Parliamentary and Health Service Ombudsman

Complaints about the NHS in England: Quarter 1 2019-20

Contents

Introduction

In this quarterly report we have published more information about our casework than in previous reports, as part of progress towards our strategic commitment to publish the majority of our casework online. For the first time, we have published data and information from the first quarter of this year on the complaints we received, assessed and investigated about health organisations, and recommendations we have made to the organisations we investigate.

Some people come to us looking for an apology or explanation when something has gone wrong. Others are seeking financial compensation, while many just want to make sure the same mistake doesn't happen again.

While as a whole the NHS provides an excellent service despite financial and resourcing challenges, we often find significant failings when we investigate complaints about the NHS. When this is the case, the purpose of our recommendations is to remedy the injustice suffered by members of the public, and also help the relevant organisation reflect on and learn from the mistakes it has made so others do not experience the same poor service. We hope that publishing this information about our recommendations helps other organisations to learn from our casework.

In our casework spotlight this quarter are two cases that demonstrate how things can go wrong when the NHS fails to meet the needs of people with a learning disability or autism when providing treatment. NHS England launched its Ask Listen Do project last year to make it easier for people with a learning disability, autism or both, to raise concerns and make complaints. The cases we highlight in this report show the importance of this initiative and the need for it to become fully embedded at all levels of the NHS.

We have highlighted other cases we investigated between April and June this year, as well as some of the work carried out by the wider ombudsman community.

We would also like to shine a spotlight on good practice. For instance, have you made specific commitments to support projects like Ask Listen Do? Have you delivered innovations in your complaint handling or made improvements in how you get feedback from patients or your service users?

Whether you work in the NHS, in Government or another organisation we investigate, let us know what you have done by emailing: researchteam@ombudsman.org.uk. If other organisations could learn from your successes, we will include the best examples we receive in future reports.

Finally, as we continue to evolve these reports we would welcome your feedback on how we can further improve them. If there are ways we could make our data more user-friendly or accessible, please let us know.

This report

The Parliamentary and Health Service Ombudsman provides an independent and impartial complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments. We investigate complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right. We share findings from our casework to help Parliament scrutinise public service providers and to help drive improvements in public services and complaint handling.

This report presents information on complaints we received, assessed and investigated about the NHS in England from April to June 2019 (Quarter 1 2019-20). In our strategy for 2018-21 we committed to publishing the outcomes of our casework, including where we found against the organisations we investigate and the actions they take to comply with our recommendations. We are publishing our recommendations data for the first time alongside this report and will update the data each quarter to indicate where compliance has been closed for each investigation. In advance of publishing all of our casework online, we are also working to ensure greater consistency in how we describe the recommendations we make to organisations following investigations. This will give complainants and organisations we investigate greater confidence in what we do and how our decisions have made an impact.

As well as recommendations data, we have published a full data table of complaints received, assessed and investigated about NHS organisations during Quarter 1 2019-20. This is a major step in our objective to increase the transparency and impact of our casework.

Your feedback

We welcome your views on how we can improve these reports. Share your comments and feedback by completing this short survey.

Key facts: Quarter 1 2019-20

We completed our initial checks on

We assessed

1,416 health complaints, and passed **208** to our investigations team – step three in our process

We accepted

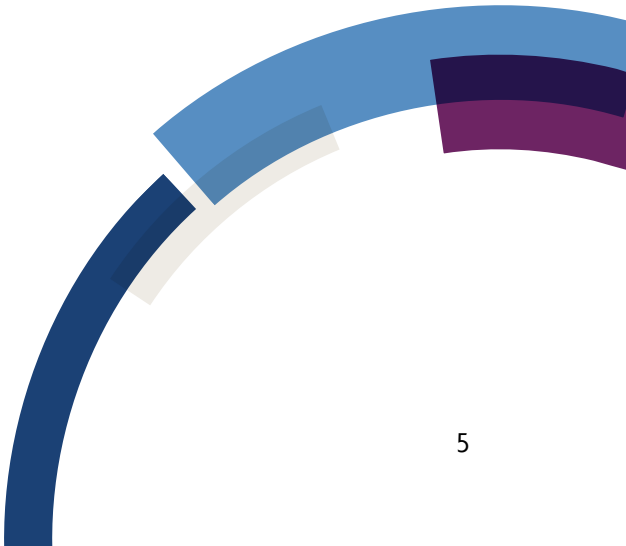
208 health complaints for investigation concerning **238** NHS organisations

We closed

343 investigations concerning **401** NHS organisations

We made

342 recommendations for health investigations we upheld or partly upheld



Casework spotlight

Each quarter we use this report to highlight some of the emerging themes we see in our casework. Here, we look at issues experienced by patients with autism and learning disabilities in NHS services.

