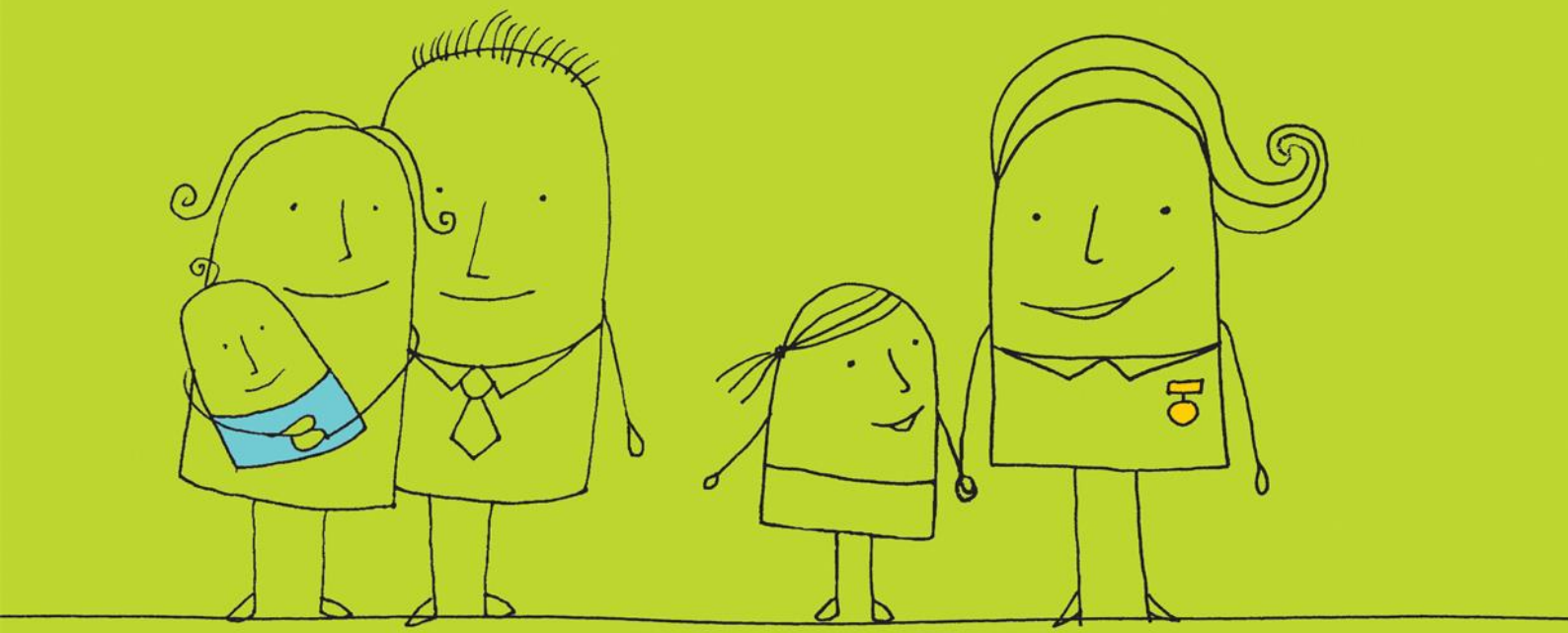
Patient and Client Council

# Serious Adverse Incident Complaints

## A Thematic Review of Complaints Support Service Cases 2014-2018

## October 2019



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## 1. Background

In 2014 a report was issued by RQIA following the controversy over the management of Serious Adverse Incidents (SAIs) by the Belfast Health and Social Care Trust and in particular the failure of the Trust to inform and involve families where an SAI review was undertaken. In 2017, the report of the Inquiry into Hyponatraemia Related Deaths was published. This made 96 recommendations and included specific recommendations, in particular focused on ensuring family involvement in Serious Adverse Incident review processes. Of particular interest to this report was Recommendation 37 in the Inquiry into Hyponatremia. The recommendation states:

***Trusts should seek to maximise the involvement of families in SAI investigations and in particular:***

- *Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints.*
- *Families should be given the opportunity to become involved in setting the terms of reference for an investigation.*
- *Families should, if they so wish, engage with the investigation and receive feedback on progress.*
- *A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.*
- *Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports.*
- *All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive*
- *Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing.*
- *Family GPs should, with family consent, receive copies of feedback provided.*
- *Families should be formally advised of the lessons learned and the changes effected(x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation*

The Patient and Client Council (PCC) is a member of the workstream established under the hyponatremia implementation to ensure the implementation of Recommendation 37. The purpose of the following report is to describe the key themes in SAIs dealt with by the PCC. These themes and issues will be used in evidence by the PCC to the Workstream to support improvement in the management of SAIs.

