Parliamentary and Health Service Ombudsman

Complaints about the NHS in England: Quarter 4 2018-19

Contents

Our role

We make final decisions on complaints that have not been resolved by the NHS in England and UK government departments, and some other UK public organisations. We do this independently and impartially.

We are an independent public ombudsman service. We are not part of government, the NHS in England or a regulator. We are neither a consumer champion nor an advocacy service.

The purpose of this report

This report presents statistics on complaints about the NHS in England from January to March 2019 (Quarter 4 2018-19). It includes data about the NHS complaints we received, assessed and investigated during this period.

We have not presented the quarterly data on complaints about UK government departments and other organisations we investigated due to the relatively lower volumes involved, but we do publish this data annually.

Our data

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

Due to the different ways of recording data on the two systems we have used only data from our new CMS when presenting our analysis of the issues people complain about. This ensures consistency and will enable us to carry out trend analysis over time. The proportion of health cases we investigated recorded on our old system that we closed in Quarter 4 was just over 1%, and will continue to decline.

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

We undertake a full data audit at the end of each financial year, which can lead to some reclassification of a small number of cases. This means that the data presented in this report differs slightly from our first three quarterly reports for 2018-19.

Our process

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

Step one: helpline

We look at whether a complaint is ready to come to us. We usually expect people to complain to the organisation they are unhappy with first so the organisation has the chance to put things right.

We give people advice on how to complete an organisation's complaints process and we ask organisations to do more where we can see that this might resolve a complaint. When we aren't the right organisation to help, we explain why and let people know which organisation can help.

The significant volume of advice and support we provide at this step often helps people get an answer to their complaint at this stage.

Step two: assessment

At this step we decide whether we can and should investigate a complaint, or whether we can resolve it without an investigation.

We look at what happened and what outcome the complainant is hoping for, and for signs that mistakes have been made that have had a negative effect and what has already been done to put this right.

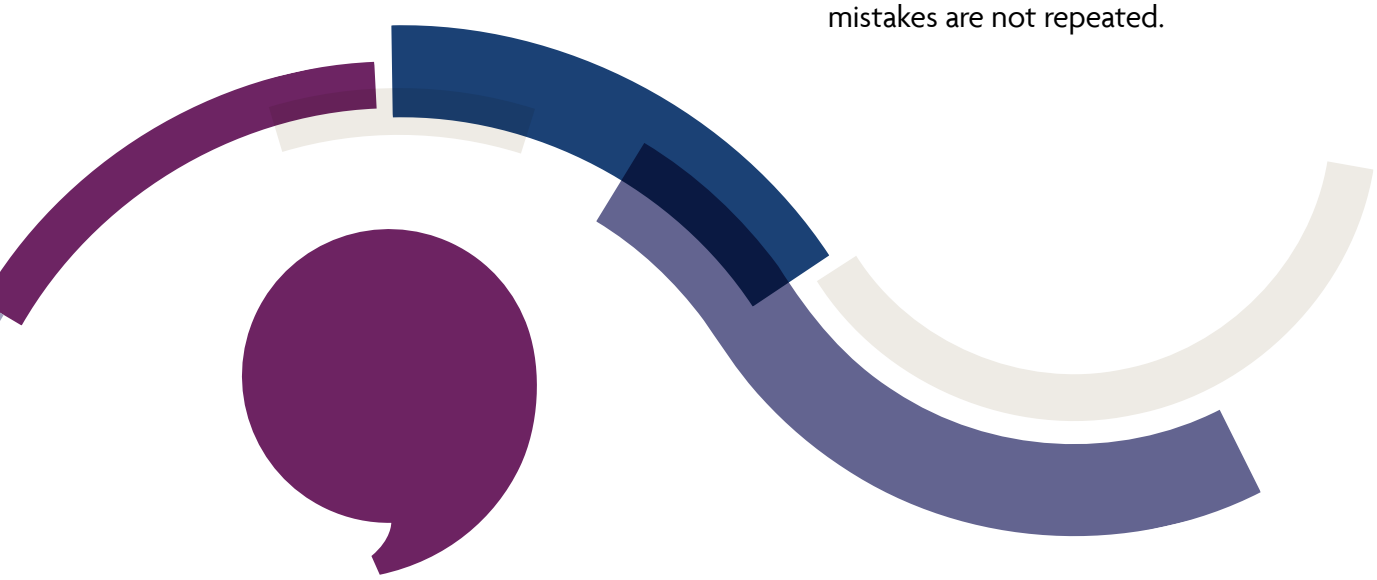
We can usually only investigate if the complainant has been affected personally by what happened, and there is normally a limit on the time between when the complainant first became aware of the problem and bringing it to us. We will also determine whether legal action is an option.

Step three: investigation

At the start of an investigation, we discuss the scope of what we are going to look at with the complainant. We gather relevant information and evidence from them and from the organisation complained about.

For health complaints, we may need to get expert advice from doctors and other health professionals. We compare what happened with what should have happened, and we look at how that has affected the person concerned.

If we find that the organisation did not act correctly and it has not already put things right, we make recommendations to ensure that mistakes are not repeated.



Step one: initial checks

During Quarter 4 we completed our initial checks on

6,249

health complaints, including complaints continued from the previous quarter.

These were progressed in the following ways:

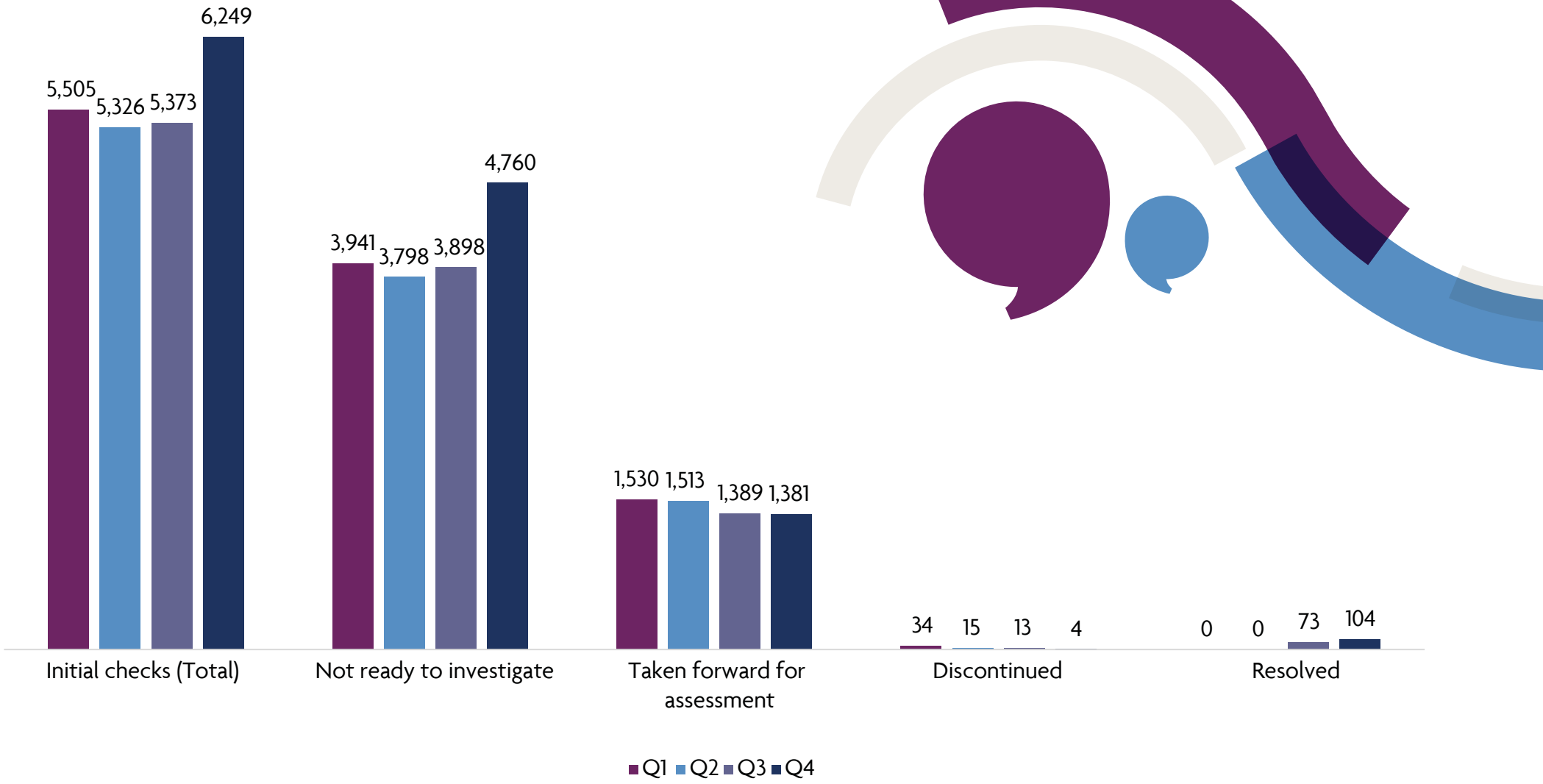
4,760 We gave information on how to make a complaint to the NHS in England, or other public organisations, or signposted to another organisation that would help.