Ask Listen Do

In July 2018 we signed up as one of the strategic partners for NHS England's Ask Listen Do project. Ask Listen Do aims to make it easier for people with a learning disability, autism or both (and their families and carers) to give feedback, raise a concern or make a complaint about health care, social care or education.

The Care Quality Commission's recent 'State of Care' report identified that difficulties in accessing the right care can result in people with a learning disability or autism being detained in unsuitable hospitals. The case summaries below are complaints we investigated during Quarter 1 that highlight some of the issues patients with autism and learning disabilities experienced with NHS services.

Case summary 1:

Ms G complained that Tameside and Glossop Integrated Care NHS Foundation Trust failed to provide her late brother, Mr G, with sufficient food or water and that he was inappropriately transferred to different wards without a suitable care package in place. Ms G also complained about poor complaint handling and communication by the Trust.

Mr G was admitted to the Emergency Department and diagnosed with pneumonia. Our investigation found that:

- there were appropriate assessments and plans in place for Mr G
- he was adequately hydrated during his time at the Trust
- the Trust's complaint handling was thorough and timely.

Our investigation found failings in:

- the length of time it took the Trust to implement intravenous feeding
- the level of communication with Ms G
- the continuity of care between wards.

Ms G's brother had mild learning difficulties and was moved between wards five times in as many days during his stay at the Trust. Our investigation found that the management of Mr G's transfers, and communication about this with him and his sister fell short of relevant standards, and was a failing. Staff at the Trust expressed concerns to Ms G over whether they could provide the level of care needed by Mr G. Ms G also spoke to staff expressing concerns that, although her brother may have indicated that he understood, this was often not the case and he was often frightened and confused at the time of the moves. Nutritional assessments also indicated that Mr G was malnourished due to the length of time it took the Trust to give intravenous feeding, which would have also caused him and Ms G further distress.

The Trust had already produced an action plan following the local complaints process. This addressed the issues we identified in our investigation relating to the level of communication and the level of continuity in care between wards, as well the length of time it took the Trust to implement intravenous nutrition. We recommended that the Trust provide written confirmation that the plan had been implemented and monitored within three months of our final report. We also recommended that the Trust update the action plan to include learning from its failures in relation to the delay in completing a capacity assessment.

Case summary 2:

Ms R complained about the care and treatment her son received during an eight day stay at Lancashire Care NHS Foundation Trust. Ms R contacted the Trust's mental health service as her son was experiencing paranoid beliefs, hallucinations and was becoming increasingly agitated. He was subsequently admitted to the Trust's acute psychiatric ward. Ms R complained that this was not a suitable environment for her son due to his autism, and that mixing with patients with substance and alcohol abuse issues was frightening and had a detrimental impact on him.

We also investigated several events that occurred on the ward which were extremely distressing to Ms R and her son. Ms R complained that her son was allowed to walk around the ward with a holdall of wet clothing, and to cover himself and his bedding with his own faeces on more than one occasion. Ms R also complained that her son suffered physical attacks and poor care, and that an inpatient stole his phone and falsely informed Ms R that her son had attempted suicide.

The Trust carried out an initial assessment in line with Department of Health guidance. Our investigation identified failings in documenting risks to Ms R's son while he was on the ward, and the lack of a structured care plan. While the Trust recognised that the events Ms R complained about had occurred, they could not say how they happened as there was no record in the medical notes. This was also a failing, particularly as Ms R raised concerns with the Trust at the time.

The Trust had already carried out a full investigation and acknowledged the failings we identified during our investigation. They apologised to Ms R, and invited her to take part in planned improvements to the service at the Trust. However, the Trust had not recognised some specific failings identified in our report relating to care planning, risk assessments and record keeping. The Trust's response letters also did not address the impact these failings had on Ms R and her son, or set out how they would improve services to ensure the same failings did not happen again.