The data were extracted from the PCC Complaints Service database. The data were analysed and reviewed to explore:

- The background and nature of SAIs (between 2014 and 2018);
- Why individuals come to the PCC when dealing with a SAI;
- How SAIs have been dealt with by Trusts and whether there are any recurring issues in SAI management;
- Nature of support provided by the PCC.

Access to the database by a PCC research intern was approved by PCC senior management for the specific purpose of producing this report.

## 2. Introduction

Health care is one of most important and challenging aspects in today's society, particularly in Northern Ireland, where the population is ageing much more rapidly than any other part of the UK[1]. Whilst the majority of individuals and families have had a positive experience with their treatment in the health service, a very small minority of the millions of interactions each year have negative outcomes due to poor management or provision of care. In some cases, this leads to a Serious Adverse Incident being declared.

Whilst SAIs can often be dealt with in communication between the patient/family and the Trust, the Patient and Client Council (PCC) has been offering support to families involved in Serious Adverse Incidents since 2014.

### *2.1 What is a Serious Adverse Incident?*

The current definition of an SAI is **'any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'**[2]. SAIs are specific to health and social care services. Examples of SAIs include situations where:

- A large number of patients are involved;
- There is a question of poor clinical or management judgement;
- A patient has died under unusual circumstances.

An SAI has three different levels of investigations, depending on the seriousness and complexity of the incident:

- Level 1 Investigation: Significant Event Audit (SEA)
- Level 2 Investigation: Root Cause Analysis (RCA)
- Level 3 Investigation: Independent Investigation

While most SAIs will be subject to a Level 1 investigation, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 investigation immediately following the incident[2].

*2.2 What role can the Patient and Client Council play in SAI cases?*

Individuals involved in SAIs come to the Patient and Client Council (PCC) for numerous reasons. For example, the PCC may:

- Help people to develop a complaint letter about their case;
- Support the contact between Trust and client, via PCC Client Support Officers;
- Contact staff for an explanation of delays with the SAI process;
- Attend meetings to support the client; and
- Provide information and advice to clients if they are unsure of the process.

## 3. Patient and Client Council Complaints Support Service

The PCC Complaints Support Service is a confidential, independent and free service that can help patients and clients to make a complaint about any HSC service. The Service's role is defined in the Health and Social Care Reform Act (2009)[3] as:

'*Providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care…'*

The PCC has a team of six Client Support Officers (CSOs) and a Service Manager. The PCC CSOs manage a caseload of client complaints across the five HSC Trust areas (Belfast, Northern, Southern, South Eastern, and Western) and also the Northern Ireland Ambulance Service (NIAS).

## 4. Types of SAI clients and cases supported by the Patient and Client Council

*4.1 Client types and demographics*

Of the 56 SAI cases supported by the PCC Complaints Support Service between January 2014 and December 2018, 44.6% (N=25/56) had caused or contributed to a death.