1,381 We referred these complaints for more in-depth consideration (an assessment – step two in our process).

4 We closed these complaints because they were not pursued by the people who brought them following their initial approach to us.

104 We were able to close these complaints with a positive outcome for the complainant without the need for an investigation, for example an apology, further explanation or financial remedy was provided.

Chart 1: Initial checks, Quarter 1 - Quarter 4 2018-19



Step two: assessment

During Quarter 4 we assessed

1,534

health complaints which involved either closing the case, resolving the complaint or continuing with a more in-depth investigation.

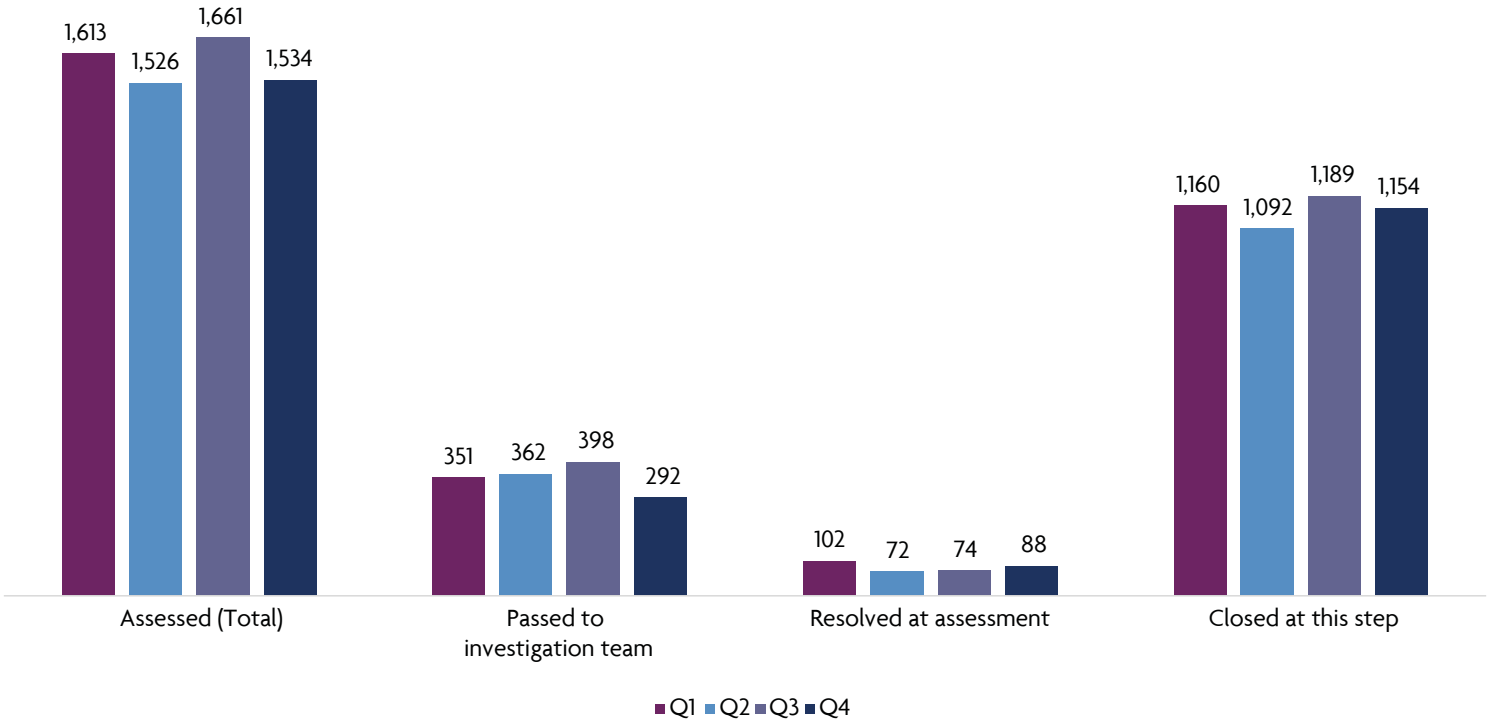
These were progressed in the following ways:

292 We passed these complaints to our investigations team – step three in our process. This accounted for **19%** of all the complaints we dealt with at this step.

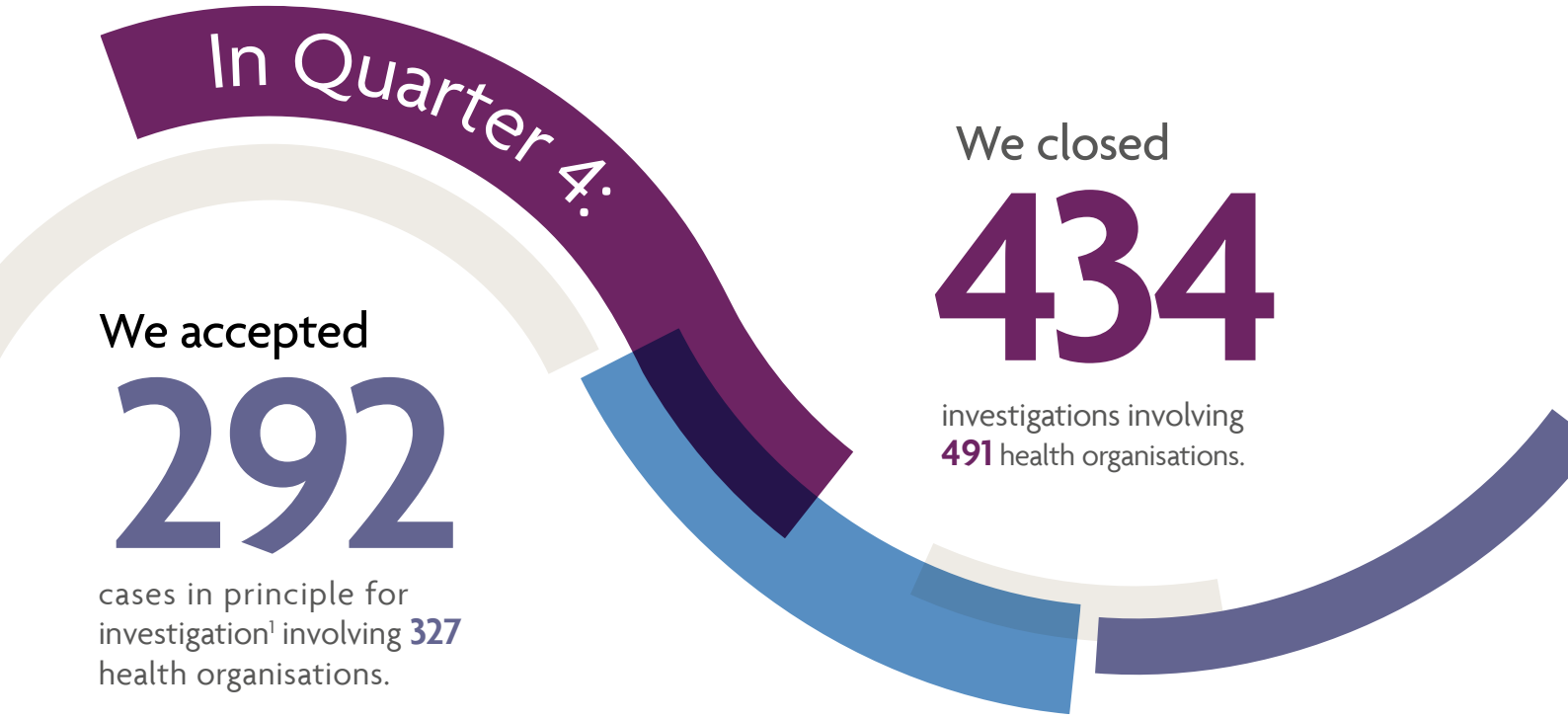
88 We were able to close these complaints with a positive outcome for the complainant without the need for an investigation, for example an apology, further explanation or financial remedy was provided.

