The All Party Parliamentary Group for Patient and Public Involvement in Health and Social Care

A.P.P.G

Patient and Public Involvement in Health & Social Care

Inquiry into Complaints Handling in the NHS and Social Care sector

Based on written and oral evidence collected in 2015, organised by the Patients Association and chaired by the All Party Parliamentary Group for Patient and Public Involvement in Health and Social Care.

2015

Proudly supported and assisted by the Patients Association in its role as Secretariat to the APPG
1. Executive Summary

The NHS complaints system still exposes many patients to a gruelling and unsatisfactory process, despite numerous high level calls for reforms. Research conducted by the Patients Association found high levels of dissatisfaction with the complaints process with patients frequently encountering unhelpful and defensive staff, complicated procedures to negotiate and sometimes dishonest replies. The findings show that some patients are so daunted by the procedures or worry about being seen as a trouble-maker by hospital staff, that they do not bring a complaint - despite having grounds to do so.

The APPG listened to evidence from a broad section of organisations, groups and individuals with expert knowledge and experience of complaints handling.

At this first evidence session we will be hearing from patients (and relatives of patients) who have been through an unsatisfactory complaints process. They will ‘set the scene’ for the Inquiry. Future sessions (to be held in September and October) will hear evidence from Clinical Commissioning Groups, hospital Trusts, regulatory bodies and other organisations with an interest in complaints handling.

The key findings of the first session were:

Lack of communication: Throughout this session there was a clear issue regarding communication whether it was adequate, appropriate, sensitive or clear.

Timelessness: Evidence heard in this session often related to the ‘Complaints process’ dragging on needlessly when information was ever present. This often led to increased anxiety as appeals to the Ombudsman were time restricted.

Being Ambushed: Patients also suggested that they felt ambushed, particularly at local resolution in one case were the Trusts minutes were being taken by a barrister.

Missing information and withheld access to records: Complaints pointed to evidence that was missing in the reports and access to medical and other records were unjustifiable delayed.

Self-investigations: The complaints all went through the internal complaints procedures, that meant in the initially stages the outcomes were ‘skewed’ in favour of the Trusts, concluding that the investigation of the complaint was ‘satisfactory’.

External investigations: Recommendations from external experts were often ignored such as the Coroner’s Rule 43 letters which provides recommendations.

Complaints regarding identifying key staff: The evidence from this session showed that Trusts were ‘blocking’ the identification of key staff who had carried out non-consensual and life threatening procedures.

Default defensiveness: All evidence heard pointed to the defensive position to the complaints made.
Lack of Accountability: The session heard that throughout the complaint and investigations there was no clear sense of accountability. Many departments did not understand their roles and responsibilities to the patient. There was a sense of dread and fear were the process was not transparent and departments did their best to ‘pass the buck’.
## 2. APPG Overview

### The All-Party Parliamentary Group for Patient and Public Involvement in Health and Social Care 2015

**Title:** All-Party Parliamentary Group for Patient and Public Involvement in Health and Social Care

**Purpose:** To promote engagement between healthcare and social care providers and users in order to provide a more responsive patient-centred way of supplying medical care; and to inform the parliamentary debate on patient and public involvement and public participation.

**Officers:** Co-Chairs: John Pugh (LD) and Huw Irranca-Davies (Lab)  
Vice-Chair Baroness Marsham of Ilton (CB)

<table>
<thead>
<tr>
<th>Government Party</th>
<th>Main Opposition Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Pugh – LD</td>
<td>Siobhain McDonagh</td>
</tr>
<tr>
<td>Margot James – Con</td>
<td>Baroness Thornton</td>
</tr>
<tr>
<td>Stephen Hammond – Con</td>
<td>Lord Harris of Haringey</td>
</tr>
<tr>
<td>David Amess – Con</td>
<td>Andy Love</td>
</tr>
<tr>
<td>Daniel Byles – Con</td>
<td>Baroness Wilkins</td>
</tr>
<tr>
<td>Penny Mordaunt – Con</td>
<td>Kelvin Hopkins</td>
</tr>
<tr>
<td>Dominic Raab – Con</td>
<td>Baroness Wall of New Barnet</td>
</tr>
<tr>
<td>Sir Peter Bottomley – Con</td>
<td>Rosie Cooper</td>
</tr>
<tr>
<td>Martin Horwood – LD</td>
<td>Virendra Sharma</td>
</tr>
<tr>
<td>Baroness Gardner of Parkes – Con</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Baroness Howe of Idlicote – CB</td>
<td></td>
</tr>
</tbody>
</table>
3. Acknowledgements

The members of the APPG would like to thank all the participants who submitted evidence (both written and oral) to this inquiry. All references made to statements quoted in this publication are the views of the individuals and should not be taken to convey an official organisational position.

The Chair of the APPG would especially like to thank the Patients Association in its role as secretariat to the APPG.

The information provided throughout the course of this inquiry has enabled us to be better informed about the views and experiences of a wide range of organisations and bodies, and has allowed us to produce this report that we hope will be of use within the wider policy debate.

4. Background

“A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public’s trust in the service.” (Sir Robert Francis QC, 2013)

The NHS complaints system still exposes many patients to a gruelling and unsatisfactory process, despite numerous high level calls for reforms. Research conducted by the Patients Association found high levels of dissatisfaction with the complaints process with patients frequently encountering unhelpful and defensive staff, complicated procedures to negotiate and sometimes dishonest replies. The findings show that some patients are so daunted by the procedures or worry about being seen as a trouble-maker by hospital staff, that they do not bring a complaint - despite having grounds to do so.

The APPG will be listening to evidence from a broad section of organisations, groups and individuals with expert knowledge and experience of complaints handling. The APPG would especially like to hear from organisations that have developed best practice guidelines and protocols for dealing with NHS complaints.

5. Aims of the inquiry

To promote engagement between healthcare and social care providers and users in order to provide a more responsive patient-centred way of supplying medical care; and to inform the parliamentary debate on patient and public involvement and public participation with particular focus on the complaints handling. This inquiry through the APPG looked more closely into the issues surrounding the NHS complaints process and the handling of complaints. Evidence was sought (both written and oral)
from a range of organisations and individuals who have recent experience, knowledge and expertise of complaints in the NHS.

6. Evidence:

The Evidence from this session focused on the Patients experience of the complaints system and procedure. We collected the evidence in writing from patients as well as oral evidence that was presented to the APPG on 17th June 2015.

List of contributors

Written Evidence has been provided by:

**Individuals**
1. Stuart Finch
2. Dee Speers
3. Peggy Banks
4. Brenda Prentice
5. Valentine Gal
6. Lindsay Jackson
7. Richard von Abendorff
8. Daniel McMorrow
9. Jill Mizen
10. Colin N Rock
11. Judith Gibbs

**Clinical Commissioning Groups and Trusts**
1. Southampton CCG
2. Somerset CCG
3. Chorley South Ribble and Greater Preston CCGs
4. West Berkshire CCGs (Newbury & District, North & West Reading, South Reading and Wokingham)
5. The London Ambulance service

Summary of written evidence

**Questions:**

The following questions were sent to all parties to assist them in providing their responses:

**Complaints at a local level**

1. What are your views on the effectiveness of the NHS’s current approach to handling and investigating complaints at a **local level**?
2. Which aspects of the complaints handling process do you think works well and which do not (and why)?