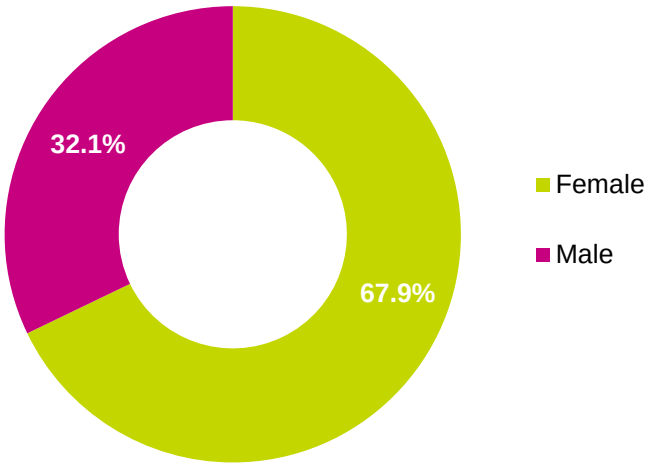
**Table 1: SAI clients by type**

| Client | Number | Percentage |
|---|---|---|
| **Child of service user** | 15 | 26.8% |
| **Parent of service user** | 14 | 25.0% |
| **Partner of service user** | 10 | 17.9% |
| **Patient (themselves)** | 9 | 16.1% |
| **Sibling of service user** | 4 | 7.1% |
| **Cousin of service user** | 1 | 1.8% |
| **Social worker of service user** | 1 | 1.8% |
| **Family (Not specified)** | 1 | 1.8% |
| **In-Law** | 1 | 1.8% |
| **Total** | **56** | **100%** |

In about 70% of cases, the person raising or dealing with an SAI was a relative of the client. In a small number of cases (about one in every six), the clients were the patients themselves.

As can be seen in Table 1, SAI cases are most commonly initiated by the son or daughter of the person involved (26.8%; N=15/56). This reflects the fact that SAIs often originate from complaints made by people on behalf of their parent, who may be elderly or in hospital.

**Figure 1: SAI clients by gender**

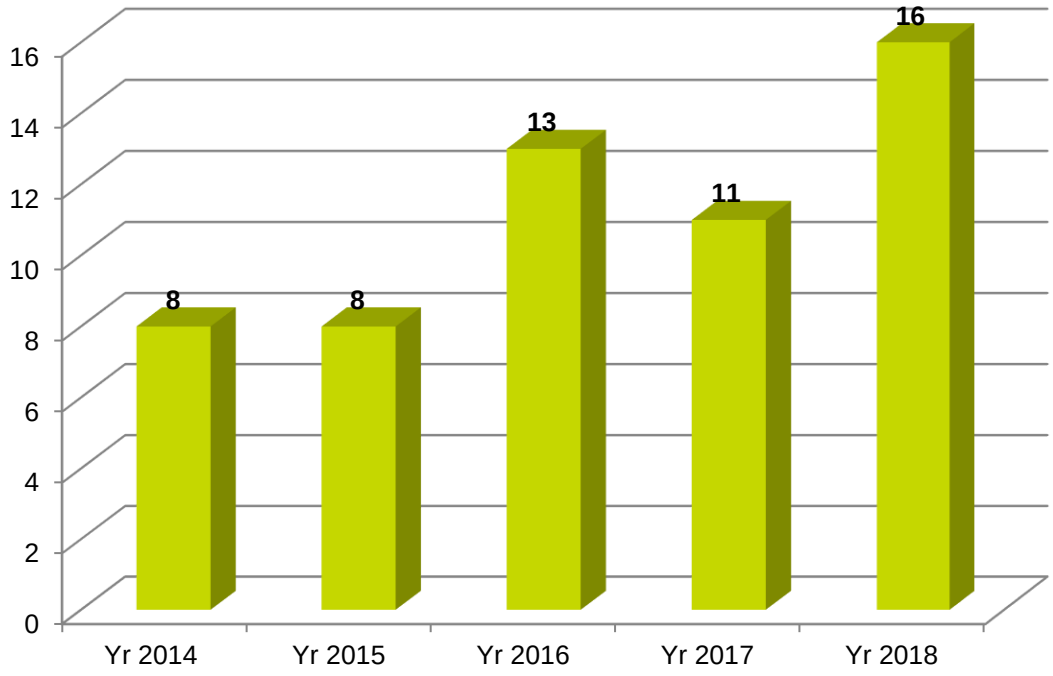



As seen from Figure 1, the subjects of SAIs were mainly female 67.9% (N=37/56) with 32.1% (N=16/56) of SAI clients being males. The youngest of the clients was 33 and the oldest 65. The average age was 47.

*4.2 SAI cases over time*

In 2018, the PCC dealt with 16 cases involving SAIs. Over the period in question, the PCC's SAI caseload has generally increased, with the number of new cases effectively doubling between 2014 and 2018 (Figure 2).