We recommended that the Trust apologise to Ms R and her son for the failings we identified. We also recommended the Trust share an action plan with Ms R and the Care Quality Commission setting out how it will address the problems identified, including how it will improve its complaint handling process. Finally, we recommended the Trust pay £750 to Ms R and her son to compensate them for the injustice they experienced.

Casework publications

During Quarter 1 we published details of several cases we investigated.

We investigated a complaint following the death of Adrian Munday, a vulnerable adult who was murdered in October 2015 by a person on probation and under the supervision of the Community Rehabilitation Company (CRC). We found the CRC did not prepare a Victim Summary Report (VSR) at the correct time or make it available on request. We also found the CRC presented a draft copy of the report containing errors to the family of Mr Munday, which caused unnecessary delays. We found there were delays in communication and poor complaint handling by the CRC. We recommended the CRC apologise in writing, provide an updated report and take action to address the failings we identified.

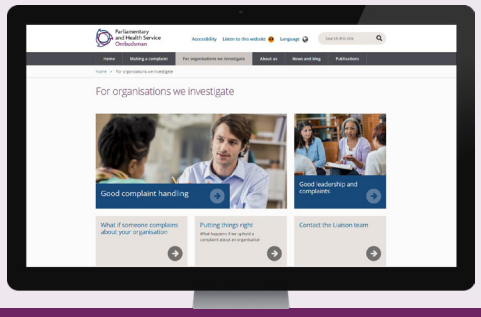
We investigated a complaint brought to us by Mr K, a personal trainer. Mr K underwent surgery at Manchester University NHS Foundation Trust in December 2016. Following surgery Mr K was told that two lipomas (painful lumps) in his leg and back had been removed. However, our investigation found that the Trust had failed to remove the lipoma in Mr K's back. This caused Mr K unnecessary pain and stress. Mr K also had to take time off work and have follow-up surgery to remove the lipoma in his back. We recommended the Trust write to Mr K to apologise and pay £1,000 in recognition of the pain and stress caused by its failings.

In June we published 'Missed opportunities', an investigation report into the deaths of two vulnerable young men at the North Essex Partnership NHS Trust. Our report alerted Parliament to systemic problems in the care and treatment of patients with acute mental health problems at the Trust. The Trust accepted our recommendations and has committed to making improvements. The Public Administration and Constitutional Affairs Committee also held a follow-up session examining the report. The Committee heard from representatives from NHS England, NHS Improvement, the Department of Health and Social Care, and the Minister for Mental Health. The Committee also questioned witnesses on progress made on the key issues raised in the report.

You may have missed...

During Quarter 1 2019-20 we published:

A blog about the first meeting of the Health and Social Care Regulators' Forum and our work to create a system-wide Complaints Standards Framework, setting out a unified vision of best practice in complaints handling for the NHS.

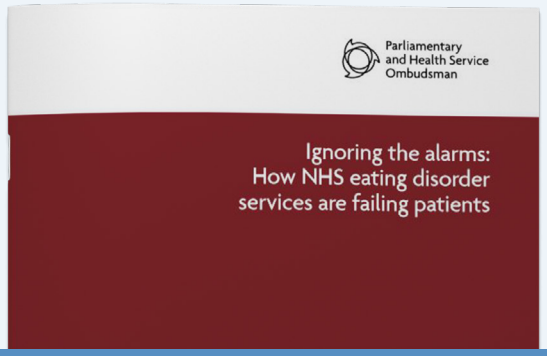


Updated guidance for organisations we investigate on good complaint handling and good leadership and complaints.

Updated guidance on our three-step process for dealing with complaints, explaining how we reach final decisions on unresolved complaints.

Our submission to the National Audit Office investigation into healthcare penalty charge notices and our submission to the Health and Social Care Select Committee's NHS Long-term Plan.

The latest episode of our Radio Ombudsman podcast, with Rosemary Agnew, Scottish Public Services Ombudsman, on the benefits of being a Complaints Standards Authority.