3. What staff training have you implemented (or would like to see implemented) to improve complaints handling?

4. What role should Trust Boards and senior managers play in developing a culture that takes the concerns of individuals seriously and acts on them?

5. How can complainants be more appropriately supported during the complaints process (e.g. advice, mediation and advocacy)? How do you assess this need?

6. Do you have examples and/or guidance of best practice (or standards) on complaints handling - and how have you implemented them?

**Complaints at second stage**

7. What are your views on the effectiveness of the NHS’s current approach to handling and investigating complaints at second stage?

8. Which aspects of the complaints handling process do you think works well and which do not (and why)?

9. What are your views on the effectiveness of the Parliamentary and Health Service Ombudsman (PHSO) - as the final adjudicator - to investigate complaints?

**Going forward**

10. How can best practice guidelines, recommendations and learning be disseminated and shared with other organisations?

11. Do you have guidance or examples of how to engage with the complainant and involve them in the complaints process?

12. Do you think that the establishment of a new single investigation body at the Department of Health is necessary to improve the complaints handling process? How best could any new body support the work of the PHSO?

13. Would you support the appointment of a named minister who would have overall responsibility for complaints handling?

14. Do you have any other information or experiences that you would like to share with the APPG?

**Individual Responses:**

**Stuart Finch**
Stuart suffers from Pelvic Venous Congestion (PVCS) which causes him extreme pain due to varicose veins. He is unable to work, having to cease £40,000 p.a. employment, and is dependent on benefits for himself and his young family. Stuart’s PVCS was originally misdiagnosed as psychological. He believes that this is a
tactical misdiagnosis to prevent access to treatment on the NHS as varicose veins are now treated under private health care; PVCS is a treatable condition.

PHSO said that the refusal by the hospital to treat him was reasonable and failed to intervene and investigate contradictions from multiple NHS Hospitals responses to his complaint. He challenged PHSO’s decision and handling of his case as they did not apply the principals of good complaint handling. They dismissed his case on the basis on clinical advice from a renal general surgeon.

*Report into privatisation by stealth, Eddie Chaloner, Vascular surgeon:* Routine operations for complaints such as varicose veins are being cut back to save the NHS money, leaving patients to suffer with an agonising condition or pay for expensive private treatment. It’s just privatisation by stealth, and once again, it’s the patient who suffers.

**Dee Speers**

Dee is a member of the PHSO Pressure Group and has been in the complaints system for almost ten years. She complains of numerous systematic failings in the complaints system:

- The CQC inherited the responsibility to “safeguard the interests of detained patients” from the Mental Health Act Commission (MHAC), which it fails to do.
- The Healthcare Commission Investigation Team was disbanded, despite her being given assurances regarding “continuity” when the CQC took over.
- She proposes a complaints pool where each trust pays in for independent investigations. Trusts that fail a local resolution would pay in substantially more.

**Peggy Banks**

Peggy started to suffer severe pain in her abdomen, coccyx, and legs subsequent to a routine smear test, causing her to be housebound. She filed a complaint of malpractice to the PHSO. During the investigation, she did not see anyone to discuss her problems with and was concerned about not being supplied with the name of the clinical advisor. She felt that the copy of the report that she received did not act on her behalf and that those responsible for her pain were being protected. The report did not seek information from the practice nurse who carried out the smear test, as she had left the practice, despite conceding that this would have been beneficial. Peggy also found that the PHSO report included information about an internal examination that had never happened. After several complaints about the use of false information, the investigator admitted fault, but stated they could not correct the report as it had been finalised.

Since joining the pressure group – PHSO the facts - Peggy has been in contact with many people with similar stories. She describes the system as wasteful in every way and suggests that there need to be a single tier, local system.

**Brenda Prentice**

Brenda’s son Andrew became ill with childhood hereditary pancreatitis, aged 15. Though he received good paediatric care, when transferred to adult wards, a senior doctor assumed that his pancreatitis was “alcohol induced”. The disease progressed to the point where his pancreas was removed aged 28 and was unable to digest a meal without intervention. Andrew’s illness caused a succession of events, first

*APPG for Patient and Public Involvement in Health and Social Care*

Complaints Handling in the NHS and Social Care sector
losing his job, then his wife, being made homeless, being taken in by his parents, and finally being moved to a hostel under the advice of a psychiatrist. After social services continually saying he did not have special needs, eventually Andrew was assessed for Continuing Health Care. The report said Andrew needed 24hr live in care as he was in danger of a catastrophic event. Ten months later he was not receiving this care and passed away.

After having a series of complaints rejected, Brenda went to the PHSO. She found a number of issues during this process:

- The Health Ombudsman colluded with authorities to find nothing wrong.
- They had taken advice from the wrong medical specialists.
- Miss-interpreted some evidence and ignored other evidence.
- Not reviewed decision only the methods of arriving at decision.
- Her complaint was upheld but they did not send it to CQC

A different joint complaint was upheld by PHSO and LGO and a remedy agreed by everyone that she should be paid £2500: a figure she is still yet to receive.

**Valentine Gal**

Valentine offers several general, systematic failures in the complaints system, including: poor timeliness, high turnaround of complaints-handling staff, protection of medical staff, a failure to learn from mistakes, and a lack of transparency. With regards specifically to the PHSO, she complains of: incompetence regarding time-scales, use of incorrect medical advisors, lack of responsiveness, and lack of impartiality. She also perceives the PHSO as a get-out-clause for first tier complaints systems.

She suggests that staff training should include role-play to engender greater empathy with those who go through the complaints system, more should be done to raise awareness of the poor treatment to whistle-blowers, and a named minister to have overall responsibility for complaints handling, who could step in and do something is PHSO lets people down, would be of benefit.

**Lindsay Jackson**

Lindsay’s brother is a paranoid schizophrenic, who lacked treatment for his condition. She filed three complaints, which failed to reach a satisfactory outcome. The third was halted due to the NHS trust requiring her brother’s consent for the investigation to be carried out. Due to the nature of schizophrenia, Lindsay’s brother denies his condition. As such, she was unable to follow the trust’s request. She then took up the complaint with the PHSO, who took two months to dismiss her complaint and stated too that they require her brother’s consent. At no time did the PHSO consult a mental health specialist.

Lindsay strongly believes that policies should take into account the inability or lack of willingness of mental health patients to make complaints about their own care, and that psychotic people should not necessarily have to give consent for an investigation when a relative expresses concern about their lack of treatment.