**Figure 2: Number of SAI cases dealt with by the PCC each year**




*4.3 Patient and Client Council SAI Cases by organisational area*

**Table 2: Table showing organisational area in which SAI complaints were raised**

| Trust Area | Number | Percentage |
|---|---|---|
| **Belfast** | 19 | 33.9% |
| **Southern** | 10 | 17.9% |
| **Western** | 9 | 16.1% |
| **Northern** | 8 | 14.3% |
| **South Eastern** | 7 | 12.5% |
| **GP** | 2 | 3.6% |
| **Northern Ireland Ambulance Service** | 1 | 1.8% |
| **Total** | **56** | **100.0%** |

As shown in Table 2, the Trust area with the most PCC cases involving SAIs between 2014 and 2018 was the Belfast Trust with 33.9% (N=19/56) of all cases. However, these figures should be taken in the context of the Belfast Trust's significantly larger and more complex caseload, relative to other Trusts.

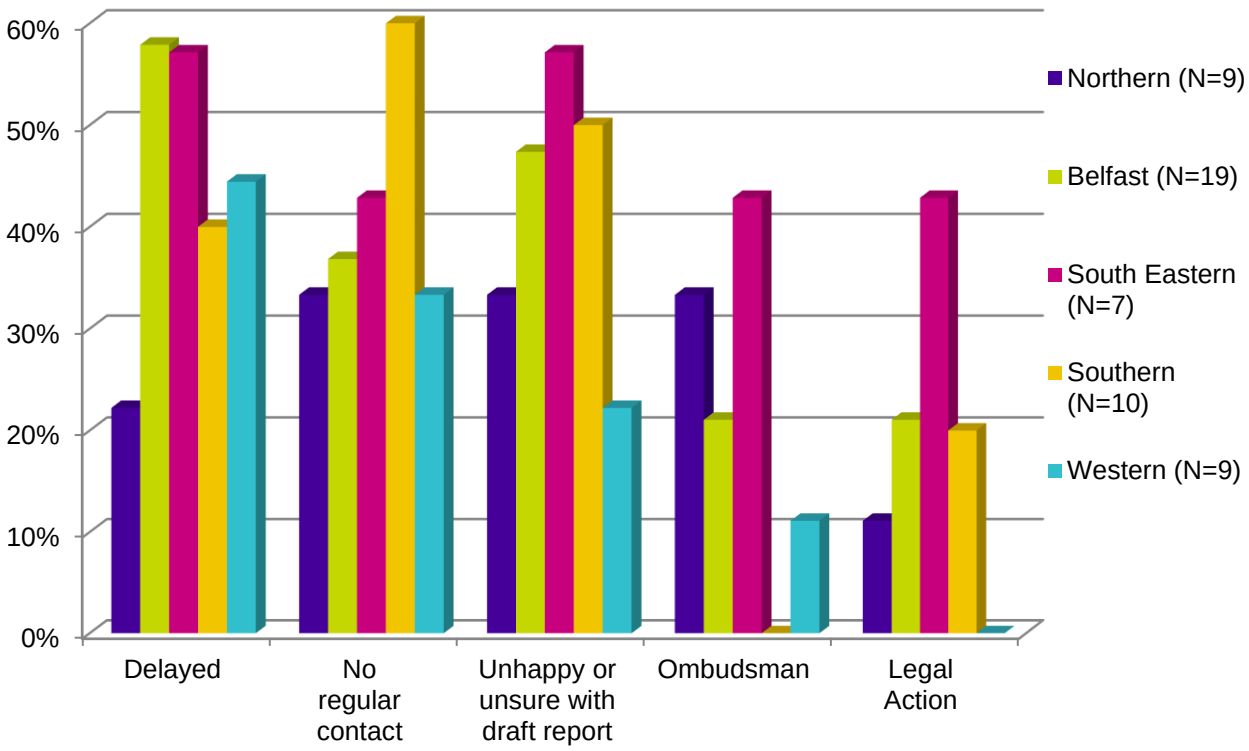
Issues raised by families about the management of the SAI process by the Trust included:

- Delays in the Trust completing the SAI or starting the process;
- The Trust not keeping in regular contact with the clients;
- The client being unhappy or unsure of the draft report.

In eleven cases, clients' unhappiness with the Trust's handling of the process or the SAI report itself led them to take further action with the Ombudsman and ten cases escalated to the point where clients considered taking or did take legal action.

These are presented in Figure 3 according to Trust area. This will be further broken down and examined in the following tables below.