Our submission to the Public Administration and Constitutional Affairs Committee's follow up inquiry into our 'Ignoring the Alarms' report and a blog on the oral evidence sessions held as part of the inquiry.

Other organisations

Other publications included:

- the UK Administrative Justice Institute published a blog by Richard Kirkham setting out a manifesto for legislative reform of the ombudsman sector
- the Scottish Public Services Ombudsman published their annual statistics for 2018-19
- the Office of the Ombudsman in Ireland published their annual report for 2018-19
- the Northern Ireland Public Services Ombudsman launched an 'own initiative' investigation into Personal Independence Payments
- the Northern Ireland Public Services Ombudsman published their Case Digest for Spring 2019
- the Public Services Ombudsman for Wales Act 2019 came in to force
- the School of Law at University of Glasgow published Being Complained About guidelines
- the Ombudsman Association launched an Ombudsman Case Law Database.

Complaints we investigated: Quarter 1 2019–20

Our quarterly reports for 2018-19 and reports about NHS organisations are available to read on our website.

Like our previous quarterly reports, this report presents statistics on complaints about the NHS in England from April to June (Quarter 1 2019-20). In addition, we are publishing more information on the complaints we have received, assessed and investigated. This will give complainants and organisations we investigate greater confidence in what we do and a better understanding of how our decisions have made an impact.

In addition to the data below we have also published a full data table of complaints received and our decisions about NHS organisations during Quarter 1 2019-20 on our website.

Our process

As the last port of call in the complaints process, we provide the final opportunity for people to resolve their complaint. We have a three-step process for dealing with complaints about UK government departments, the NHS in England and other UK public organisations. Not all the complaints that come to us go through our whole process. Where we can, we will seek to resolve complaints earlier in the process and provide complainants with answers more quickly. Our focus is on making the right decision at the right time.

Step one

At this stage, we look at whether a complaint is ready to come to us. We usually expect people to complain to the organisation they are unhappy with first, so the organisation has the chance to put things right. We give people advice on how to complete an organisation's complaints process and ask organisations to do more when we can see that it could help resolve a complaint. When we aren't the right organisation to help, we explain why and let people know which organisation can help. The significant volume of advice and support we provide at this step often helps people get an answer to their complaint at this stage. We also look for ways to work with the organisation and complainant to resolve a complaint, without an investigation, at the earliest opportunity.

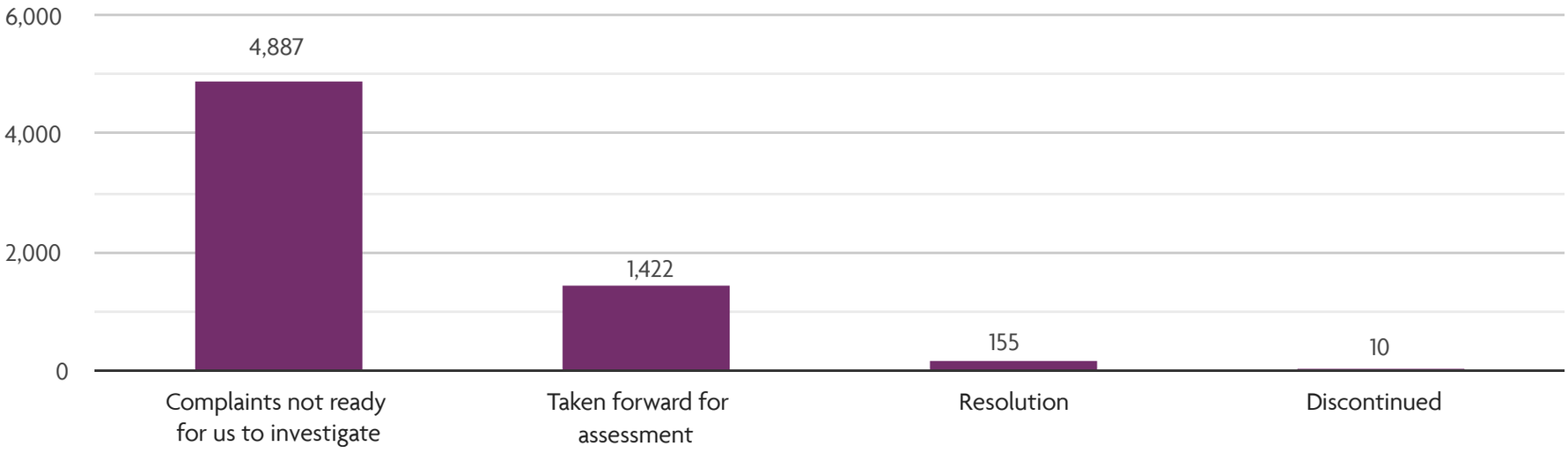
During Quarter 1, we completed our initial checks on

6,474

health complaints, including complaints continued from the previous quarter.