1,154 We closed the remainder at this step for a variety of reasons, for example, because the complainant asked us to.

Chart 2: Assessment cases, Quarter 1 – Quarter 4 2018-19



Step three: investigation



Of the cases we investigated:

200 (46%) were either fully upheld (32 or 7%) or partly upheld (168 or 39%).

198 (46%) were not upheld.

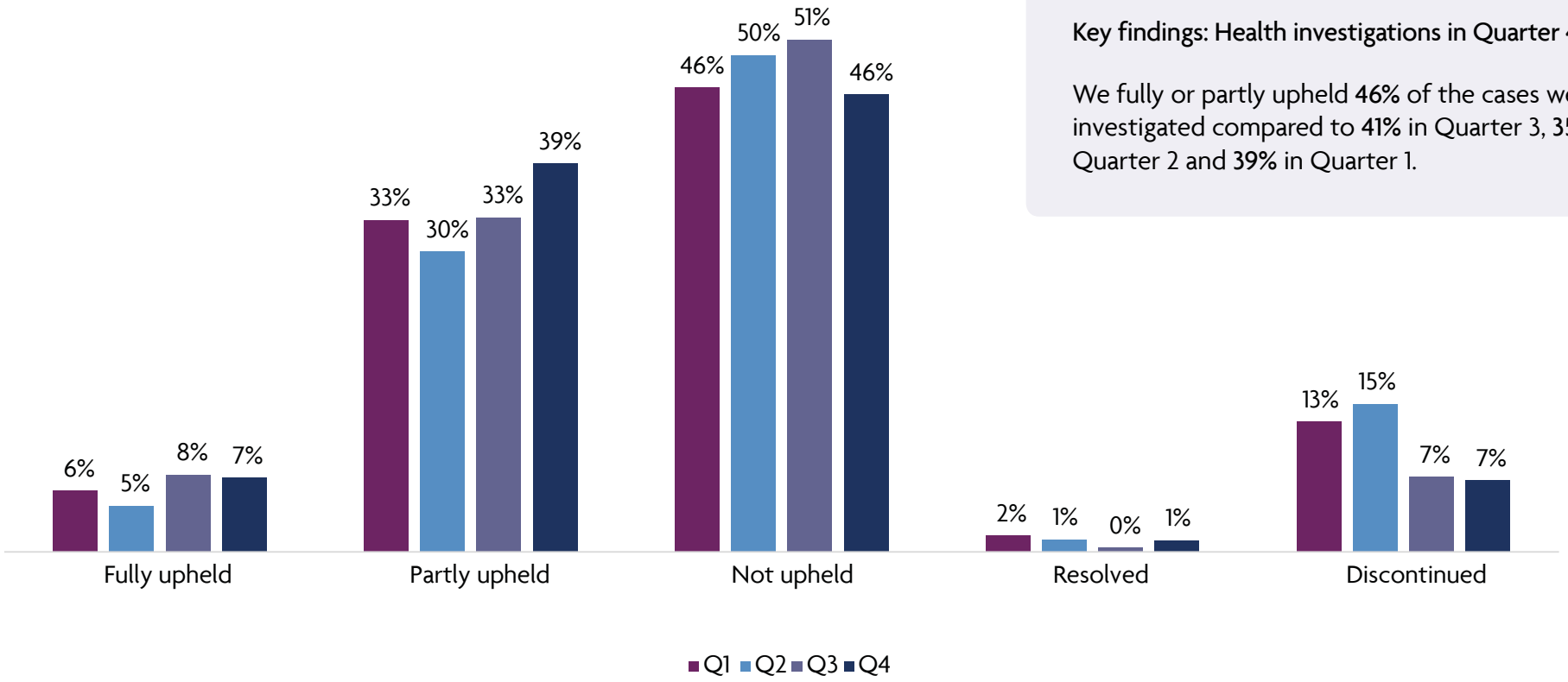
5 (1%) were resolved before the investigation was concluded.

31 (7%) were ended for other reasons, for example because the complainant asked us to[2].

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

2 Please note percentages may not add up to 100% due to rounding.

Chart 3: Decisions made at investigation, Quarter 1 – Quarter 4 2018-19



Key findings: Health investigations in Quarter 4 2018-19

We fully or partly upheld **46%** of the cases we investigated compared to **41%** in Quarter 3, **35%** in Quarter 2 and **39%** in Quarter 1.

Charts 4 shows the number of cases we accepted in principle for investigation during Quarter 1 to Quarter 4, 2018-19.

Chart 4: Cases accepted in principle for investigation, Quarter 1 - Quarter 4 2018-19

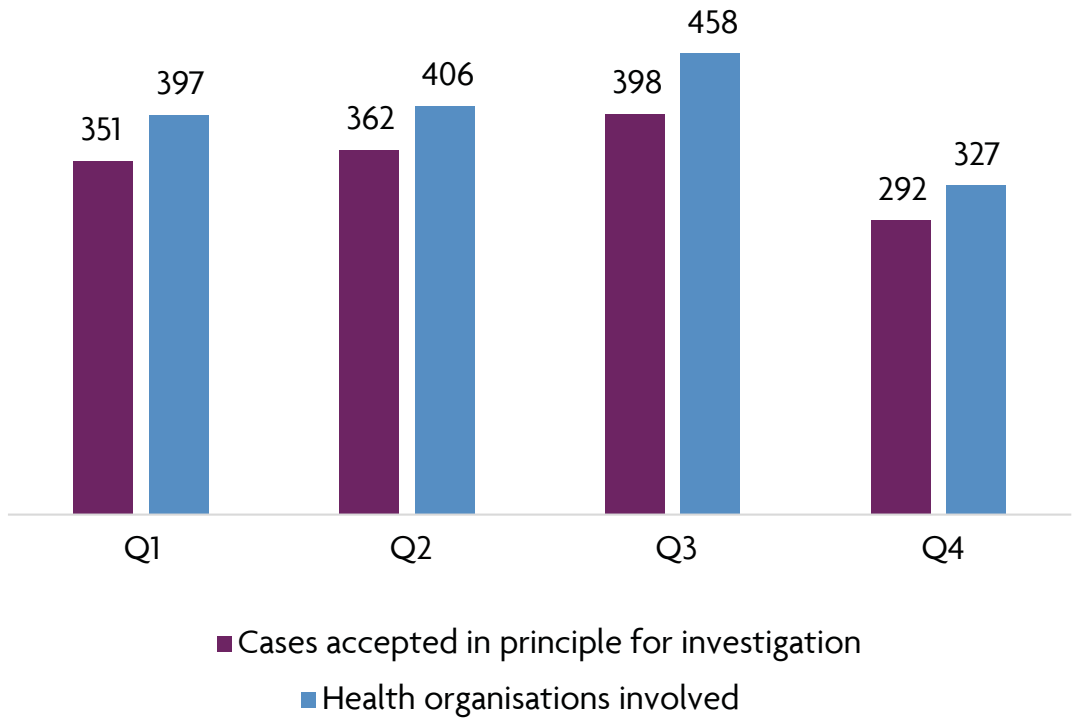
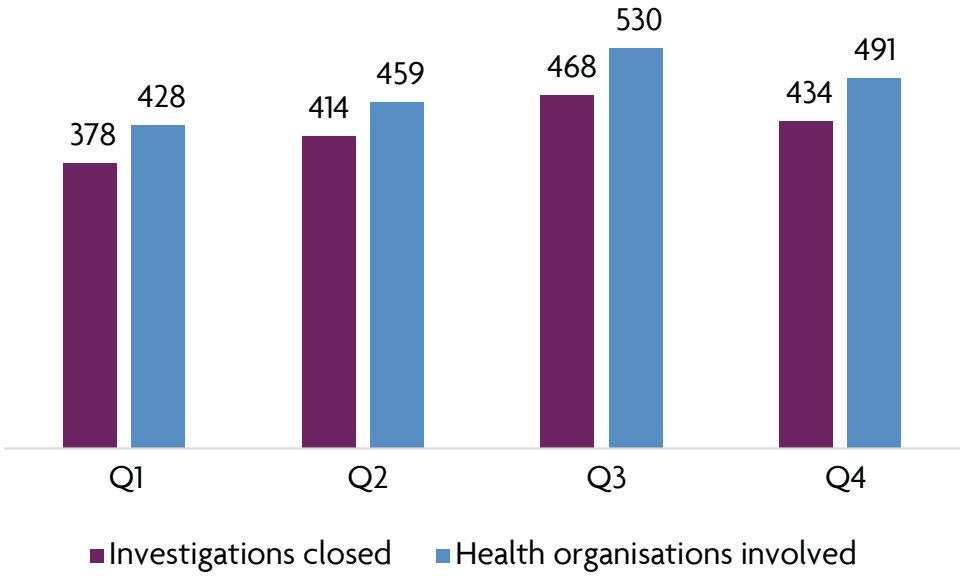


Chart 5 shows the number of investigations we closed during Quarter 1 to Quarter 4, 2018-19[3].