**Richard Von Abendorff**

Richard’s mother suffered a painful death due to a variety of errors and failings in palliative care. The NHS trust failed to address safety concerns, despite evidence of
major deficiencies in care from CQC, and the coroner. The PHSO also failed to investigate thoroughly and did not draw on adequate palliative expertise. Richard then commissioned an expert report, which was ignored by the NHS trust and PHSO. He then went on to present this report to the Royal College of Anaesthetists who took the report very seriously and it eventually reached NHS England Patient Safety who issued a patient safety alert to all trusts and CCGs. The fact that the PHSO refused to acknowledge Richard’s report indicates major failings in the PHSO’s lay investigator led process.

**Daniel McMorrow**
Daniel’s complaint regarded a violation of his personal data by a neurodisability service, where he was receiving therapy for meningitis. The service replied to a letter from his work, which he had expressly forbidden. He had complaints to Lewisham Safeguarding and CQC ignored, but a later investigation by CQC confirmed faults in the service’s handling of personal data. Despite this, a letter from the PHSO defended the actions of the service and said that they could not investigate his case. Daniel felt that the PHSO were too quick to defend the service and misrepresented his information. He also feels that a minister responsible for complaints handling would simply add another level of bureaucracy.

**Jill Mizen**
Jill’s complaint regarded the loss of medical information subsequent to the transferal of her notes from written to computerised form. This complicated diagnosis of a historical condition which has caused her to suffer a myriad of symptoms, including chronic fatigue. Jill believes that there is a systematic failure in the care of people diagnosed with Chronic Fatigue Syndrome who often have diverse symptoms. After failed complaints attempts at local level, Jill took her complaint to the PHSO. She found numerous shortfalls in their operating procedure, including: not using a relevant specialist for advice, only keeping records for two years, and not being a sufficiently independent authority. She suggests that face-to-face meetings at each stage of the complaints procedure would be beneficial, to ensure misunderstandings do not lead to a loss of trust; complainants should have the support of a clinical adviser from the beginning, who could help liaise between the complainant and the medical profession; and clinical/professional advisers to the PHSO should not have their names withheld.

**Colin N Rock**
Colin’s son suffered from psychosis/schizophrenia, for which he felt that his GP and Mental Health Trust (MHT) provided insufficient care. In five years that the services had been aware of the condition, nothing was prepared for crisis. Despite his concerns, Colin was unable to complain without his son’s permission. Ultimately, Colin’s son killed himself. He feels that if communication and support systems been in place at the GP and MHT, he would have been in a far better informed position. He filed a second complaint to the MHT suggesting that his son died in an avoidable manner. His complaint was passed to the PHSO, which lead to “despair and actual further distress”. He also felt that the PHSO fails to learn from its mistakes.

**Judith Gibbs**
Judith raised concerns about the governance in a Primary Care Trust (PCT) where she worked. Despite an official investigation was set up but ended soon after as the PCT was replaced. Out of desperation, due to the continuing lack of clinical
governance, dishonest recruitment practices and disregard for patients, Judith resigned her position. Judith alerted the PCT before she left and Public Concern at Work, as technically she was not ‘whistleblowing’. The Healthcare Commission (at the time) told her that there was validity in her claim but despite much correspondence nothing got changed.

**CCG & Trust responses**

**Southampton CCG**

Listening to the feedback from patients about the complaints system, it seemed that the new system was complicated and difficult to navigate and to know who to contact e.g. NHS England, Healthwatch, providers, CCGs etc. The CCG felt with the new legislation there is an inconsistency across providers in terms of time frames for responses.

Southampton CCG therefore took the decision to develop their own in-house complaints/Patient Experience Service where we are the first point of contact. The CCG has proactively provided complaints handling training with Continuing healthcare team and staff. They would like this added to trust inductions, the CCG have also introduced ‘share patient stories’ at Board level to develop a culture that takes the concerns of individuals seriously.

In order to support the complainant through the process the CCG offer all out patients/service users a one to one meeting should they require further information about the complaints process and to discuss their complaint further. The CCG also felt that SEAP is less effective than ICAS.

Examples of best practice, included were Southampton CCGs own Patient Experience Service that was developed with patients and actively promoted. The service have produced user friendly leaflets along with an easy-read document for learning disabilities clients.

The CCG act as a first point of contact and liaise with other organisations should the patient have contacted the incorrect organisation.

The CCG encourage patients to share stories at board level should they wish and CCG runs a communications and engagement group, where patients and representatives can also raise patient concerns for the CCG to investigate.

The Patient Experience Service is currently carrying out an evaluation of the first year to ensure continuous improvement.

Learning is shared through regular network meetings take place but also feel that this should be supported at a national level to ensure this happens.

Southampton CCG has currently had no dealings with the PHSO.

Looking forward Southampton CCG felt that there were too many organisations and that their patient feedback confirms that it would be better if there was a single point of contact.

**Somerset CCG**

The Somerset CCG understand that they are accountable to the population of Somerset for the delivery of high quality health care and complaints handling is an important part of this.

**APPG for Patient and Public Involvement in Health and Social Care**

Complaints Handling in the NHS and Social Care sector
We felt it was vital that complaints are investigated locally as the local services and the Clinical Commissioning Group (CCG) have easy access to resources and knowledge of local healthcare. They maintain that the provider should remain responsible for handling their own complaints. It also makes the service provider accountable for their own failing and for the improvements required to services in response to the complaint. When there is a complex complaint across a range of services, the CCG takes the lead in coordinating the complaint across services and as commissioner they are in a position to be able to oversee the lessons learned and improvements to health services through their quality monitoring arrangements with the local NHS providers.

In Somerset we have good networking with the Complaints Managers in all of our NHS providers to handle multi-agency complaints and local providers work together in responding to complaints. This is achieved through quarterly Complaints Managers Network Meeting and a joint protocol for handling complaints involving more than one provider.

The division between NHSE leading for primary care and the CCG's secondary care is difficult for patients and staff to understand and makes multi-agency complaints involving primary care extremely difficult to manage and adds an additional time burden to get responses out.

Somerset CCG as Commissioners has led, with the support of the Patients Association, Training and Peer Review Panels and events which included the CCG and our local NHS trusts and NHS Treatment Centre. This helped develop a shared understanding of the Patients Association Standards for complaints handling. It was really beneficial for the Trusts to be involved in the improvement journey together.

Somerset CCG train staff at induction to understand and assist with responding to their complaints handling process and involve and encourage staff to understand the concerns raised by people about the services commissioned. The CCG ensures that complaints are everybody's business and all commissioning managers need to be able to investigate complaints for their area of responsibility.

At Somerset CCG the Director of Quality, Safety and Governance, has been instrumental in the way she has led the system to value the concerns raised by individuals and to understand and learn by them. The Managing Director and Chairman equally regard complaints as an important source of feedback and are thorough when signing off complaints in making sure all the complainants concerns have been addressed. This is transformative in the way other leaders across Somerset regard complaints. The role of the Governing Body / Trust Board and senior managers should be to do likewise to ensure this culture is shared across the organisation. Ensuring that the CCG Governing Body and Governance Committee receive detailed complaints reports that include a summary of each complaint and the key themes arising from complaints to inform commissioning. At the CCG Governing Body have used a patient story about challenges in using the Choose and Book System to inform improvements to the commissioning of the elective care pathway. The patient story raised the awareness of the Governing Body members of the importance of driving improvements across in this pathway.

