NHS COMPLAINTS PROCESS IN WALES

EVIDENCE TO THE INQUIRY OF THE HEALTH AND SOCIAL CARE COMMITTEE OF THE WELSH ASSEMBLY

Rt Hon Ann Clwyd MP

8 July 2014

1. Introduction

My submission to the Committee relies heavily on the insights, analysis and conclusions arrived at during the review of NHS Complaint Handling in the English NHS, which I co-chaired.[1] Generally speaking the evidence available to me suggests that the underlying concerns about the way in which complaints are handled are the same in Wales. There is a similar failure to learn from complaints, and, unsurprisingly, the changes required to go forward are along the same lines as I have recommended in the English context.

The recently published detailed report by Keith Evans arrives at broadly similar conclusions.[2]

Sources: The evidence is qualitative in nature, and largely extracted from the hundreds of letters I received from patients or their relatives who had complaints about the standard of service they received from NHS Wales. Other examples are taken from constituency casework, and from testimony given in person at meetings. In each category below, the examples have been chosen because they are representative of considerable numbers of typical cases. All cases are from Wales, and have been brought to my attention within the last 18 months.

I make important additional reference to the recommendations of the Welsh Ombudsman, whose deliberations reflect markedly the workings of the complaints system, in cases brought to her attention.[3]

It should be noted that I have confined my evidence to the acute sector, which was in turn the remit of my review of the English NHS. I am however acutely aware of the importance of ensuring that the complaints system is effective for the primary care sector

2. The Experience of Using the NHS Complaints System in Wales

Here I provide examples from Wales which illustrate the same themes which I listed in the report of my review “A Review of the NHS Hospitals Complaints System - Putting Patients Back in the Picture” (October 2013).

[1] Rt Hon Ann Clwyd MP and Professor Tricia Hart, *Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture*, Department of Health, 28 October 2013
[2] Keith Evans, *Review of concerns (complaints) handling within NHS Wales – 'Using the gift of complaints',* Welsh Government, 2 July 2014
[3] Professor Margaret Griffiths, *The Ombudsman's Casebook,* Public Services Ombudsman in Wales, Issue 16, May 2014

3. Information and accessibility

Many reported that they could find no information about how to make a comment, ask a question, or complain, and could not access the means to complain if they did. The need for this information often occurred at a stressful time in people's lives when they were not best placed to explore the correct procedure for their complaint.

Information appears not to be available in many wards about the system for complaints or feedback, and it is all too frequently the case that there is confusion about who is in charge of a patient's care.

> *"It took four days for me to get anyone to even speak to me about my dad's care"*

> *"No-one was able to advise on how to make a complaint."*

Others felt the present system was inaccessible to all but the most literate and determined, with the onus on the patient or their relative to compose documentation and to supply clinical or technical information. NHS organisations could make it harder to put together a complaint too, by either not keeping proper records or withholding information from complainants.

> *"You only get back what the hospital says has happened. You must identify every part and go through the process. It feels like being smothered, a constant battle."*

Some people who had asked for critical information did not get it:

> *"My mother suffers from Alzheimer's disease. We were informed that a member of staff on the ward had been accused of abusing patients and that an investigation was underway by POVA. This was some time ago and no-one will tell us anything."*

4. Fear of complaining

This is a very strong theme in many letters I have received. Both patients and relatives believe that they will lose the empathy of those who should be caring for them, or that their subsequent treatment will be affected detrimentally if they make a complaint. Patients alone in a hospital bed feel uniquely vulnerable, and dependent on the very staff they wish to complain about. Relatives may feel that complaining may rebound in the attitude towards the patient when they themselves are not at the bedside.

> *"I saw a patient being treated badly (in ITU) but was too afraid to say anything at the time."*

> *"My late husband had poor care, and I was questioned by the consultant about why I raised a complaint. After that I was too scared to complain again at the time, for fear of making future treatment more difficult, even though he was given the wrong medication, and had bruises on his arms."*

For some patients their fears seemed justified:

> *"It's dangerous to complain. The fact that I had complained was made visible on all my records."*

5. Insensitivity

All too often the tone and language used in interacting with complainants is felt to be inappropriate or at worst callous and unsympathetic, especially in what may be a stressful time for patients or family members.