Chart 5: Investigations closed, 2018-19



3 Our casework management system records the date on which we have proposed to investigate a case, rather than when we confirm an investigation. In some cases, following comments from the parties, we may decide not to investigate. The number of complaints we accept each quarter for investigation during a financial year differs from the number of investigations that we complete each quarter during that same year. This is because our statistics only provide a snapshot of our casework flow at a given time. For example, we may have accepted a complaint for investigation in 2018-19 but may not complete it until the following year, 2019-20. Similarly, we may have completed an investigation in 2018-19 which we originally accepted for investigation in the previous year, 2017-18.

Recommendations

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

Each case can have more than one recommendation. In Quarter 4, for complaints about the NHS we upheld or partly upheld, we made the following recommendations to organisations to put things right:

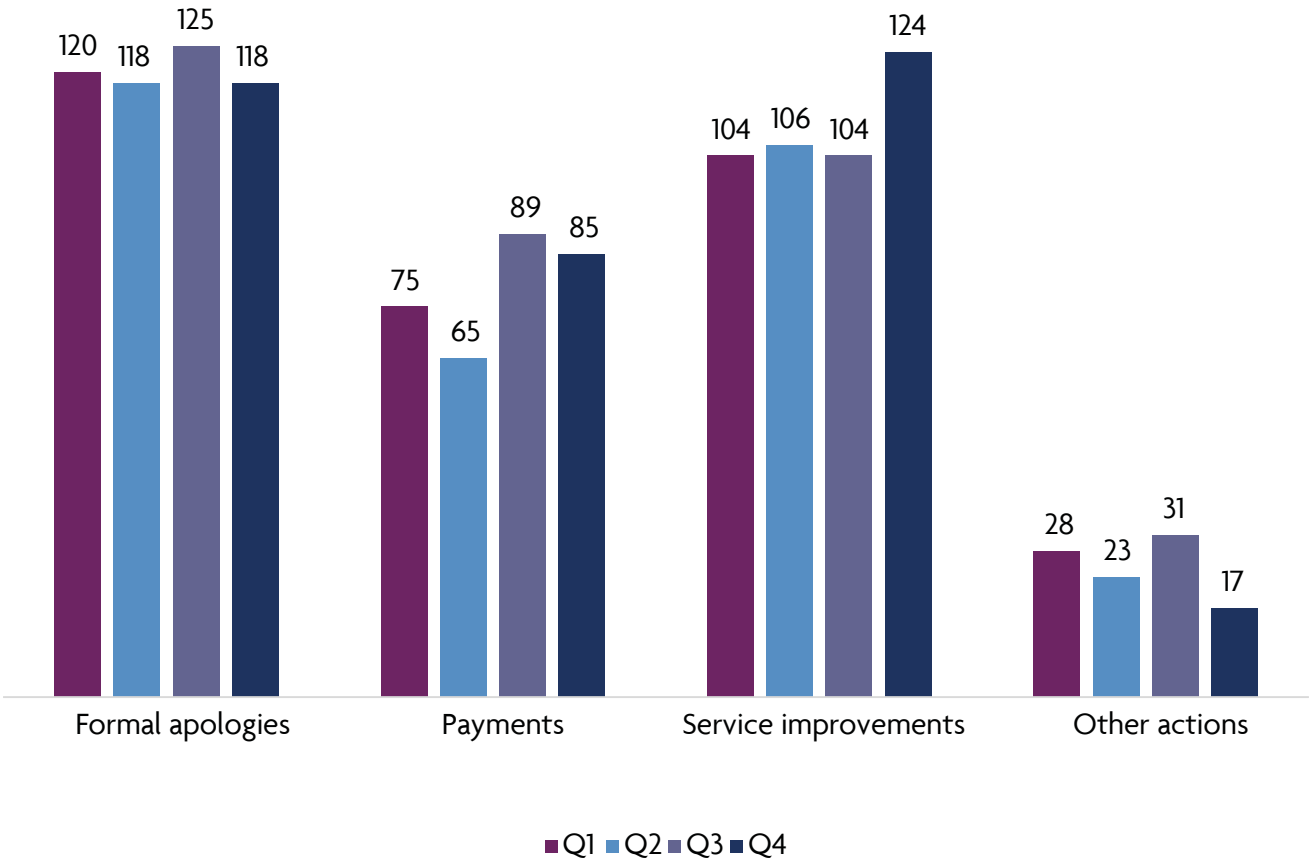
118 formal apologies.

85 payments to make up for financial loss or to recognise the impact of what went wrong. This totalled **£57,061.35** from the NHS organisations we investigated.

124 service improvements such as changing procedures or training staff.

17 other actions to put things right, for example, asking a GP practice to correct errors in medical records.

Chart 6: Recommendations made, Quarter 1 – Quarter 4 2018-19



Financial remedy

Our Principles for Remedy state that where maladministration or poor service has led to injustice or hardship, the public body responsible should take steps to provide an appropriate and proportionate remedy. We can recommend that organisations provide explanations, apologies, actions to improve services, and financial remedies to service-users. When recommending financial remedy, we refer to our Severity of injustice scale, and review similar cases where similar injustice has arisen to determine an appropriate amount. We also take into consideration the financial amounts recommended or already paid by other organisations, awarded by courts, or paid following mediation.

The case summaries below are examples of investigations that we completed during Quarter 4 where we recommended that the organisations involved provide financial remedy to the complainant's to make up for financial loss or to recognise the impact of what went wrong. As well as these examples, we have also published information for NHS trusts, and NHS staff who manage complaints, outlining our role and relationship with NHS Resolution in responding to complaints and compensation claims.

Case summary 1

Mr W complained about the care provided to his late mother by Calderdale and Huddersfield NHS Foundation Trust. Mr W complained that there were multiple misdiagnoses before his mother was eventually diagnosed with lung cancer. Although Mr W accepted an earlier diagnosis would not have affected the outcome for his mother, Mr W stated the delay and the uncertainty caused him significant distress and meant he was unable to bring his mother home sooner, which was important to him, particularly as his mother died a month after the diagnosis. Mr W also complained that the Trust provided incorrect information when his mother was discharged, and had not fully acknowledged or accepted that there were failings, or provided appropriate remedy.

Our investigation found that the working diagnoses and treatment provided to Mr W's mother by the Trust were appropriate. However, we found that poor communication by the Trust meant that Mr W was given incorrect or incomplete information about his mother's condition. In several instances, we found that Mr W was under the impression that working diagnoses were final diagnoses, and that there was no record that Mr W was warned of the possibility of his mother having a primary cancer. We also found that there was a delay in diagnosing Mr W's mother's cancer and that, had further investigations taken place, it is likely that Mr W's mother could have received a diagnosis 10 days sooner than she did.

In their investigation into the complaint, the Trust explained why there was multiple working diagnoses, and acknowledged that a diagnosis of lung cancer could have been made sooner. The Trust also addressed Mr W's complaint regarding his mother's discharge, and apologised that the discharge note did not mention the diagnosis of lung cancer. However, as their response did not demonstrate learning had been taken from the delay in diagnosis, we recommended that the Trust put together an action plan to address the failures in investigating Mr W's mother's primary cancer. We also recommended the Trust pay Mr W £850 in recognition of the injustice he suffered as a result of the poor communication.

As well as paying Mr W the amount we recommended, the Trust produced an action plan, and provided evidence of sharing the learning from Mr W's complaint in their Patient Safety and Quality Board meeting to ensure the same mistakes would not be repeated.

Case summary 2

Miss F complained that she received root canal treatment from the Dentist at the Practice that she did not consent to, and which was performed in a rushed and unsatisfactory manner. Miss F also complained that the procedure and aftercare were not explained properly, that she had to spend £650 to repair the damage caused, and that she had been left with half a tooth which could impact her profession as an actress. Miss F sought an apology and financial compensation for the personal impact she experienced, and redress for the £650 costs she had incurred.