Somerset CCG believes that the single most effective way of supporting complainants is to make early personal contact with complainants to gain an understanding of what they want to get out of their complaint and to assess their needs along with the level of support they require. Patients in Somerset have the autonomy and flexibility to tailor support to the individual's needs. This includes the involvement of CCG staff and experts to assist in providing independent explanations to the complainant. This is in addition to any advocacy provided by ICAS.

**APPG for Patient and Public Involvement in Health and Social Care**

Complaints Handling in the NHS and Social Care sector
In terms of examples, guidance and standards of best practice, The Patients Association Standards for complaints handling in recent years has been Somerset CCGs overarching framework for complaints handling and their commissioned NHS providers.

The CCG actively reviews all national reports and recommendations and incorporate them into their Complaints Handling Improvement Programme. The CCG has an agreed joint protocol with their commissioner providers on how we will handle complaints that involve multiagency complaints. Somerset CCG has implemented the Patients Association Standards across the county and through the Somerset wide Complaints Managers Network which meets formally several times a year. The CCG has also included compliance with Patients Association Standards and participation in county wide peer review into the contracts with all of our NHS Providers in Somerset.

Somerset CCGs views on the effectiveness of the NHS’s current approach to handling and investigating complaints at second stage suggested that it is helpful to have the option for complaints at first stage to go to the Commissioner rather than provider where the complainant does not feel confident to complain directly to the provider service. The CCG have also commissioned independent investigation of complaints on behalf of NHS Trusts where either the complexity of the complaint or the nature of the complaint particularly where it relates to serious concerns about fundamental standards of care indicate that a greater level of independence in the investigation is required.

Their experience with the PHSO has been positive and in their view, complainants that have used the PHSO have found it to investigate and respond appropriately. The CCG found it useful to have final adjudication that sits outside the local health economy.

In terms of sharing learning, the CCG considered the process that Somerset is using i.e. The Patients Association Standards to support training and peer review is a useful model, and one that could be adopted by other health communities. The Somerset model of complaints managers in more than one organisation, including social care, coming together in a network provides valuable support and learning for complaints managers and their staff. The use of ongoing peer review of complaints handling each year involving all NHS providers assists in disseminating learning and sharing best practice.

When engaging with the complainant the CCG continually considers the complaint cases they handle as an opportunity for asking them to become involved with presenting their experience as part of their improvement work programme. The CCG has no formal process for this as it can happen in a number of ways, from patient stories at Board Meetings to asking patients to become involved in service developments.

Somerset CCG recognise the quality of response from providers can be defensive and not always answers the questions and concerns raised by the complainant, but feel the best place to carry out investigation is with the provider of the services. The CCG do not believe it is necessary or helpful to employ a single investigating body, but there should be some other remedy for challenging Providers responses before they reach the complainant. There is also recognition that the Chief Executive or Director signs off the complaint responses within provider organisations and this has not always remedied the problem. The CCG suggests the involvement of a lay representative in the review of draft responses for comment and sense checking.

The CCG would support the appointment of a named minister who would have overall responsibility for complaints handling. The minister should ensure that action is taken at leadership level to set examples and encourage a more open and supportive culture.
Somerset CCG understand the concerns raised by people who find it difficult to understand who to complain to, as it is even confusing for NHS staff. They have considered options for central submission of complaints either nationally or locally but find this proposal difficult to reconcile with an additional layer of complaints handling leading to further hand-offs, delays and additional resource requirement. The CCG suggest that the solution may be to advise complainants to seek advice from local Health watch if they don’t know who to complain to.

Chorley South Ribble and Greater Preston CCGs

Chorley South Ribble and Greater Preston CCGs understands that the NHS constitution clearly sets out patients’ rights in respect of complaints; however, different NHS organisations often take different approaches to handling and investigating complaints, particularly in relation to the timescales of responses. Having one standard, consistent approach to timescales, language, messages and communication accessibility would make the complaints process a lot easier and clearer for patients, particularly as a patient may often have to deal with more than one organisation to gain responses.

In terms of what Works well:

• Each NHS organisation has its own complaints department

Not so well:

• Customer care can be fragmented across organisations

• There can be multiple teams within an organisation dealing with customer care

• There is not enough joined-up working between organisations, including collaboration and appropriate signposting to patients – this is something that Chorley South Ribble and Greater Preston CCGs is very committed to doing – they suggest it is important to help patients navigate the system even if we cannot deal with their complaint

• There is not enough joined-up intelligence to capture themes and trends

• There is no mediation support to improve local resolutions

• Complaints handling can sometimes be ‘template’-based, rather than individual, tailored and bespoke

• There can be a lack of understanding amongst wider NHS staff of the importance of the complaints process, particularly in relation to its use as a positive tool for service and patient experience improvements. Chorley South Ribble and Greater Preston CCGs made changes to their customer care service to tackle all of these issues.

The CCGs promote learning and development. Their relatively new customer care team:

• Has undertaken accredited FOI training

• Has undertaken conflict resolution training

• Has attended Equality and Diversity workshops to understand the needs of our diverse communities

• Keeps up to date with national and local legislation
• Shadows CCG colleagues to gain an understanding of how service are commissioned/monitored

• Takes part in provider quality visits with our quality team

• Has pro-actively met with provider counterparts to build up a working relationship in order to improve communication and subsequently make the complaints process run more efficiently

• Has undertaken CSE training

• Is working with the local advocacy service to develop advocacy training across the local economy

• Has regular meetings planned with our local Healthwatch in order to identify issues and themes that are reported to them

• Records issues raised via external engagement in order as part of the data triangulation work

Furthermore, the CCGs are taking lead role to refresh a Lancashire-wide joint complaints protocol, which aims to make the complaints process easier and more effective for patients, setting out clear responsibilities for all organisations.

In order to improve complaints handling, Chorley South Ribble CCG and Greater Preston CCG would like to see a more joined-up approach to training across all NHS commissioning and providing organisations to facilitate a more consistent approach to handling complaints.

Complaints and customer care-related training usually takes place in London. To make this training more accessible for complaints and customer care staff in the North of England, the CCGs would welcome more local training opportunities. They suggested a national online training programme could be developed that sets out the minimum requirements for complaints and customer care staff. Furthermore, this could be delivered at different levels such as basic, intermediate, and advanced, with organisations receiving a quality mark after completion. This will identify to what level an individual organisation is trained to.

A dedicated helpline for complaints and customer care staff would also be helpful for customer care (and wider) staff to have access to information and advice quickly. Time can be of the essence, particularly if we receive a call from a particularly anxious or upset patient.