> *"The complaints people were not helpful. I felt lower than them – there was a great lack of communication on their part."*
>
> *"The language used in their letters was patronising, condescending and full of platitudes. I felt insulted."*
>
> *"The hospital wrote to me and said that my complaint about my sister's death had "been a learning curve" for the staff involved – no apology."*

6. Unresponsive to issues raised in complaint

Too often too, the response received to a complaint sidestepped or missed the point about which the complaint was originally made.

> *"When you make a complaint, their reply makes you feel you are being smothered by NHS words – it makes you sick."*
>
> *"A nice friendly letter is not enough – you want an explanation about what has happened to someone while they were in their (hospital) care"*
>
> *"Eventually I got a reply – but it completely overlooked the dehydration and malnutrition issues that were the cause of my complaint. I felt I was being fobbed off."*

7. Prompt and clear process

This was an overwhelming message from significant numbers who made contact with me. The process of complaining was not explained to the person complaining, with often unexplained lengthy intervals between stages, and the entire process extending into many months and indeed years in some cases. People said that they were not told what to expect, what kind of investigation would take place by whom, or when they could expect to receive a response.

For bereaved relatives in particular the often protracted process added to their distress, diverted their energy, and disrupted the grieving process.

> *"It's now two and a half months since my letter was sent to the Chief Executive of the Health Board, and I have received no reply whatsoever. This reinforces my belief that we are being treated with contempt for daring to question our treatment."*
>
> *"I wrote to the concerns team on 1st August about the death of (family members) and now on 19th March I have yet to receive a response. I will never give up until my questions are answered."*

"I've been waiting since 6th September for a credible reply to my complaints about my father's treatment. The silence has been deafening. I eventually referred it to the Ombudsman in February"

"Instead of being able to grieve for my husband, I've spent years of my life trying to get the truth about why he died."

8. Seamless service

Where more than one service (e.g. hospital and GP is involved) – typically people find complaining about the interface between primary and acute care a trying experience, with time wasted in assessing who to blame. Inappropriate arrangements for discharge and referral were a common cause for complaint.

"Correspondence about my complaint seemed to go endlessly to and fro between the hospital and the GP – I was worn down in the end and gave up."

9. Support

Patients often want help with complaining, from someone who understands the complex NHS Wales system. Few in Wales seem to be aware of the independent complaints advocacy service, or of any source of advice or guidance on complaining, either at the time of an incident or later. This indicates that not only do hospitals not display information about the service but that they fail to make referrals to it routinely as they should.

Of the very few people who I met who had used the advocacy service, opinion was divided. Some who had tried to use it they found the help provided was limited and not worthwhile, although others said the service was good.

"I'm very angry having raised serious issues about my mother's treatments for years and been fobbed off, but I didn't know about the CHC and the advocacy service and had no help from them"

"Fortunately my son-in-law is a clinician and pursued my concerns about my husband's death assiduously – there was no other expert help."

"I found the advocacy service good – the problem is the NHS!"

10. Effectiveness

Patients want their complaint to have made a difference, and to make sure that others didn't experience the same problems. Many who did complain felt that it resulted in no change for themselves or others, or simply that they were never told if changes had been made as a result of their complain.

"I complained 10 years ago about bad practice in taking blood sugar tests and was told it would never happen again. I went back recently and nothing has changed. I won't go on my own to the clinic anymore."

> *"I complained to the Ombudsman who upheld my complaint about my mother's death in 2011...and the hospital was told to correct slack procedures, which to date they still haven't done."*
>
> *"I wasn't asking for money, I just wanted to make sure that no-one else suffered from the same errors. I couldn't believe they were so defensive and uninterested and never found out if anything changed"*

11. Independence

Patients are concerned that their complaint is looked at fairly and without bias. In particular they lack confidence in a system where complaints are investigated by the very people involved in the issue that they have complained about.