Our investigation found no records in the clinical notes about gaining consent or explaining the procedure before starting the temporary root canal treatment, or on the follow-up actions Miss F would need to take after the procedure. We found that, on the balance of probabilities, it was likely that the procedure on Miss F's tooth began before consent was obtained, and that aftercare advice was not given. This amounted to a failing. After seeking clinical advice from a dental adviser we also found that the dentist used a material intended as a permanent root canal sealer, rather than a temporary restoration during the procedure which also constituted a failing. Miss F stated that she was not told after the procedure that she would require further treatment meaning her tooth broke in half three months later and required emergency treatment.

In considering recommendations and remedy we noted that a separate dentist had referred Miss F for specialist private treatment so we were unable to comment on whether this was appropriate or not, and were not able to speculate on what, if any impact these events might have on Miss F's career. However, we recommended the dentist at the Practice should pay Miss F £450 in recognition of the injustice we identified and apologise to her for what had happened. The Practice complied with our recommendations.

Investigations by organisation type

Sometimes, we receive individual complaints that involve more than one organisation. Table 1 shows the organisations involved in the health cases we completed our investigations into in Quarter 4. Case outcomes recorded as 'Other' refer to cases we investigated that we ended for a variety of reasons, for example because the complainant did not wish to pursue the case further.

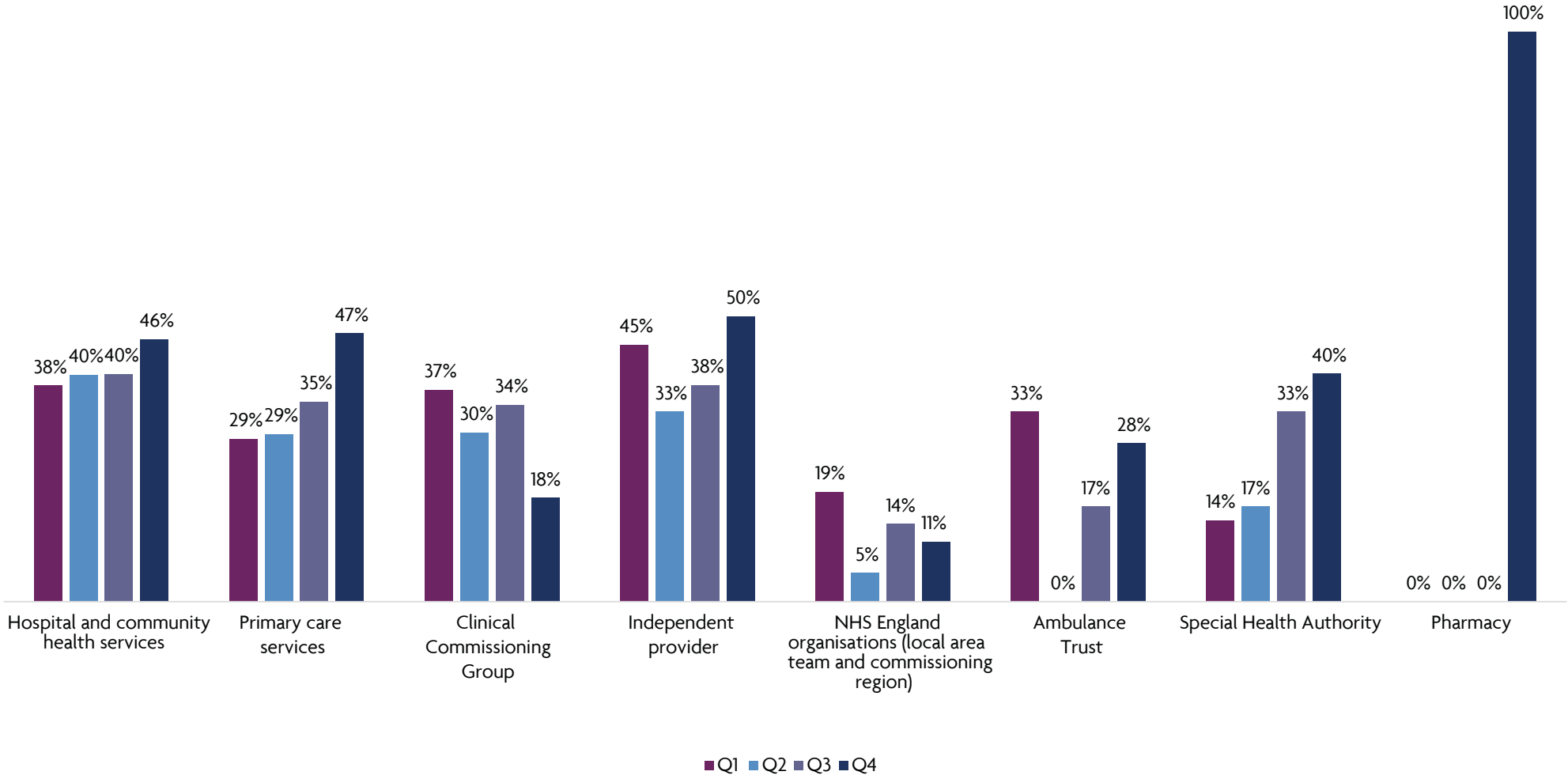
Table 1: Health investigation outcomes by organisation type, Quarter 3 and Quarter 4 2018-19

Organisation type	Fully or partly upheld		Not upheld		Other		Total	
	Q3	Q4	Q3	Q4	Q3	Q4	Q3	Q4
Hospital and community health services	127	150	169	157	22	19	318	326
Primary care services	40	32	65	30	9	6	114	68
Clinical Commissioning Group	10	4	11	8	8	10	29	22
Independent provider	11	16	13	13	5	3	29	32
NHS England organisations (local area team and commissioning region)	3	2	18	16	1	1	22	19
Ambulance Trust	2	5	9	12	1	1	12	18
Special Health Authority	2	2	3	3	1	0	6	5
Pharmacy	0	1	0	0	0	0	0	1
Total	**195**	**212**	**288**	**239**	**47**	**40**	**530**	**491**

Chart 7 shows the uphold rate for organisations we investigated in Quarter 4.

It is important to note the low numbers of investigations for some of these settings means that only a small change in the decisions we make will make a big difference to the uphold rate.

Chart 7: Health investigation outcomes by organisation type, Quarter 1 - Quarter 4 2018-19



Hospital and community health services

The area in which we saw the most complaints about healthcare provision in Quarter 4 was in hospital and community health services. Chart 8 shows the five most common types of service within hospital and community health service complaints that were fully or partly upheld during Quarter 4:

Chart 8: Upheld complaints by type of service in hospital and community health services, Quarter 1 - Quarter 4 2018-19