These were progressed in the following ways:

Initial checks, Quarter 1 2019-20



Step two

At this step we decide whether we can and should investigate a complaint, or whether we can resolve it without an investigation. We look at what happened and what outcome the complainant is hoping for. We also look at whether mistakes have been made that have had a negative effect on the complainant and what has already been done to put this right. We can usually only investigate if the complainant has been affected personally by what happened, and there is normally a limit on the time between when the complainant first became aware of the problem and bringing it to us. We will also determine whether legal action is an option. Where we can, we seek to resolve complaints earlier in the process and provide complainants with answers more quickly.

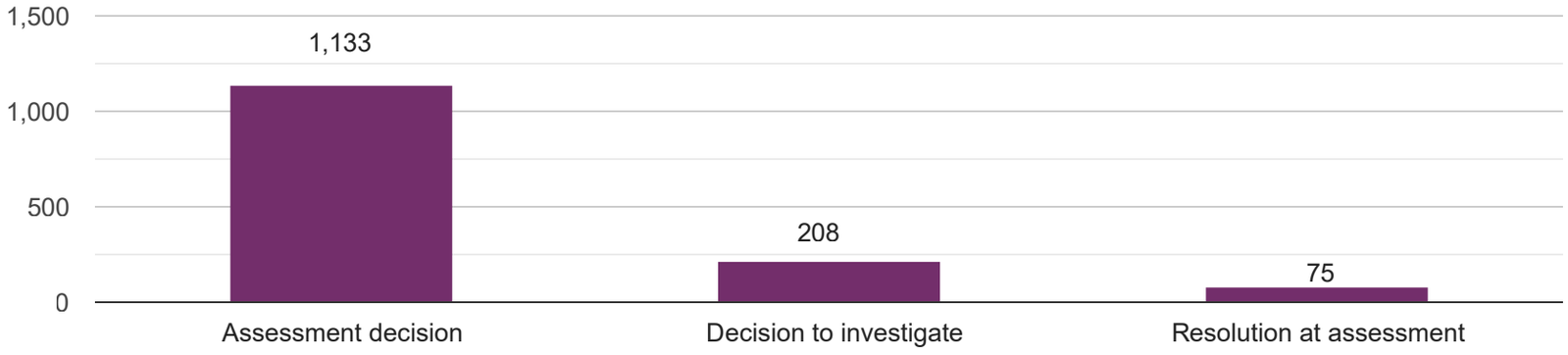
During Quarter 1 we assessed

1,416

health complaints

These were progressed in the following ways:

Assessments, Quarter 1 2019-20



Step three

At the start of an investigation, we discuss the scope of what we are going to look at with the complainant. We gather relevant information and evidence from them and from the organisation complained about. For health complaints, we may need to get expert advice from doctors and other health professionals. We compare what happened with what should have happened, and we look at how that has affected the person concerned.

In Quarter 1:

we accepted

208

cases in principle for investigation involving **238** health organisations.