**Figure 3: Nature of SAI issues by Trust area**




InThe greatest variation across Trusts was in the proportion of clients contacting the PCC due to delays in the SAI process (57.9% in the Belfast Trust vs 22.2% in the Northern Trust).

When issues are calculated as percentages in each Trust area, it can be seen that Belfast and South Eastern Trust have issues with delays with their SAI processes. It is also noted that Southern Trust has the highest percentage in relation to not keeping in regular contact with the client.

The South Eastern Trust has the highest proportion of clients who are unhappy with their draft SAI report, and also by far the highest percentage of clients considering or taking legal action, with the Belfast Trust second in this area. However, these percentages should be treated with caution, as bases sizes are all small.

Disaggregating the figures for legal action, 10.7% (N=6/56) of all SAI clients ultimately took legal action after the whole SAI process was finished. This was because they were unhappy with the handling or the outcome of the complaint from the Trust. At the time of writing, 5.4% (N=3/56) had informed the PCC they were still considering taking legal action.

*4.4 Status of Patient and Client Council SAI cases*

At the time of writing, there were 10 SAI cases still ongoing, with which the PCC was helping. Cases can vary in complexity and some of the cases have lasted a long time. This is noted in one case, which dates back to 2014. One case is still ongoing from 2017 and the remainder are 2018 cases.

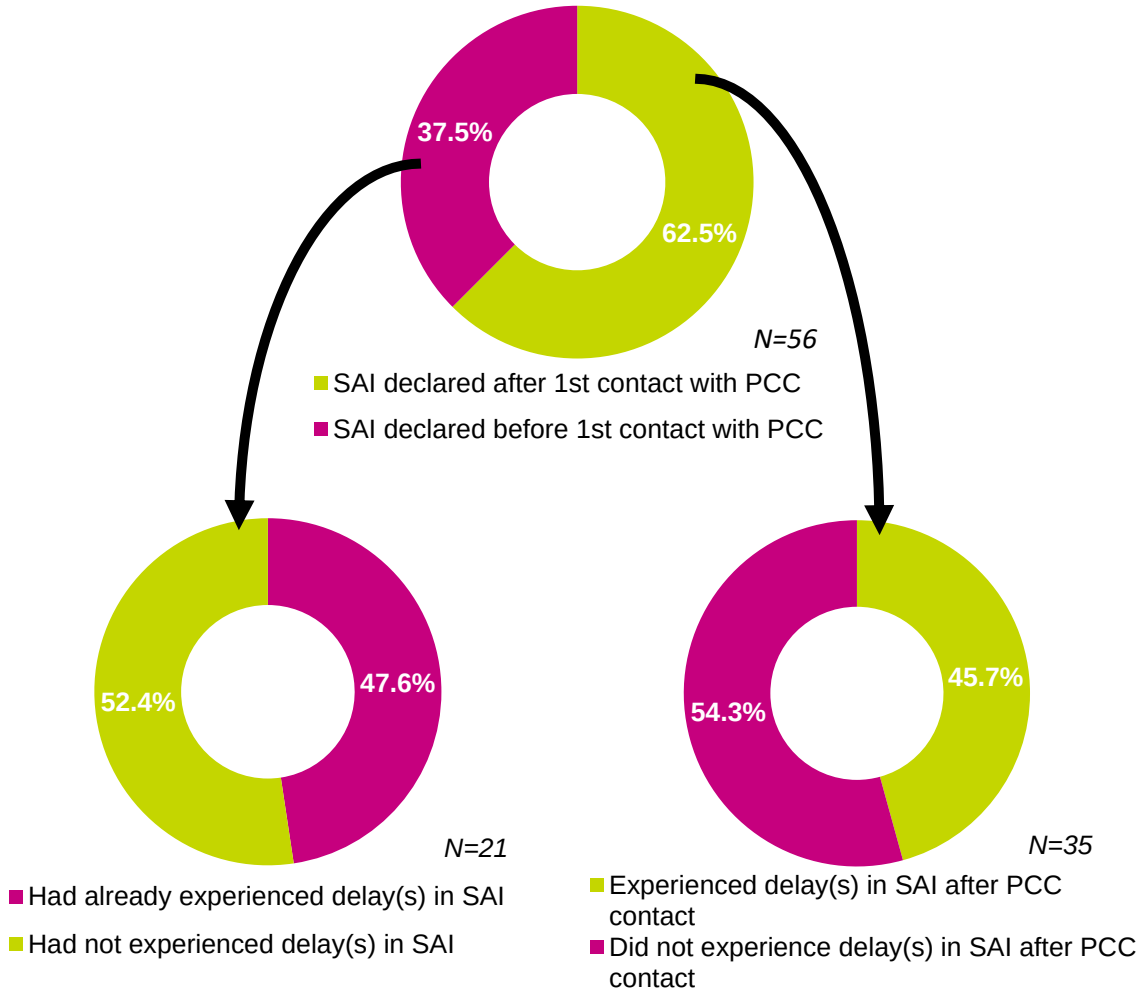
Figure 4 presents the proportion of SAI clients experiencing delays, broken down by whether the PCC became involved before or after an SAI was declared.