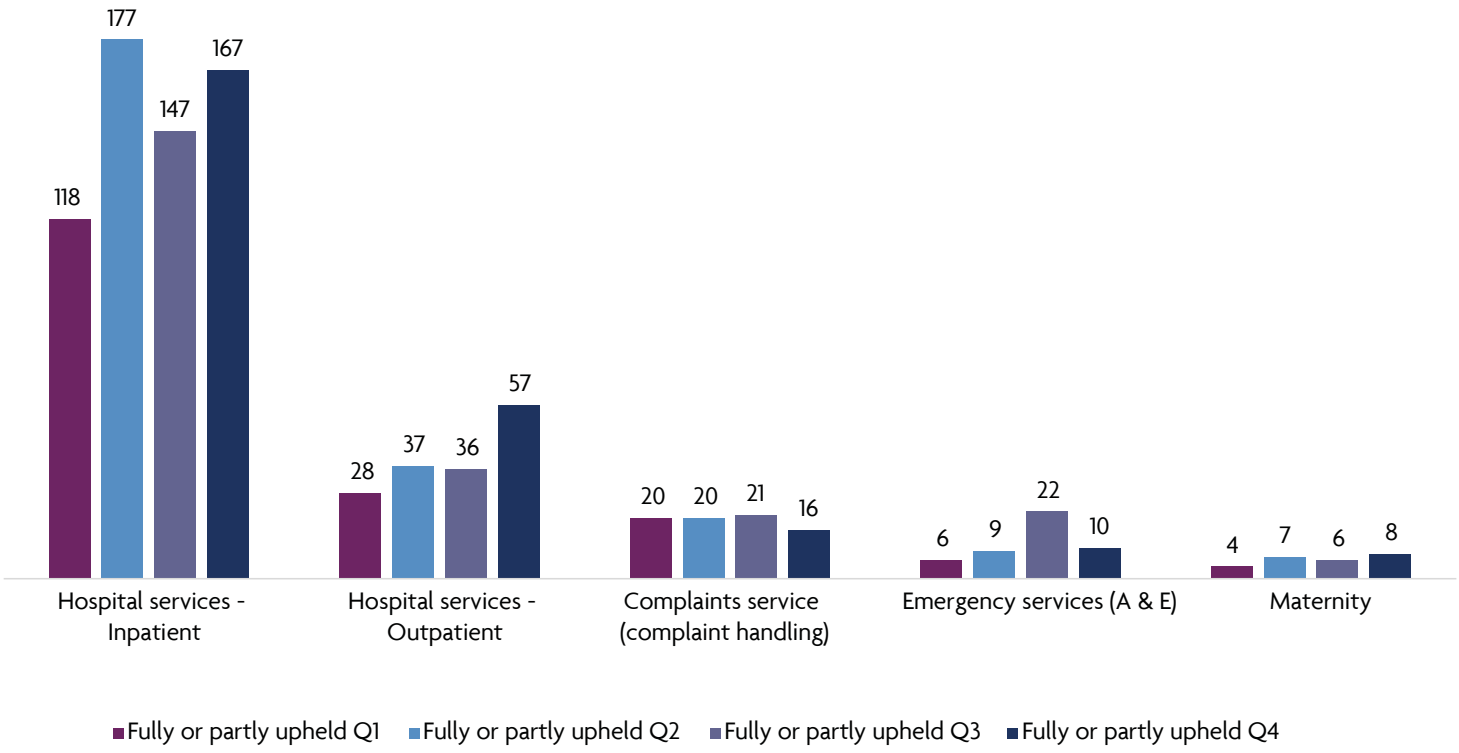
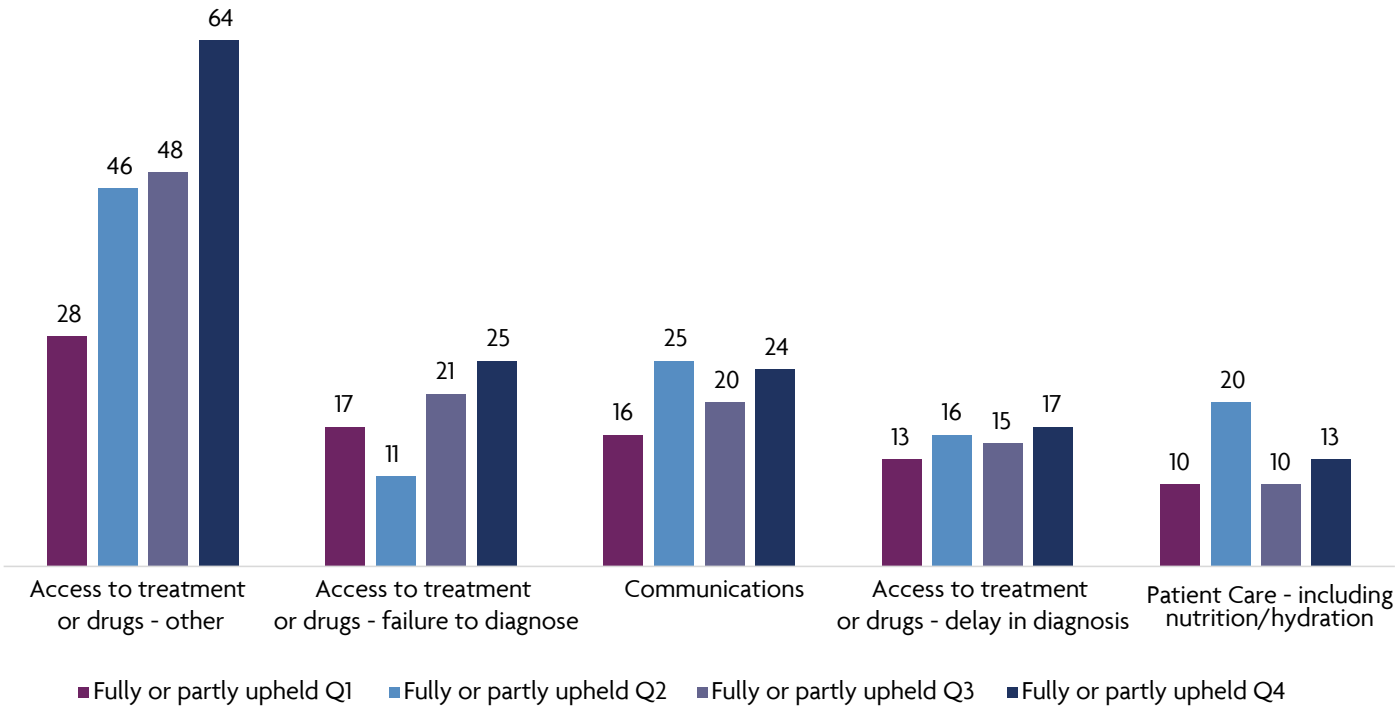


Chart 9 shows the five most common complaint issues for cases we fully or partly upheld in Quarter 4 in hospital and community health services. These issues were:

- **Access to treatment or drugs – other:** 'Access to treatment or drugs' includes eight sub-categories covering issues around diagnosis, referrals and visits. This 'other' category is used to record any issues that fall outside these more specific categories.
- **Access to treatment or drugs - failure to diagnose:** These were complaints about a misdiagnosis or a failure to diagnose a condition that the complainant believed was not acceptable.
- **Communication:** Communication issues could include how clinical decisions have been explained and whether the implications were made sufficiently clear.
- **Access to treatment or drugs – delay in diagnosis:** These are complaints where there has been an unreasonable delay in diagnosing an illness or starting treatment.
- **Patient Care – including nutrition and hydration:** Patient care issues concerning follow up care, and privacy and dignity are not included in this category.

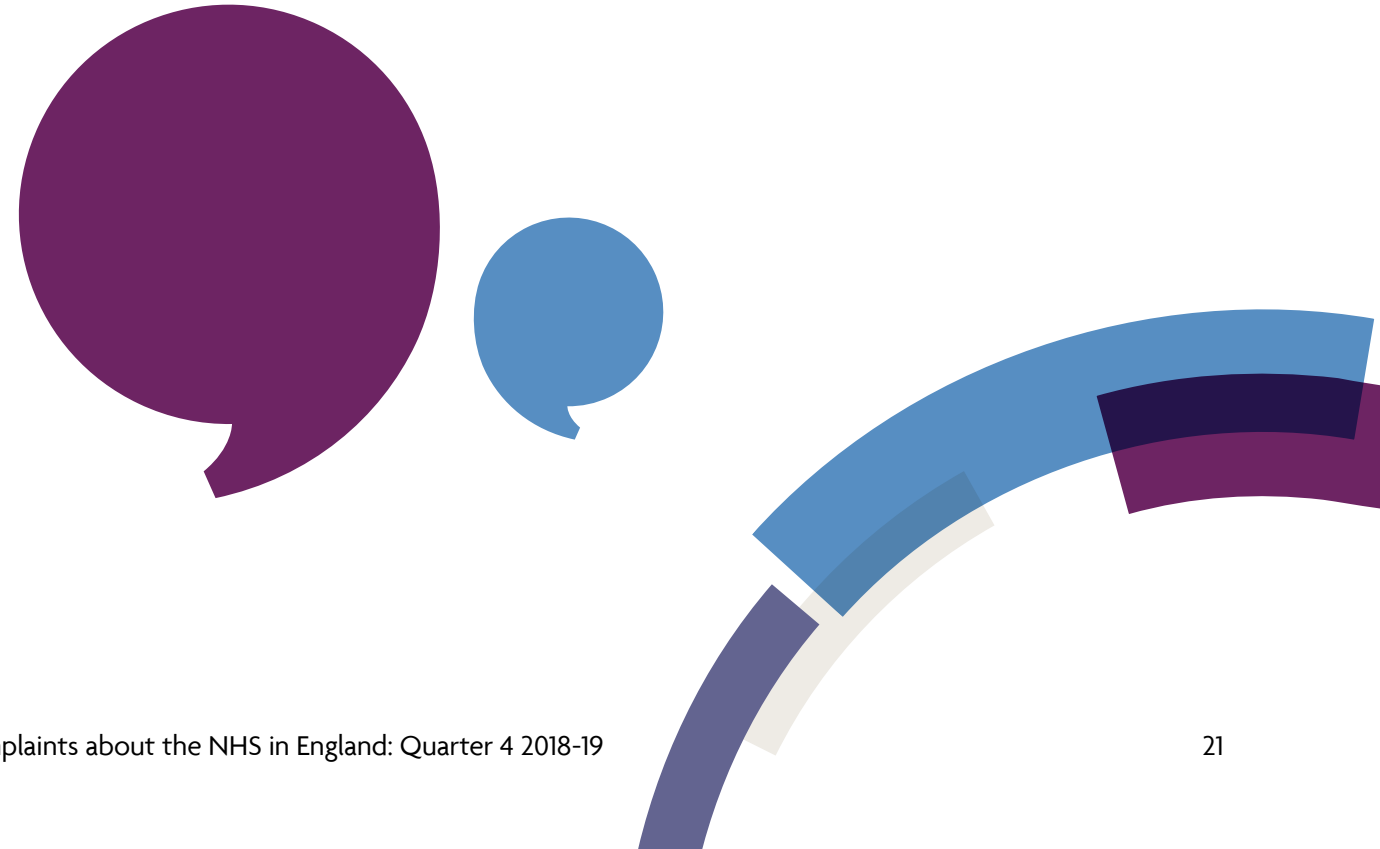
Chart 9: Upheld complaints for hospital and community health services by complaint issue, Quarter 1 – Quarter 4 2018-19