we reached a final decision on

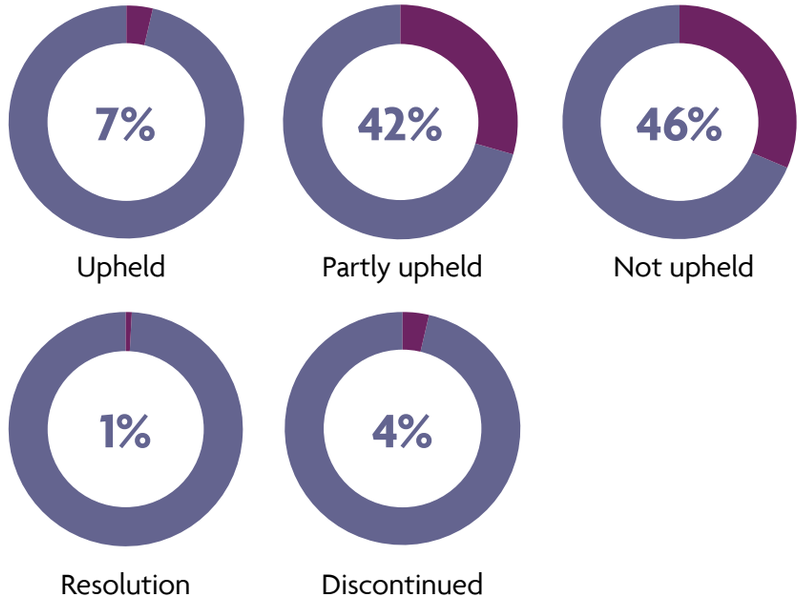
343

investigations involving **401** NHS organisations.

Of the cases we investigated:

- 168 (49%) were either fully upheld (24 or 7%) or partly upheld (144 or 42%)
- 158 (46%) were not upheld
- 3 (1%) were resolved before the investigation was concluded
- 14 (4%) were ended for other reasons, for example because the complainant asked us to.

Decisions made at investigation, Quarter 1 2019-20



Health investigation outcomes by organisation

Sometimes, we receive individual complaints that involve more than one organisation. Table 1 shows the organisations involved in the health complaints we investigated in Quarter 1. Case outcomes recorded as 'Other' refer to cases we investigated that we ended for a variety of reasons, for example because the complainant did not wish to pursue the case further.

Table 1: Health investigation outcomes by organisation, Quarter 1 2019-20

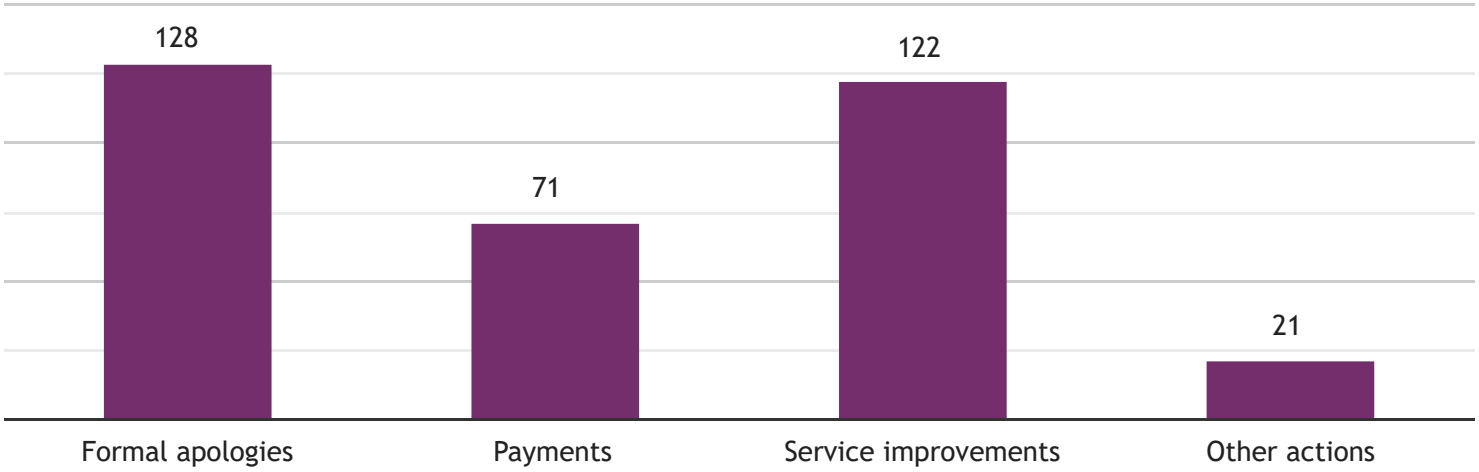
Organisation type	Upheld or partly upheld	Not upheld	Other	Total
	Q1	Q1	Q1	Q1
Hospital and community health services	125	131	16	272
Primary care services	27	43	0	70
Clinical Commissioning Group	12	3	6	21
Independent provider	7	4	3	14
NHS England organisations (local area team and commissioning region)	1	12	0	13
Ambulance Trust	2	7	0	9
Special Health Authority	1	0	1	2
Total	175	200	26	401

Recommendations

When we identify mistakes, we make recommendations to organisations to put things right. In most cases these are accepted by the organisations in question. On the rare occasions they are not accepted, we can highlight these to the Public Administration and Constitutional Affairs Committee in the UK Parliament.