In terms of the roles of the Board and managers to develop a culture that takes complaints seriously, regular reporting in relation to complaints handling statistics, themes and evidence of how improvements have been made should be embedded into organisational governance. Chorley South Ribble CCG and Greater Preston CCG report this information into a Quality and Improvement Committee, which in turn provides assurance on those areas to the Governing Bodies.

All board members and senior managers should act as champions for both the processes, and the benefits that receiving complaints can bring. For example, there should not be a culture of fear at getting ‘too many complaints’. An increase in complaint numbers can often be viewed as a negative indication that ‘too many things are going wrong’, rather than with the positive view that more people know how to complain, patients feel able to come forward without fear of reprisal, and that more information can lead to even more service improvements.
Boards, Governing Bodies and staff teams should, wherever, use patient stories throughout its activity to ensure that they are continually reminded of why and how they can make things better for the populations and communities they serve.

When supporting a complainant the CCGs suggested that organisations should be aware of the different kinds of advocacy that is available locally and promote this widely to patients and members of the public. Training should be available for all staff working in the customer care and complaints field.

Patient information should clearly set out how patients and members of the public can raise an issue or make a complaint, and be distributed widely using different methods.

Chorley South Ribble and Greater Preston CCGs disseminate information:

• Promote access to the local advocacy services via websites
• Have developed a patient leaflet that has been tested with patients and provides information on how and where to make a complaint to and gives the contact details of key partners
• Are working with the local authority to develop and deliver advocacy training for customer care and complaints staff.

Examples and guidance of best practice in Chorley South Ribble CCG and Greater Preston CCG (which have a joint management and staff team) include bringing its customer care service in-house in an effort to be more patient-centred and improve quality. Prior to this, the service was provided directly to patients by the local Commissioning Support Unit, while it was outsourced, all elements of customer care were dealt with by different teams making the service fragmented and confusing for patients, and staff.

A patient-centred customer care service was designed that would:

• Bring all elements of customer care into one team
• Have a dedicated landline number to enable a single point of contact
• Enable the CCGs to triangulate data and share with quality, contracting and performance teams
• Improve access for patients by giving them an ability to contact us via telephone, email, via websites or through social media

Because this was a new service very different to what was in place, the CCGs were able to recruit to a new team that as well as dealing with complaints took on a ‘PALS’ (Patient Advice and Liaison) function, handles concerns, enquiries, MP letters and FOI (Freedom of Information) requests. New processes were developed that clearly set out pathways for each element of customer care, including timescales and ‘hand-offs’. Interim processes were developed for a transition period, and have been refined as the service has been embedded into the CCGs, taking the learning from hands-on day-to-day delivery.

Having all elements of customer care in one place, the service is delivering a quick turnaround of enquires, complaints, responses to MP letters and FOI requests. Patients are giving positive feedback to the service, and in some cases, we have been able to prevent escalation to a formal complaint by providing early resolutions for the patient.
Having an in-house service is enabled better control of all complaints-related data, and allows them to share in real time some of the themes and trends that can be addressed through contract reviews and quality visits.

Additionally, complainants are encouraged to get involved with the CCGs by joining the online patient network, patient groups and any related service re-design activity or procurements we may be undertaking.

Chorley South Ribble CCG and Greater Preston CCG suggested that they did not have enough experience of dealing with any second stage complaints directly, to be able to give a view on this or the PHSO.

In relation to what works well in a complaints handling process:

- Resourced online network
- Online resources in one place (dedicated user website accessible via pin code)
- Standardised training packages
- Publication of case studies and patient stories
- Annual conference
- More regionally-based activity, outside of London

Examples of engaging with the complainant include:

- Person-centred customer care service implemented 1 September 2014
- New standard operating procedure, including service level agreements, for complaints handling – i.e. our local commitment to patients and colleagues regarding complaints
- Dedicated point of contact for the patients
- Regular contact with the complainant, especially if there are delays
- Offering opportunities to involve the complainant in other/ ongoing CCG activity
- Involving patients in the development of patient information on ‘how to complain’
- Encouraging the complainant to ‘tell their story’

Additionally, we believe that the key is to provide good guidance, reduce fragmentation and variation, and provide helpful support and enablers, rather than adding further politically-motivated pressure, and potentially targets, into the process.

When looking at the role of the PHSO the CCG felt that, potentially, more bodies and regulatory organisations and teams could make what is already a complex place to navigate, even more difficult and confusing for patients and NHS staff teams involved in the arena of complaints.

The CCGs suggest that the primary focus should be to improve at its heart the PHSO.
West Berkshire CCGs (Newbury & District, North & West Reading, South Reading and Wokingham)

The joint written evidence from the 4 West Berkshire CCGs is outlined below:

On the three groups outlined in your letter:

On ‘Complaints at a local level’: although considerable information is available to patient/families in hospitals, community clinics, GP Practices and on related websites, including those of the four CCGs and Health Watch, there is still confusion for patients about where they should address their concerns. I have attached the flyer we have produced locally to clarify this. In some cases there is a reluctance to complain directly to the provider. Increasingly we receive complex complaints about a whole pathway of care involving a number of providers. In these situations the CCG can provide a “catch all” arrangement and oversee the total investigation. This can be a complex and lengthy process.

While the CCGs take the necessary action to investigate complaints received about the quality of commissioned services, particularly where patients and their families are reluctant, for whatever reason, to address their complaint to the provider organisation, it is preferable that the provider organisation be given the opportunity to carry out the initial investigation – in line with the PHSO approach to ‘local resolution’.

When receiving a complaint about the quality of provider services one of the CCGs’ first steps is to contact the provider (with the consent of the complainant) to ask the provider to carry out an investigation and provide the CCGs with a written response on the outcome of the investigation. Complainants do not always understand that the CCGs do not hold patient records and that CCGs are obliged to contact the service provider to request an investigation. The matter of seeking consent from the complainant can delay the process by several days, if not weeks, and in the past there have been cases where following the request from the CCGs for the complainant to complete a consent form (especially where the complainant is not the patient) no further communication has been received from the complainant.

We are concerned that this process may be daunting to patients and that we are missing an opportunity to learn from their feedback.

On ‘Complaints at second stage’: The right for complainants to take their complaint to the PHSO is well recognised. And, where there are serious complaints surrounding the care and treatment of patients in a hospital or community setting, the PHSO remains the appropriate body to which to direct such complaints. However, given the increasing number of complaints from families and their legal advisers surrounding requests for retrospective reimbursement of continuing care costs a separate process/dedicated resource for this could be considered.

With regard to the “Going Forward” section of your letter we would be concerned about the establishment of a single national body to investigate complaints. This could result in a disconnect between the outcome and learning from complaints for the local system. Local people with knowledge of the local system are better placed to handle the patient facing aspect of complaints handling.

Instead we would suggest that NHS bodies report on the learning from complaints though their quality accounts and that this is collected at a national level and disseminated for wider adoption.