Key findings: Hospital and community health service complaints

The largest proportion of complaint issues we fully or partly upheld in hospital and community services in Quarter 4 was in inpatient services. The number of complaint issues we fully or partly upheld in inpatient services was **167** in Quarter 4 compared to **147** in Quarter 3, **177** in Quarter 2 and **118** in Quarter 1.

The most common complaint issue we fully or partly upheld in Quarter 4 in hospital and community health services was 'Access to treatment or drugs – other'. The number of complaint issues concerning 'Access to treatment or drugs – other' that we fully or partly upheld was **64** in Quarter 4 compared to **48** in Quarter 3, **46** in Quarter 2 and **28** in Quarter 1.



Primary care services

The area in which we saw the second largest amount of complaints about healthcare provision in Quarter 4 was in primary care health services. Chart's 10 and 11 show the outcomes for complaints about primary care organisations we investigated in Quarter 4. Complaint outcomes recorded as 'Other' refer to complaints we investigated that we ended for a variety of reasons, for example because the complainant did not wish to pursue the case further.

Chart 10: Decisions made at investigation for GP organisations, Quarter 1 - Quarter 4 2018-19

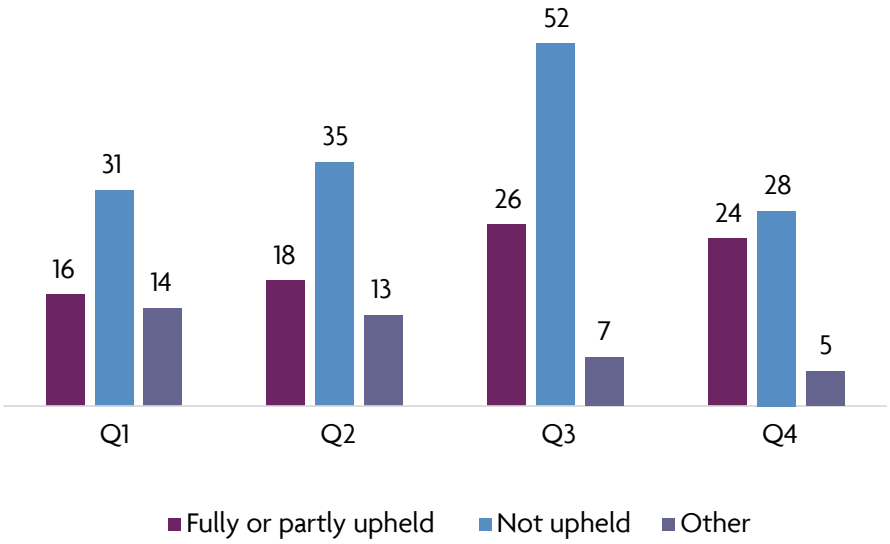
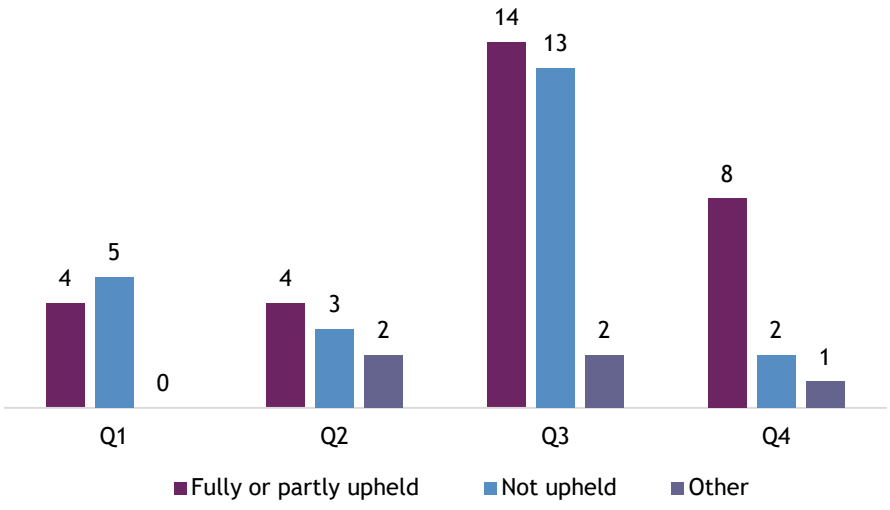


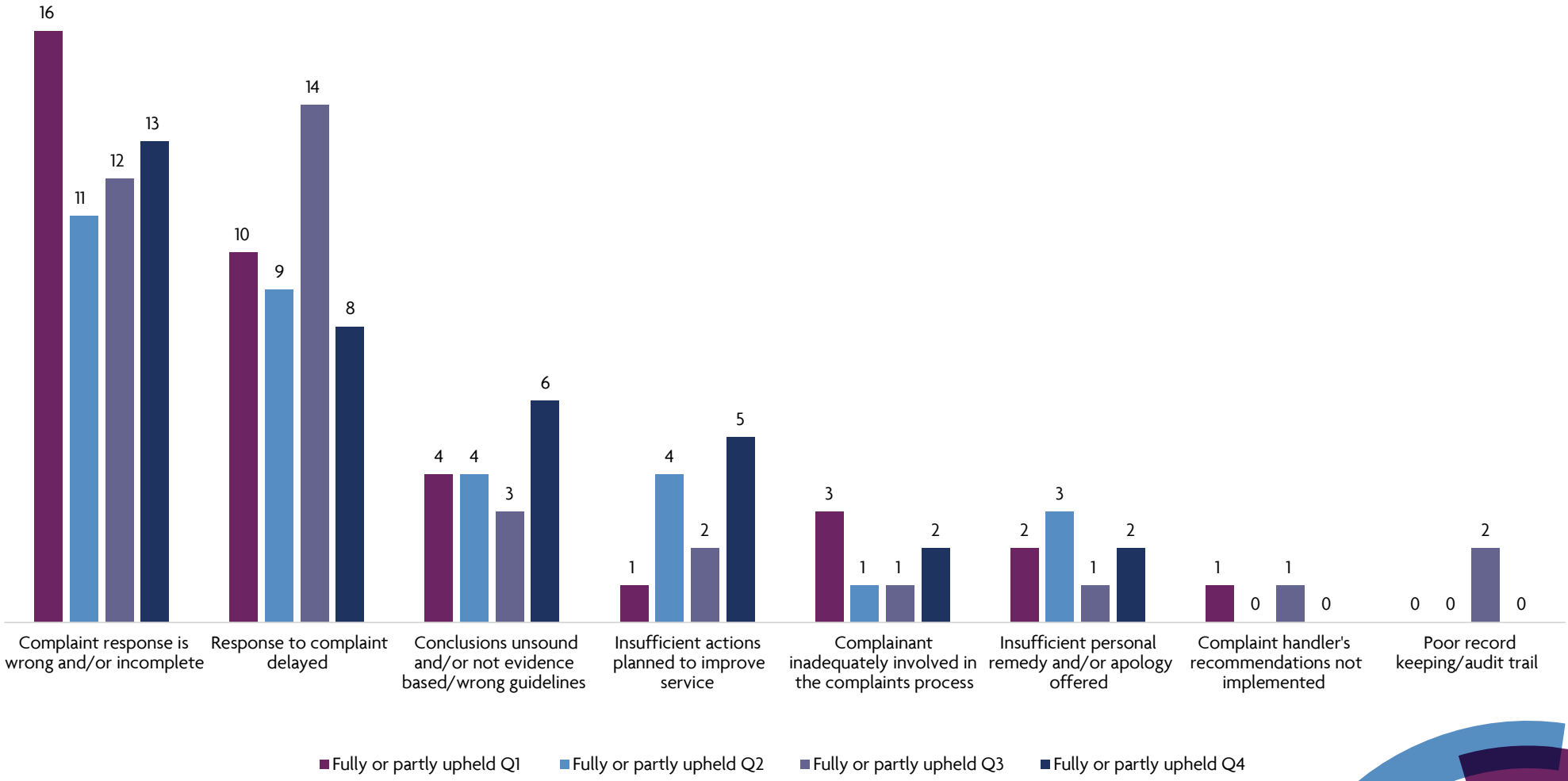
Chart 11: Decisions made at investigation for Dental organisations, Quarter 1 - Quarter 4 2018-19



Complaint handling

Chart 12 shows the different categories of complaint handling issues that were brought to us as complaints for health organisations for cases completed in Quarter 4.