Many people told me that they felt the system closed ranks on those who complained, and that independent oversight of their complaint was lacking. Against this, the ordinary person felt powerless to get to the truth about what had happened to them or their family member, to the extent that they sometimes felt there was a conspiracy to cover up mistakes and bad practice by medical staff.

Some reported that they were engaged in distressing and lengthy battles over years where Boards denied information and refused to admit mistakes, only to eventually be vindicated by independent clinical opinion from overseas, or the Ombudsman or in some other way. Considerably larger numbers told me that they had fallen by the wayside in similar endeavours, lacking the personal or financial resources to continue their search for answers.

The lack of an independence in the complaints system was *the* major theme emerging from all of the contact I have had with patients and families over the past two years.

> *"There's now no independent stage in the complaints system in Wales, or the previous good practice being implemented anywhere else to ensure fair play."*
>
> *"Health Boards seem to be their own judge and jury."*
>
> *"Doctors club together if there's a complaint against one of them. There's a lot of self-interest for directors and managers too in defending the hospital against a complaint."*
>
> *"The CHC's are supposed to be independent but they have mixed roles and are far too cosy with the Health Boards in my opinion."*

12. Learning from Complaints

It seems clear that NHS Boards have been slow to understand the value of complaints as a means of service improvement, or to set up suitable systems by which Boards can oversee the complaints system and ensure that attention is paid to addressing the causes of complaints. If they had, it is hard to believe there would be such strength of dissatisfaction.

The importance of learning from actual complaints is accentuated by the widely accepted view that considerable numbers of people who want to complain do not. As I have discovered, many people give up pursuing their case at an early stage, having lost faith in the system.

Perhaps the most telling recent evidence of the failure to learn from complaints is to be found in the reports of the Welsh Ombudsman. There was an 11% increase in the number of complaints against NHS Health Boards and Trusts, in 2013/14 which is noteworthy, and should in itself be taken seriously.

Discounting those “premature” complaints which are referred back to Boards, the very fact that cases have reached the Ombudsman, points to the failure of the complaints system at its local stage to provide both a satisfactory response to the complaint, and crucially to its failure to address the underlying policy and practice concerns which have given rise to it.

The Ombudsman’s recommendations in upheld cases represent a devastating indictment of the failure of Health Boards to both handle complaints, as they are supposed to, and to use the complaints system to identify the most serious of clinical, nursing and management system failures.

All of the recommendations below have resulted from complaints which had already been through the complaints systems of the Health Board concerned. It must be assumed that the Health Boards had failed in investigating the matter to acknowledge the shortcomings which the Ombudsman’s robust recommendations demand be addressed.

Furthermore, for the Ombudsman to have mounted an investigation, the complaint is unlikely to have been capable of “informal resolution”, since the Health Board concerned had not been prepared to acknowledge poor service and issue an apology.

In the attached Appendix, I have listed a sample of the Ombudsman’s recommendations in order to convey the gravity of the matters which Health Boards’ own complaints systems appears to have failed to identify and address, and which it was left to Ombudsman to expose.

I have not provided the full details of each case, as these can be accessed easily elsewhere. I have however provided a list of recommendations from recent cases, organised by Health Board. These have been compiled from the Ombudsman’s Casebook, for the final quarter of 2013/14.

Patients and the public will quite rightly question the value of a complaints system in which it is left to the Ombudsman to recommend that such elementary steps be taken, and to identify a learning opportunity apparently rejected by the Health Board concerned, exposing future patients to risk.

13. Next steps

It is clear that radical reform is required in the way in which complaints are handled in NHS Wales. How NHS Wales responds in detail to this challenge is a matter for others, but I would suggest that any thoroughgoing reform should conform to the following principles:

- Patients should be provided with every opportunity to comment and complain about the services they receive, in whatever way they find it easiest to communicate
- Openness to complaints – everything should be done to make it clear that comments and complaints are welcomed, and that they can be made without fear.
- Those who comment or complain should be kept in touch with what is happening to their comment, concern or complaint, and be told what will change as a result of it. There must be effective, timely, and sensitive communication in particular with those making serious complaints.
- Support and advocacy for those who complain must be provided from a source which has no conflicting interest in the Board complained of.