In closing, I would add that, while written communication is important in complaints handling, experience has shown that in the majority of cases, personal communication – whether by telephone or in person with complainants is as, if not more, effective in engaging complainants in the complaints handling process.
The London Ambulance service

As a pan-London Trust and based on their experience, without central coordination, it is problematic to encourage best case management practice or analyse emerging trends. Local staff may not have access to case management systems or have any expertise with complaints procedure of regulatory obligations. That does not mean that all staff cannot act as a PAL (c/f Supporting the Implementation of PALS, DH, 2002)

What works well in a complaints handling system:

The 2009 Regulations were the most ambitious attempt to reform the complaint procedure, especially in combining health and social care. However, the application is still mostly NHS focused with social care operating a historically different methodology and process to that practiced by the NHS. Although a laudable intention, the ‘hosting’ regulations do not often enable a joined-up response as the host Trust is under too much pressure to conform to its own response targets, which means the other agencies involved tend to write to the complainant separately, in direct converse to the purpose of the regulation.

Again whilst a laudable intention, as the regulations no longer close down a complaint where legal action is intended, this is exploited by solicitors so they can use the complaints procedure to approach the Ombudsman as a way of finding out if there is a case to answer at absolutely no cost. There is a concomitant increase in this type of approach which is not consistent with the objective of achieving learning.

What does not work well:

Contracting advocacy services on a tender basis has not enabled continuity or quality of service provision.

Complainant expectations are often unrealistic about what can be achieved. In their experience, many complaints are driven by bereavement and much time and effort is used when there was no service failure or injustice identified. Similarly, complaints from patients with mental health problems are often influenced by their illness but involve disproportionate time and effort. It is also impossible to believe that how the complaint will be managed can be decided in liaison with complainant in each case. This can also conflict with the regulations given statutory obligations. Finally, many local resolution meetings are incredibly resource and time intensive, often for very little added value or outcome.

There continues to be a tension between achieving a quality response and the overly simplistic performance measure of speed of throughput. This is however an organisational rather than departmental issue as throughput can depend on other departments with the Trust, for example clinical opinions, Quality Assurance reports (the evaluation of the management of a 999 call) etc.

Very few Trusts interpret the regulations in the same way and methodology, recording and even the categorizations used vary immensely. This makes benchmarking effectively unhelpful, as it does not compare the same things.

Although commendable in many ways Francis presents a lawyer’s view of complaints management, for example in the simplistic notion of ‘upheld’ against ‘not upheld’. This simply does not apply to the much more complex nature of emergency care where a delay in
responding to lower acuity patients can be caused by high demand and prioritisation to patients deemed to be immediately life-threatened.

Francis, Clywd et al have prompted a veritable industry in the assumption that the most unfortunate practice by a handful of Trusts is prevalent across the NHS. This tars every Trust with the same brush whilst there is no evidence to support this view.

In relation to training, The Making Experience Counts programme envisaged the establishment of national vocational training but that has not become a reality. The LAS would like to see this revamped. The LAS complaints staff receive collective and individual training geared to their personal development. This included seminars to discuss developments, e.g. Francis, Clywd, and Kirkup. Network discussion is another valuable mechanism for discussion and sharing of best practice.

In reality, change is often driven by multiple and sometimes triangulated drivers, not simply complaints alone (e.g. issues already identified by the Trust, which may also be the subject of a Coroner’s PFD decision or an Ombudsman decision). Paradigm theory often applies here where the body of evidence eventually over turns the existing belief.

To help change the culture in order to take complaints more seriously, Reg 4 intended to support visibility but PALS has largely dropped off the radar and needs to be highlighted. One contributory way of achieving the intended objective would be for CEOs to be obliged to directly line manage complaints managers and complaints and PALS be adopted as a regular standing item at senior management and Trust Board meetings.

The main problem is having sufficient resources to keep complainants informed of progress, a very important consideration within complaints management.

The advocacy tendering process has caused confusion and inconsistency. Advocacy services it was suggested, should have a defined local structure, funded by central government. A national training programme should be introduced.

To support complainants, the LAS have long adhered to the Ombudsman’s principles of complaints handling, administration and remedy and would very much recommend these as best practice guidelines.

The focus of reports tends to focus on acute Trusts, which means that other NHS (and social care) services have tended to be compelled to adopt practice recommendations that simply do not fit their service (especially ambulance Trusts). One size does not fit all in this respect but the 2009 regulations were designed to enable maximum flexibility.

The LAS believed it was sensible to remove the historic second tier (Independent Review Boards, the Health Service Commission) which did not add very much of value.

The LAS felt that the triage by the Ombudsman’s office is usually very thorough. The improvements in developing relationships with NHS Trusts and greater contact with complainants are helpful initiatives.

LAS think the current complaints system is mostly effective and feel the Ombudsman’s office, although not perfect, has been unfairly criticized. The LAS have been encouraged by the Ombudsman’s changes in practice, especially in working more closely with Trusts to develop a better working relationship, rather than an adversarial approach, which can only help promote a patient-centred way of working.
The PHSO could more effective by the creation of a national central repository according to sectors (acute trust, primary care, social care, pre-hospital emergency care) would be helpful.

In relation to best practice and engagement, the LAS believed it is mostly a question of keeping the complainant informed – and having the resources to do that. They felt public have very little insight into how pre-hospital emergency care (999 system) works and many complaints are driven by this and unrealistic expectations. Citizenship in schools may be beneficial here.

The LAS felt strongly that establishment of a new single investigation body at the Department of Health is not necessary to improve the complaints handling process. They suggested the lesson of history is that such a quango would muddy the waters. Despite there being more information available than ever about how to access the complaints procedure, complainants already approach MPs, CQC etc. who have no ostensible role in the complaints procedure and whilst it is naturally within the complainant’s right to do so, this prompts more administrative effort without actually achieving very much of value. The Ombudsman’s office are fully capable of leading measures to improve understanding of the complaints process and most importantly, what can and cannot be achieved.

The LAS no strong view on the appointment of a named minister who would have overall responsibility for complaints handling. However, this is not considered necessary for any other sector (e.g. the financial sector) so it is not apparent why the NHS and social care should be an exception.

The LAS policy was also highlighted by ICAS as the best they had seen across the NHS and we would be most happy to further discuss the unique position of ambulance Trusts.

Summary of oral evidence

The first oral evidence session took place on the 17th June 2015: Room Q, Portcullis House, Westminster 10am-12pm. A summary of the oral response is given below.