There were 37.5% (N=21/56) SAIs already in progress and the remaining 62.5% (N= 35/56) of SAIs were initiated after contacting the PCC. This indicates that:

- A high proportion of SAIs were initiated as a result of complaints raised with the support of the PCC; but that
- Contacting the PCC prior to an SAI being declared appears to have no bearing on whether delays were experienced in the SAI process, with almost a half of clients in each group reporting delays.

21.4% (N=12/56) of clients had already received their SAI report before contacting the PCC.

**Figure 4: SAI clients experiencing delays by timing of PCC contact**




## 5. Nature of SAIs dealt with by the Patient and Client Council

*5.1 Areas of service in which SAIs were raised*

As can be seen in Table 3, Mental Health was the specialism with the highest incidence of SAIs, with acute services and A&E the second and third most common areas in which complaints were raised.

*NB: the Acute Services include one case from each of the following areas: Cardiology/Cardiac Surgery, Domiciliary Care, Emergency Ambulance, ENT, Family and Childcare, Gastroenterology, Intensive Care Unit, Oncology, Orthopaedics, Prison Healthcare, Podiatry, Respiratory, Renal and Urology.*

**Table 3: Main areas of service for SAIs**

| Main area | Number | Percentage |
|---|---|---|
| **Mental Health** | 13 | 22.8% |
| **Acute Services** | 13 | 22.8% |
| **A&E** | 6 | 10.5% |
| **Maternity** | 6 | 10.5% |
| **Residential and Nursing Home** | 3 | 5.3% |
| **Elderly** | 3 | 5.3% |
| **ENT** | 2 | 3.5% |
| **Children's** | 2 | 3.5% |
| **GP** | 2 | 3.5% |
| **Medical general** | 2 | 3.5% |
| **Neuromedicine/neurosurgery** | 2 | 3.5% |
| **Vascular** | 2 | 3.5% |
| **Unspecified** | 1 | 1.8% |

*5.2 Mental health cases involving suicide*

Of the thirteen mental health SAI cases in which the PCC was involved between 2014 and 2018, eight of these involved suicides. When suicide attempts were made, the Trusts involved had put actions in place. These included Home Care Treatment and detention under the Mental Health Act, among others.