- The public should be consulted with and involved in any redesign of the complaints system.
- Health Boards and their managers, professional bodies and regulators must review their attitude to complaints by both by patients and whistleblowers, taking advantage of the learning opportunities these present, and creating a positive culture around complaints as a means of service improvement.
- Independence should be a key element in any reform of the complaints system in Wales. This needs to be ensured at every level, and what was lost in the 2011 reforms needs to be restored in this regard. This is most problematic in a small nation, with a similarly small medical and managerial community, but cannot be overlooked.
- The complaints system should form a central plank of the NHS Wales regulatory system, with the aim of guaranteeing common standards and application of national guidelines in complaints handling. As HIW is in itself in the process of reform, I would strongly support the suggestion made by Keith Evans for the appointment of an Independent Complaints Regulator for NHS Wales in the shorter term. The Regulator should be appointed as a matter of some urgency, and have the teeth required to drive change.

APPENDIX

Abertawe Bro Morgannwg University Health Board

The Ombudsman recommended that the Health Board should:

- remind the relevant staff of the importance of good record keeping;
- remind the relevant clinicians of the importance of fully documenting assessments and reviews in the medical records;
- remind all staff of the need to ensure that patient's fluid levels are adequately monitored;
- provide refresher training for the relevant staff on dehydration and when to initiate fluid monitoring;
- ensure adequate blankets are available to all patients within the First Hospital;
- consider how Consultant care is impaired by the current weekend working arrangements, and provide evidence of what consideration has been given to resolve the matter;
- review the failings identified in a report with the clinicians involved in a patient's care and discuss them as part of their professional development/appraisal process;
- share the Ombudsman's report with nursing staff who were involved in Mr X's care and with senior SAU staff, so they are aware of the lessons to be learned from it;
- undertake a review of the current triage/early warning system to ensure it is working appropriately;
- ensure that nurses working in the SAU are trained in the use of the triage system;
- identify criteria for the skills and level of experience required by nurses before they can undertake the triage role;
- review the Royal College of Physicians' Acute Medical Task Force 2007 report to ensure that its recommendations have been implemented;
- issue a reminder about the need for a Consultant review within 24 hours of both acute admissions and transfers on from the AU towards;
- issue a reminder to junior doctors about the availability of on-call Consultants and their general availability for advice at the weekend;
- review the Stroke Policy.

Aneurin Bevan Health Board

The Ombudsman recommended that the Health Board should:

- formally remind the Cardiology Directorate of the Annual Leave Policy;
- formally instruct Cardiology Directorate clinicians of the requirement to ensure that onward referrals to other services, including tertiary care and the Specialist Hospital are dealt with promptly (in line with the Waiting Time Guidance);
- complete an independent audit of first 100 inbound referrals received by the Cardiology Directorate (excluding those to a named cardiologist) since 1 February 2014. The audit to identify whether there has been any similar failing to arrange necessary diagnostics (e.g. echocardiography). If indicated by the outcome of the audit, the process used by the Cardiology Directorate for dealing with inbound referrals should be revised and all relevant staff should be informed of the revised process;
- complete an independent audit of the first 50 onward referrals made by the Cardiology Directorate to other departments/ hospitals since 1 February 2014. The

audit to identify the routine time taken between the decision to make a referral and the referral being sent. If the audit identifies unreasonable delays, the process used by the Cardiology Directorate for making onward referrals is to be revised and all relevant staff should be informed of the revised process;
- discuss the Ombudsman's report and the results of both audits at the next meeting of the Cardiology Directorate's management team;
- provide evidence to this office that all the above recommendations have been completed.
- review its failure to diagnose heart failure with clinicians.