List of Contributors:

Oral Evidence was heard from the following:

1. Maggie Brooks
2. Nic Hart
3. Stephen Stent
4. Donna Devenney
5. Ita Cadogan
6. Richard von Abendorff

Maggie Brooks

- First brought a complaint 5 years ago – 5 days after her mother’s death
Problems: patient should have gone to the ITU earlier but there was an unexplained delay, death certificate was not accurately filled out

Talked to the doctor, explained that the family wanted a post mortem but were dismissed – said it had already been signed off for the coroner

Took 6 months to gain access to the patient’s medical records, when access was granted there was missing information

Local resolution: dragged on for 6 months – felt that this was to delay them so that they would run out of time to appeal to the Ombudsman
  o At the local resolution meeting the minutes were taken by the barrister – unrepresentative of the meeting

Ombudsman:
  o Draft report was released after one year
  o ‘appalled’ by the draft report: it contained no fresh information or statements, merely summarised the records provided by the trust – no investigation of other questions or issues raised
  o Painful for the family to have to go through the medical records again – some information was withheld by the trust or had been replaced by older information
  o Despite this the report was published without amendments

Want a review of the ombudsman – permission granted but the Trust withheld records and witnesses from the coroner, argued that too much time had passed since the incident

The complaints service was ‘destructive and damaging’, traumatic, took over 5 years of their lives

Recommendations:
  o Complaints should be taken out of the hands of the Trust and Ombudsman
  o Records should be sealed after the incident

3 key problems:
  o Appalling treatment (not disputed)
  o Primary complaints procedure: person was a barrister, very defensive, primarily seemed concerned to defend the trust rather than listen to patients
  o Ombudsman process took place without relevant documents – Trust was effectively in control of the process as they had control of whether to grant access

Problem: concluded the PHSO report should be reviewed – argued that it should be taken out of circulation once this was decided, should not have been used as evidence in the inquest

Cover up: patient’s condition was missing from the records, other incorrect information was added

Nic Hart

Daughter had anorexia: spent 10 months in good care in a specialist hospital unit but discharged too early, transition to secondary care at her university was badly handled
  o Handover was delayed; community involvement did not begin for weeks, secondary care was in disarray, short-staffed
  o Only person she saw in community care was a psychologist – no medical training or experience of anorexia, was in control of weighing (therefore no longer being done by medical staff)
  o Several weekly tests should have been carried out but very few were done
o Ended up in a worse condition than before her 10 months in hospital — went back to hospital but the staff were clearly not trained in dealing with anorexia; allowed her to walk around the ward, did not put her on a drip (relied on her feeding herself)
• Mental health services were never involved — patients was never sectioned therefore medical staff did not give her glucose when they could have done (still needed her consent)
• Critical/decisive failure: initial discharge of the patient when she was still high risk and transfer to inadequate community care
  o Initial treatment was good but stopped too soon
  o Could have worked if there was good communication in transition to secondary care
• Complaints procedure:
  o Trust concluded that all care had been ‘satisfactory’
  o Cover-up: evidence from email that the Trust was trying to prevent the story coming out and prevent them from going to the PHSO
• Recommendations:
  o Complaints process should be external
  o Need better access to medical records (took parents 18 months to access them)

Baroness Masham: most important thing is communication

Stephen Stent

• 20 year old son took his own life — suffered from anxiety and depression, which was exacerbated by drug abuse (primarily ketamine)
• He was admitted to hospital but there was disagreement among doctors over whether to section him under the Mental Health Act — decided not to section him but to keep him on the ward, he dies 2 days after being discharged
• Talked to hospital staff to establish what happened — they were helpful at first until he became more questioning, then they stopped replying to his emails, no one would take responsibility
• Investigator was appointed
  o Assured that she would be independent and conduct a thorough report
  o Turned out to be employed by the Trust and lacked experience
  o Investigator was appointed 2 months after the complaint — inconsistent with Trust policy
  o Took a long time to access medical records, took 3 months to draft the report — coroner could not hear the inquest until the report was finalised
• Coroner’s Rule 43 letter July 2013: condemned deficiencies in care but recommendations are unenforceable
  o Coroner has no duty to continue involvement in a case
• Met with the Justice Secretary — he agreed that there were serious weaknesses in coroners’ power and agreed to start exploratory work into how to improve coroners’ powers
• PHSO:
  o Delayed enquiries — only confirmed that the case had been referred to an investigator after 2 months
said they could not investigate as the mental health practitioners who decided whether the patients should be sectioned were employees of local government, not the NHS – recommended complaining to the CQC.

This issue was taken to the Local government Ombudsman – never received a response.

Case was referred to complex investigations within the PHSO 9 months after initial referral.

PHSO concluded their report without information/investigation of the mental health practitioners’ decision not to section the patient.

John Pugh: surprised, seems inappropriate to have to take the case to local government because of a technicality.

- There was no named doctor in charge of the patient’s care – only had the name of the head of the ward.
- Under the MHA 1983: if 2 doctors disagree over whether someone should be sectioned, can ask the opinion of a third doctor – relevant practitioners are not aware of this.

John Pugh: key themes: lack of evidence, delays, seemingly impenetrable system.

- Everyone is saying what they ought to be doing but not doing it – not being checked by anyone.
- Trust is investigating itself.
- Report: lack of evidence, incomplete, no consultation with the patient’s parents or their lawyers.
- Thought that ending the inquest should bring closure but the whole thing was reopened by the independent forensic psychologist who then reached a different conclusion.

Baroness Masham: communication between professionals and family members is difficult because of confidentiality rules – blocking the family from helping.

Donna Devenney

- A&E:
  - 4 hour delay to see doctor, he did not disclose what treatment would be provided, sent nurse.
  - Nurse arrived: no introduction or name badge, patient told her of a previous reaction she had to the drug, nurse injected anyway and the patient had an immediate, very painful reaction.
  - Patient repeatedly told the nurse to stop, doctor came over when he heard the screams – after a quick chat with the nurse he instructed her to continue with the injection.
  - Reaction to the drug was not recorded.
- Contacted the Trust soon afterwards to complain – felt they were trying to cover it up, repeatedly apologised, said the mistake would not be repeated, tried to stop her from taking further action.
- Formal apology was issued 2 months later: only change was that all nurses would now be required to wear name badges.
  - Did not address the main issue of consent – no apology from the specific nurse and the letter contained false statements about her behaviour.
  - Trust tried to justify the behaviour on the grounds that only a very small amount of the drug was given – irrelevant as there was no consent.

APPG for Patient and Public Involvement in Health and Social Care

Complaints Handling in the NHS and Social Care sector.
o Nurse was named on the formal apology letter but when the patient checked the register she could not find the nurse
o Trust tried to blame the patient for not co-operating with treatment

- Trust said they could not investigate the actions of the nurse because she was an agency nurse
  o Asked the CQC but they confirmed that agency nurses are employed by the Trusts

- Complaints procedure:
  o ‘naïve’ – repeated by many of the patient representatives, described themselves as naïve for believing that the complaints process would help them
  o Should be more ‘compassionate and empathetic’
  o ‘inadequate’
  o Not independent – very defensive, cover-up
  o Caused more distress

- Major problem: not acknowledging/taking responsibility for actions – would solve/avoid many problems by just doing this
  o Trust said that the nurse’s behaviour was unacceptable but they moved her elsewhere

Baroness Masham: need openness and accountability, sorry gets ‘dragged out’ of them after long delays