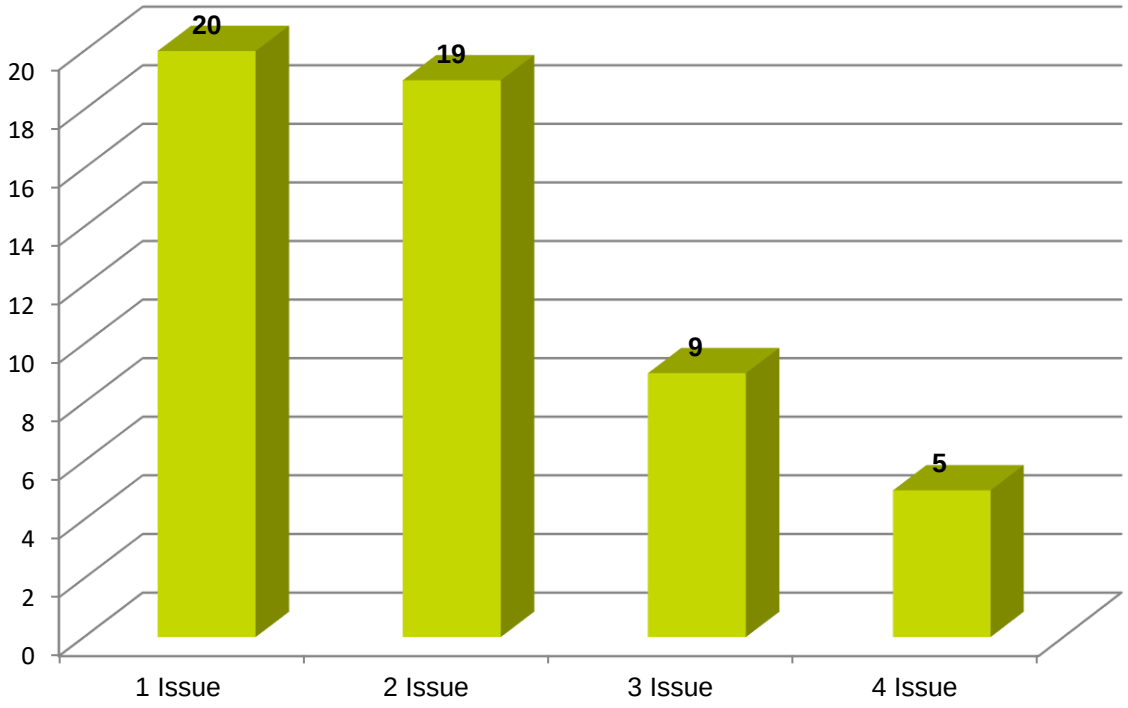
Exploring this sub-set of SAI cases, the most common areas of concern were:

- A lack of communication between the Trust, clients and their families. This is often not acknowledged within the SAI reports, despite being a point commonly made by the relatives of those involved in SAIs;
- Relatives and families not being consulted during the discharge procedure, with a tendency to focus purely on the client themselves. Some relatives argued that, had the Trust asked them for their opinion, their relative would still be alive. In some cases, the Trust admitted failing to ask close relatives. A recommendation was given in one SAI for relatives to be involved in the assessment before discharge.
- Families not being given follow-up support after discharge as to how to look after someone.

## 6. Reasons clients approached the PCC

Most of the PCC's SAI cases involve more than one issue.

**Figure 5: Number of issues raised per SAI case**




As can be seen in Figure 5, 35.7% (20/56) clients had only one area of complaint, 33.9% (19/56) had two complaint areas,16.1% (9/56) had three areas of complaints, but only 8.9% (5/56) had four areas of complaint. 5.3% (N=3/56) did not state what the complaint related to.

**Table 4: Issues raised in SAIs**

| Complaint | Number | Percentage |
|---|---|---|
| **Quality of treatment and Care** | 26 | 23.9% |
| **Diagnosis** | 15 | 13.8% |
| **Communication** | 13 | 11.9% |
| **Inappropriate treatment** | 13 | 11.9% |
| **Professional assessment of need** | 10 | 9.2% |
| **Complaints handling** | 9 | 8.3% |
| **Staff attitude** | 8 | 7.3% |
| **Nursing care** | 5 | 4.6% |
| **Discharge** | 2 | 1.8% |
| **Medication** | 2 | 1.8% |
| **Records/record keeping** | 2 | 1.8% |
| **Waiting times** | 2 | 1.8% |
| **Confidentiality** | 1 | 0.9% |
| **Treatment and Care – Surgery** | 1 | 0.9% |

It is evident from Table 4 that the most common complaints were about the quality of treatment and care. The next is diagnosis and joint third is communication and inappropriate treatment.

## 7. Nature of support provided by the Patient and Client Council in SAI cases

Since 2014 the PCC has helped 56 clients who were involved in an SAI. Of those 56 cases 12.5% (N=7/56) of the clients had limited contact with the PCC, having approached the PCC for advice, a letter template, or to check over a letter and had no further contact with the PCC.

When the client approached the PCC they were asked the type of support they would like. 44.6% (N=25/56) of clients asked the PCC for advice, assistance and support; 33.9% (N= 19/56) of the clients asked for advice only, however this advanced to more support; 5.4% (N=3/56) asked for support alone.

After approaching the PCC, clients received a range of support from the CSOs.

### *7.1 Help with paperwork*

Clients were sometimes unsure if they wanted to make a complaint or needed help with writing a complaint letter and filling in forms.