Betsi Cadwaladr University Health Board

***The Ombudsman recommended that the Health Board should*:**

- introduce additional guidance to medical staff to increase their awareness of national guidelines along with the specific need for arterial blood gas analysis in patients with respiratory disease presenting as an emergency with shortness of breath;
- review the ED arrangements for analgesia and of handover processes – copies of new protocol documents to be provided to the Ombudsman in both instances;
- undertake a governance review within 3 months of nursing professional standards covering assessments, physiological and pain monitoring, record keeping and onward transmission documents between the ED and other clinical environments. Evidence of that review to be provided to the Ombudsman within 2 months thereafter;
- to review its (over restrictive) approach to investigating concerns and complaints about primary care, and to update its written procedures on this issue;
- remind staff of the General Medical Council consent guidance and the importance of keeping records of discussions with patients;
- ensure that clinicians are reminded of the importance of patient involvement in the management of their care and treatment, and also of the need to perform further biopsies and seek specialist advice in cases where tests have shown conflicting results;
- as part of a wider learning process, discuss with the members of the UGI MDT involved in Mr A's care, consider the issues raised in this case and the learning points that arise;
- discuss the contents of a report at an appropriate consultant forum across the Health Board;
- share a copy of a serious complaint report with the Chairman of the Health Board;
- carry out a root cause analysis of the failings in respect of complaint handling identified and provide its findings to the Ombudsman;
- provide evidence of the random spot checks carried out to ensure compliance with its procedure for urine analysis on removal of catheter; and provide evidence of the training it has already organised, together with details of how it proposes to ensure that such training forms part of the ongoing development of all relevant staff;
- issue a reminder to staff on the Ward of the importance of good record keeping and the need to ensure that fluid balance charts contain all necessary information. This should form part of the training that the Health Board has already organised;
- carry out a feasibility study into the use of bladder scanners for all urology patients following catheter removal;
- demonstrate that it has in place an appropriate risk assessment procedure which ensures that urological patients being treated on a general ward are appropriately prioritised for transfer to a specialist urology ward where possible;

- review the conflicting anti-coagulation regimes recommended by the operating surgeon and the anti-coagulation clinic and, in light of the clinically significant differences between the two approaches, ensure that recognised good practice (with reference to any applicable guidance) is consistently followed by all relevant staff;
- ensure that it has a procedure in place so that recommendations from the anticoagulation clinic for post-operative care are brought to the attention of the operating surgeon pre-operatively and where differing approaches arise, the rationale for preferring one over the other is discussed and clearly documented in the patient record;
- provide the Ombudsman with evidence that it has reviewed the effectiveness of the changes it has made in relation to pain and manual handling assessments;
- remind its radiologists of the need for clarity in reports where a fracture has occurred at or around the site of a previous fracture;
- provide the Ombudsman with evidence that it has implemented National Patient Safety Alert 16 and in particular that it has satisfactory systems in place to ensure that requesting clinical teams are made aware of radiology reports

Cardiff and the Vale University Health Board

The Ombudsman recommended that the Health Board should:

- Apologise to complainants for its complaints handling failures, and make compensatory payments for time spent in pursuing the complaint;
- Review its arrangements in respect of post-admission medication reconciliation and ensure that a systematic medicine reconciliation programme is in place;
- Ensure that staff training in respect of recognising acute stroke is up to date, with particular reference to the 2012 Stroke Guidelines issued by the Royal College of Physicians;
- Ensure that use of the Rosier score system (or a similarly recognised tool), in order to identify patients who are likely to have had an acute stroke, is implemented;
- With particular reference to the current Stroke Guidelines and NICE guidance, review its arrangements for the identification and treatment of acute stroke and consider including the following measures:
- Ensure that
    a) All patients who may have had an acute stroke (i.e. have been assessed as having a positive Rosier score) should be immediately assessed by a physician trained in stroke medicine to determine whether thrombolysis is suitable;
    b) Suitable patients should have immediate CT scanning and, in all cases, within one hour;
    c) All patients who may have had an acute stroke should be admitted immediately to a specialist acute stroke unit;
    d) All patients who may have had an acute stroke should have a swallowing screening test, using a validated tool, by a trained professional within four hours.
- Review the findings set out in its various complaint responses to Mrs X and to this office and take action to ensure that its own complaints investigations are in accordance with the Putting Things Right scheme, are sufficiently robust, demonstrably independent and, where appropriate, critical of identifiably poor care, which should include the introduction of a quality assurance audit of a sample of its completed complaint investigations;
- remind relevant clinicians of the importance of obtaining serial radiographs in patients who have sustained fractures until such time as the fracture has been demonstrated

to have united on x-ray, particularly in the situation in which the patient is not improving as one would expect;