Ita Cadogen

- Agreed procedure for her operation: doctor agreed to put her to sleep before injecting her, very difficult and painful to access her veins to provide anaesthetic injection
- Procedure was not followed:
  o Patient was left dehydrated, did not see a doctor for 90 minutes, doctor said she was hypoglycaemic but instructed nurses not to check her obs as she was not diabetic
  o Patient was left in this condition for 4 hours before being taken for anaesthetic – Dr immediately injected her with a loaded needle and ignored her screams to stop (lack of consent)
- Trust refused to tell her who the anaesthetist was
  o Patient was ‘traumatised’
  o Patient subsequently suffered from PTSD – told that her recovery largely depends on finding out what happened
  o Lost trust in the medical profession
  o Complained within a few hours: blocked several times over the next 7 months
  o Trust confirmed that her records were not completed

- Complaint reached to Deputy Director – apologised and made promises:
  o The patient would receive a kidney check
  o Patient would be granted access to her medical records
  o Doctors involved would be identified and brought to a meeting

- No record of who the anaesthetist was – unwillingness to identify them (no other reason why the information would be unavailable)
- Referred to the PHSO in February 2015, not yet received a reply
- Recommend: explanation on the day of the operation as to what happened and why – could have been explained
• The Trust mentioned evidence which they could only have got from the medical records but when the patient received the records these sections were missing – clearly not lost
• Key issues:
  o Access to medical records
  o Incomplete records e.g. deleted emails
• Freedom of Information requests shed no light on these gaps

Richard von Abendorff

• Key problems (in mother’s palliative care):
  o Lack of specialist palliative care
  o Breach of her rights under the Mental Capacity Act
  o Safety issues were not addressed
• Lots of apologies were issued but not investigation of what happened and why
• PHSO conducting 3rd investigation currently – previously concluded that there were no problems
• CQC report on palliative care was ignored – it acknowledges all of the same problems that arose here
• Not reassured that the same would not happen again
• Recommendations:
  o Hospitals should be open to real scrutiny
  o Should investigate problems – damage limitation
  o Safety incidents must be uncovered
• Key recommendations:
  o Proper investigation – including listening to patients and their families
  o Examine harm and its causes
  o Action plan for change – currently even where there is an action plan everyone ‘passes the buck’ e.g. Rule 43 coroners letter
• Need to ask not how things are wrong but why
• Important requirements:
  o Adequate expertise
    ▪ Currently only exists within the system – others are not medical experts e.g. within the PHSO and Healthwatch
    ▪ Need specialist clinicians, risk assessment experts and system change experts
  o Real accountability
    ▪ Communication problems – doctors are experts therefore they quickly understand problems, PHSO take longer to understand
    ▪ Safety issues have serious financial repercussions
    ▪ Need apologies for everything that goes wrong
  o Independence
    ▪ Patients and their families are part of this
    ▪ Need more powerful independent expert bodies
    ▪ Importance of whistleblowers within the system
• Trust committees should have patient representatives but in practice they do not
• No improvement in end of life care since 2008
  o Acknowledged by the National Audit Office
  o Need independent experts to uncover why this is
• Problem with the Mental Capacity Act – no-one knows how to implement it, breaches patients’ right to consent

John Pugh: cannot design the perfect solution without acknowledging financial costs

Nic Hart: in his case the Trust spent more money on legal costs than they would have done on treatment

Richard von Abendorff: we spend for an inadequate system

Baroness Masham: honesty would save lots of money that is currently spent on lawyers

Stephen Stent: spent lots of money to expose the problems – no results, no lessons learned, there were other suicides in the same hospital during the same year

Richard von Abendorff: Trust acknowledged that they were under staffed and under resourced – unsafe care, hospitals should close if they cannot provide safe care, should not run if they are unsafe

Stephen Stent: no accountability/reasons for them to get it right

Donna Devenney: complaints procedure should represent the patients, currently it is too defensive

Richard von Abendorff: difference between what Trusts provide and what they want to provide – the worst thing is when they try to cover up mistakes

Katherine Murphy: regulators’ actions plans are meaningless – satisfies them but no-one checks them therefore there is no accountability, breach of their fundamental duty of care

Richard von Abendorff: compare to aircraft disaster – would not appoint a lay committee to conclude what went wrong and why

John Pugh: biggest problem is obstetrics – cannot close maternity care even if it is unsafe, facilities are needed

Stephen Stent: compare to the German Wings case – quick investigation, soon led to widespread requirement that at 2 people must be in the cockpit at all times, even here there were problems of confidentiality as the doctors knew of the co-pilot’s mental health problems but could not disclose this information to his employer

Katherine Murphy: everyone acknowledges that there are problems in the complaints process, why has there been no change? Would like an opportunity for the helpline patients/representatives to present their stories and their views in the House of Commons

Baroness Masham: the patient voice is getting stronger

7. Conclusions

This APPG heard evidence from patients and their loved ones who had encountered a negative, inappropriate and defensive response to their critical concerns at a time when they felt most vulnerable or in grief.

7.1 Communication

The APPG heard that many of the issues and concerns could have been better dealt with if there was clear communication between the complaints handling teams and...
the patients or relatives. There were concerns that communication was ‘one way’ and that any request for information were either ‘blocked’ or not acted on. Responses were often defensive and late which often gave rise to anxiety as the patients and their relatives felt delays were deliberate.

7.2 Transparency
There was significant concerns as to the transparency of the complaints and the subsequent investigations. Alarmingly, oral evidence suggested that medical records seemed to be tampered, conditions were missing, emails deleted and that incorrect information being added. There was an overall feeling of ‘collusion’ between the agencies used including and up to the PHSO. Patients also suggested that they felt ambushed, particularly at local resolution in one case were the Trusts minutes were being taken by a barrister.

7.3 Accountability
There were ‘blurred lines’ of accountability in the organisational complaints handling systems. There was a massive reluctance in admitting any mistakes or even oversights that would have been very helpful. Health professionals should also be easily identifiable and their employer accountable for any malpractice, particularly where consent has been withdrawn. Many of those who gave evidence suggested that an initial ‘apology’ would have been a good start, particularly when the evidence of a mistake/oversight was overwhelming.

7.4 Independence
Many of the people who gave evidence felt that an independent external body, that champions patients should be handling complaints. An external independent complaints body will, as many expressed, help in preventing collusions and potential ‘cover ups’. This external independent complaints body should be empowered to seek immediate redress or apology where they find evidence of negation of the Patients’ rights. Training in The Mental Capacity Act would help where there seem to be confusion as to the ‘right to consent’.

Next Steps

This report will be shared with all those who provided evidence to the inquiry, as well as with the members of the APPG for Patient and Public Involvement in Health and Social Care. In addition, the report will be made available to patients and the public via the Patients Association website.

The APPG will closely monitor any implementation of the concerns raised. As the secretariat for the APPG, the Patients Association will continue to record and analyse concerns raised by its members and information received via its Helpline.

A future with healthcare sector stakeholder and regulators is planned later this year. The APPG can then decide whether to take any further action.

**APPG for Patient and Public Involvement in Health and Social Care**
Complaints Handling in the NHS and Social Care sector