Chart 12: Upheld complaints for health organisations by complaint handling issue, Quarter 1 – Quarter 4 2018-19



Improving frontline complaint handling

Our three-year corporate strategy sets out how we will seek to become an exemplary ombudsman service. The third objective of the strategy outlined our commitment to working in partnership to improve public services in frontline complaint handling, and improving how the public sector responds when things go wrong.

Next year we will be publishing a detailed insight report on how complaints are handled by NHS organisations and UK Government departments and agencies. The case summary below highlights how a complaint we investigated in Quarter 4 identified failings in the action of a healthcare provider in respect of their handling of a complaint, and how the recommendations we made led to improvements in the organisation's complaints policy and processes.

Mr O complained on behalf of his son that the power wheelchair provided by a wheelchair service (the Service) was unfit for purpose and caused unnecessary pain and discomfort to his son. Mr O stated that as a result, he incurred financial loss in having to purchase a second seating system for his son's manual chair. Mr O also complained about poor complaint handling by the Service which left him feeling frustrated and ignored. Mr O sought an apology and acknowledgement from the Service and reimbursement of the cost of the second manual seating system. He also wanted the Service to acknowledge their failings in regard to complaint handling and rectify his ongoing complaint.

Our investigation acknowledged the inconvenience and frustration experienced by Mr O and his son that the first seating system provided did not deliver the expected level of comfort. However we did not consider it unreasonable that adjustments were required, particularly as the service agreement made reference to the potential need for alterations or adjustments to the seat which the Service provided after Mr O initially contacted them. The Service also provided a replacement seat for the power wheelchair, manufactured by an alternative supplier suggested by Mr O. We therefore found no failings in the actions of the Service in providing the powered and manual wheelchairs.

When we investigated Mr O's complaint regarding his experience in raising his concerns about the Service, we found that there was no evidence that his initial complaint made in writing in March 2017 was acknowledged by the Service, and that there was no evidence of any discussion between Mr O and the Service, nor was a timescale for a response to his complaint agreed.

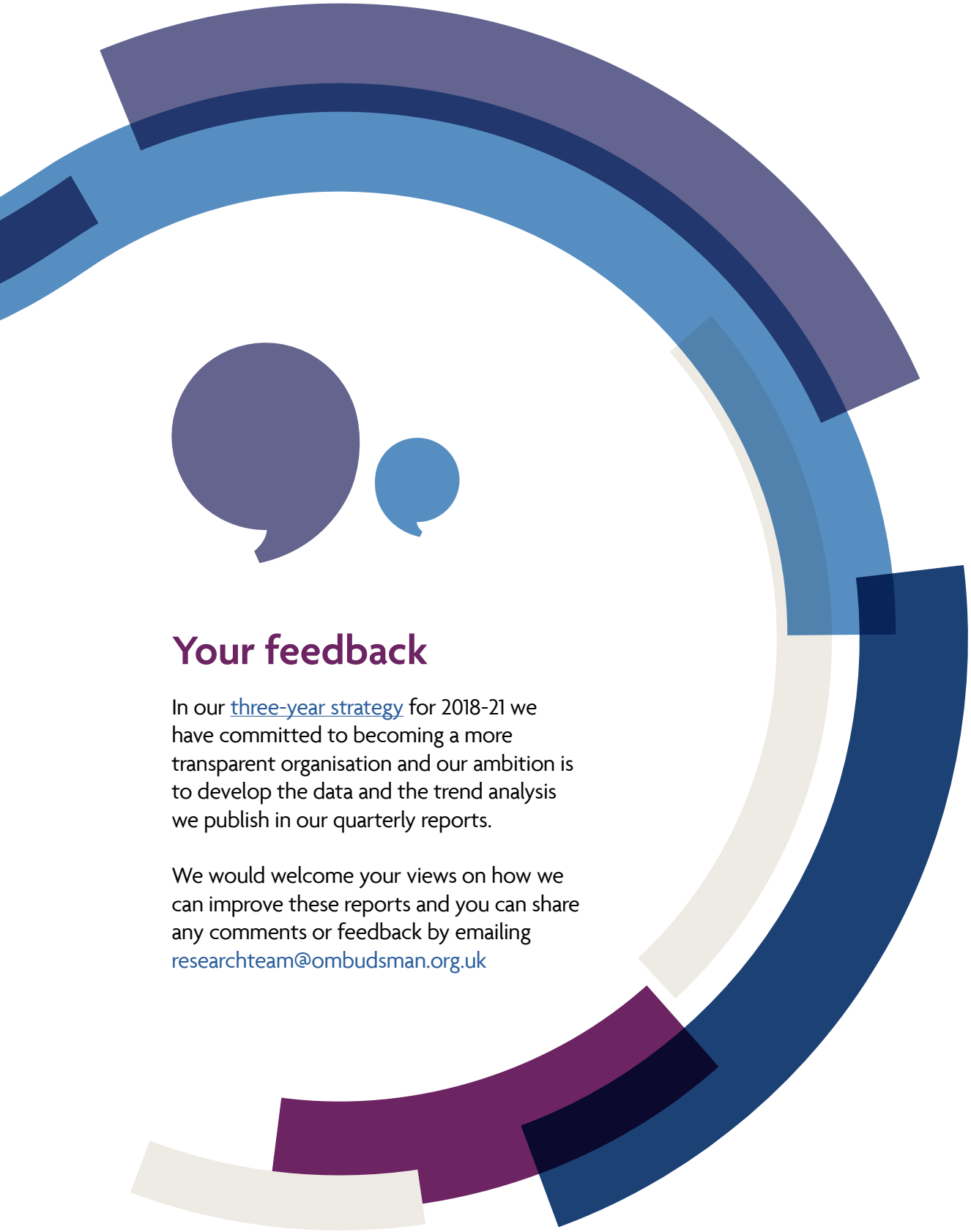
Mr O received a response after contacting the Service verbally four months after his initial written complaint, and was told that if he had any further concerns that the local resolution process would not be considered complete. However after he replied expressing dissatisfaction with the Service's response he did not receive any further response. We contacted the service on Mr O's behalf in May 2018 and received assurances the local resolution process was ongoing. We continued to contact the Service several times before a final response was eventually received in July 2018.

Following our investigation, we recommended that the Service should provide Mr O's family with an apology acknowledging that his complaint was not handled in line with NHS England's Complaints Policy or PHSO's Principles of Good Complaint Handling, and that they should also provide evidence to demonstrate they had complied with our recommendations.

The Service wrote to apologise to Mr O and his family and assured him that they had undertaken a thorough review and update of their complaint's policy and process. The Service also confirmed they had incorporated PHSO's complaint handling guidance into their complaint handling policy and procedures to ensure they provide prompt, robust and efficient complaint handling and to ensure lessons were learned from complaints.

Key findings: Complaint handling

Concerns around complaint responses being wrong or incomplete, and complaint responses being delayed were the two issues that featured most frequently in complaints we fully or partly upheld about complaint handling during each quarter in 2018-19.



Your feedback

In our three-year strategy for 2018-21 we have committed to becoming a more transparent organisation and our ambition is to develop the data and the trend analysis we publish in our quarterly reports.

We would welcome your views on how we can improve these reports and you can share any comments or feedback by emailing researchteam@ombudsman.org.uk

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