- conduct an audit of obstetric discharge letters following second trimester pregnancy loss to confirm that they are routinely sent, and contain relevant information.
- formally remind staff members to record the provision of oral care consistently;
- consider introducing specific oral assessment and care planning documentation;
- formally remind staff members to complete and record NGT positional checks;
- formally remind staff members to complete fluid charts;
- arrange to complete random audits of its Intentional Rounding Scheme documentation;
- introduce a care pathway for the investigation of persistent breathing difficulties with an unconfirmed diagnosis;
- share a report of an investigation with all staff involved in the Health Board's consideration of a complaint, to ensure that they are aware of the need to comply with the statutory guidance;
- formally instruct the staff involved in considering and investigating a complaint that they must ensure that, when a complaint involves an allegation of negligence or harm, the investigation report and final response must comply with statutory guidance;
- formally instruct the nursing and clinical staff involved in a case to follow the relevant record keeping guidance;
- provide the Ombudsman with evidence of the systems it has put place to monitor the impact of the actions it has taken, or is taking, to address the communication failings identified in handling a complaint to the Health Board;
- provide the Older People's Commissioner for Wales's report entitled: "Dignified Care?" to all staff;
- that admission clerking proforma and medication charts include a formal DVT risk assessment tool;
- that regular audits should be carried out in relation to DVT prevention;
- that the Health Board should reflect on its complaints handling to ensure that it is sufficiently robust and independent;
- that the Health Board should remind staff of the importance of good record keeping;
- that the Health Board should consider a report as part of the Consultant Physician's next appraisal;
- Apologise for taking a year to respond to a complaint.

Cwm Taf Health Board

The Ombudsman recommended that the Health Board should:

- review its procedure and provision for emergency feeding outside the times of its usual Dietetic Service;
- provide the Ombudsman with evidence of an analysis of a patient's care, any action points and the outcome of the same;
- provide a copy of the final report of an investigation to all the staff involved with Y's care for reflection;
- ensure that it keeps records of all complaint-related meetings;
- ensure that its management of hip fractures complies with relevant guidance;
- provide training related to its Falls Procedure;
- highlight to a Registrar the importance of recording patient's symptoms;
- review the policy of administrating warfarin in preference to low molecular weight heparin;

- Within two months of this report, the Health Board should forward the Orthopaedic Department's policy for the prevention of DVT in long term immobile patients including those in the community.

Hywel Dda Health Board

The Ombudsman recommended that the Health Board should:

- complete an audit of all discharges from the Ward on which a complainant was cared for, which have been completed within the last two months; the audit should analyse whether the failings identified by the Ombudsman are still apparent and, if so, then the Health Board should implement refresher training for all ward staff (including physiotherapy staff if appropriate);
- complete an audit of student physiotherapy record-keeping from the last three months, to analyse whether the failings in physiotherapy record-keeping identified by this report, are still apparent; if so, the Health Board should implement refresher training for all physiotherapy staff (including qualified staff if appropriate);
- complete an audit of all final complaint response letters issued within the last month, to identify complainants have been properly advised of how to take their complaint further if they remain dissatisfied; if the audit identifies similar failings to those found by this investigation, the Health Board should contact those complainants to give them an apology and correct advice;
- audit the use of the risk assessment form for acute surgical admissions and the recording of the reasons where preventative measures were not prescribed;
- to ensure systems were in place to monitor at ward level, compliance with local and national standards on safe medicine management and to make sure that patients with Parkinson's disease were given their usual medication, which could be outside the usual drugs round;
- to audit the completion of fluid intake charts and their accuracy.