Each case can have more than one recommendation. In Quarter 1, for complaints about the NHS we upheld or partly upheld, we made the following recommendations to organisations to put things right:

Recommendations made, Quarter 1 2019-20



Payments made by NHS organisations we investigated in Quarter 1 totalled **£105,961.42**. Due to the nature of the recommendations, there is one consolatory payment which is not included in this total as we do not know the value of the payment at this stage. There is also one recommendation for non-financial loss compensation of £250 not included as the complainant decided not to accept the payment.

Our data

There are some caveats to the data we have included in this report that anyone relying on it for research or other purposes should note. In 2016-17, we introduced a new casework management system (CMS), although some of our older cases are still held in our previous system, Visual Files (VF).

Due to the different ways of recording data on the two systems we have only used data from our live CMS when presenting our analysis of the issues people complain about. This ensures consistency and will enable us to carry out trend analysis over time. The proportion of health cases we investigated recorded on our old system that we closed in Quarter 1 2019-20 was just under 1% and will continue to decline.

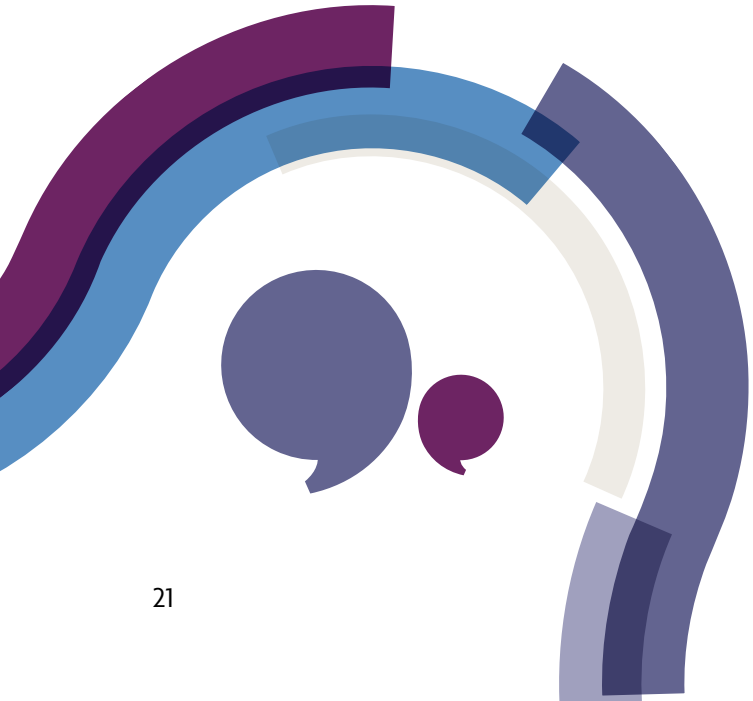
Our casework management system records the date on which we have proposed to investigate a case rather than when we confirm an investigation. As our quarterly data provides a snapshot of our casework flow at a given time, in some cases following comments from the parties involved, we may decide not to investigate.

We have included data from both systems when we explain the recommendations we have made, to give as full a picture as possible of the resolutions of cases that have been concluded in this period.

We have recently introduced a refreshed CMS, which has been designed with better data in mind. The advantages of better data are clear – it will give us, at a glance, a much richer understanding of what complaints brought to us are about. In the short-term there will be a period of crossover as we work through cases that we opened before we launched the new system. In the long-term, our improved data will mean we can publish more useful information in this report.

We also undertake a full data audit at the end of each financial year, which can lead to some reclassification of a small number of cases. This means that the data presented in this report may differ slightly to our annual data for 2019-20.

If you have any further comments or enquiries regarding this report please email researchteam@ombudsman.org.uk.



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