net

**Kidderminster Treatment Centre -** 01562 512373 (ext. 53806)
Nicola O'Hara (Lead Nurse Practitioner)
Amanda Salt amanda.salt1@nhs.net

**If your symptoms or condition worsens, or if you are concerned about anything, please call your GP, 111, or 999.**

## Patient Experience

We know that being admitted to hospital can be a difficult and unsettling time for you and your loved ones. If you have any questions or concerns, please do speak with a member of staff on the ward or in the relevant department who will do their best to answer your questions and reassure you.

## Feedback

Feedback is really important and useful to us – it can tell us where we are working well and where improvements can be made. There are lots of ways you can share your experience with us including completing our Friends and Family Test – cards are available and can be posted on all wards, departments and clinics at our hospitals. We value your comments and feedback and thank you for taking the time to share this with us.

## Patient Advice and Liaison Service (PALS)

If you have any concerns or questions about your care, we advise you to talk with the nurse in charge or the department manager in the first instance as they are best placed to answer any questions or resolve concerns quickly. If the relevant member of staff is unable to help resolve your concern, you can contact the PALS Team. We offer informal help, advice or support about any aspect of hospital services & experiences.

Our PALS team will liaise with the various departments in our hospitals on your behalf, if you feel unable to do so, to resolve your problems and where appropriate refer to outside help.

If you are still unhappy you can contact the Complaints Department, who can investigate your concerns. You can make a complaint orally, electronically or in writing and we can advise and guide you through the complaints procedure.

## How to contact PALS:

**Telephone Patient Services: 0300 123 1732 or via email at: wah-tr.PALS@nhs.net**

## Opening times:

The PALS telephone lines are open Monday to Thursday from 8.30am to 4.30pm and Friday: 8.30am to 4.00pm. Please be aware that a voicemail service is in use at busy times, but messages will be returned as quickly as possible.

If you are unable to understand this leaflet, please communicate with a member of staff.