- The PCC provided 28.6% (N=16/56) with a PCC self-help booklet on writing a complaint letter to the trust. Clients were also provided with a template letter of what should be included within their letter.
- The CSOs also drafted, advised or amended complaint letters on behalf of the client; 37.5% (N=21/56) availed of this service.
- A further 15.2% (N=7/46) of clients had the CSOs support in writing letters or filling in their forms for the Ombudsman.

### *7.2 Advice*

The CSOs also provided 66.1% (N=37/56) with general advice. General advice included how to approach the Trust if not listened to; how long is too long to wait on a letter; advice on where else to look for other support, for example, bereavement support.

### *7.3 Advocacy*

For 50.0% (N=28/56) of clients, the CSOs contacted the Trust on behalf of the client. The did this if they had not been in contact with the client; found out information on behalf of client; and set up meetings between the client and Trust. In some cases the CSOs became the main point of contact with the Trust. In 33.9% (N=19/56) of SAI cases, they also attended meetings with or on behalf of the client with the Trust.

The CSOs offered to meet before the meeting with the Trust to prepare the client for what to expect. They also advised the client to prepare questions which were sent to the Trust before the meeting.

*7.4 Emotional support / reassurance*

During the SAI process the CSOs were often a source of comfort for individuals and/or their relatives, who often stated that they felt listened to and thanked the CSO for their support.

## 8. Quality of service providers' management of the SAI review process

The review of PCC data on SAI cases showed several areas for improvement in service providers' management of the SAI process:

*8.1 Lack of steps to involve clients' families*

Families should, if they so wish, engage with the investigation and receive feedback on progress[4]. The current procedure for the reporting and follow up of Serious Adverse Incidents (October 2013) indicates that investigation teams should provide an opportunity for the service user/relative/carers to contribute to an SAI investigation[2]. It is the responsibility of each individual Trust to decide if such engagement is necessary. Trusts are advised that the level of involvement should be determined by the nature of the incident and by service users'/relatives'/carers' wishes to be involved[2].

In the cases dealt with by the PCC, 44.6% (N=25/56) of SAI clients reported being offered a meeting with the Trust. However, of the remainder, many approached the PCC for advice only (and therefore would not have been offered a meeting with the Trust) or else it was unclear whether they were offered a meeting. Only four eligible clients had not been offered a meeting, while two had been offered a meeting but declined. These meetings were for clients to discuss concerns about the SAI, to try to improve the draft SAI report or simply to ask questions of the Trust's representatives. Some clients described not feeling listened to by the Trust, which resulted in them bringing their complaint to the Ombudsman.

*8.2 Lack of updates*

Some clients described feeling a lack of communication from the Trust. There were six cases where families described not being informed that an SAI was taking place. In one case, the PCC was informed that an SAI was taking place but the client was not informed. CSOs supported clients by contacting the Trust on behalf of the client due to lack of communication regarding information about the length of the SAI process, how far along the SAI process was and when they were likely to receive the report.

*8.3 Timing of communication*

Some clients believed that the Trust had spoken to them too soon after they had been bereaved and at a time when they were not ready to speak to the Trust or to consider the information provided. Alongside other clients' perceptions of having waited too long for communication from Trusts, this suggests that the timing of communication with people involved in SAIs should be carefully considered and tailored to the circumstances and needs of the individual or family.

*8.4 Quality and clarity of SAI reports*

Some clients also felt that they could not understand the SAI report due to the terminology used. This was an issue raised in the RQIA findings. In most Trusts, the RQIA found the terminology used often caused unnecessary confusion, worry and emotional distress to the family[2]. The PCC offers support to these families through:

- Reading the report with the family;
- Getting clarification on behalf of the family; and/or
- Arrange meetings to clarify anything that is unclear.

Almost half (49.0%) (N=24/49) clients included in this analysis expressed that they were unhappy with or unsure about the Trust's draft SAI report. Of these, 41.7% (N=8/24) were still unhappy with the final report and did not feel that their questions had been answered. Some clients felt that reports did not include everything they wanted them to include. Other clients had met with the Trust and felt that they had succeeded in getting their point across but, upon receiving the final report, did not feel the Trust had listened to them or reflected their perspectives in the SAI report. Some clients described the recommendations as 'weak'. They felt that the SAI did not provide the outcome they were expecting, or were not happy due to the lack of an apology within the SAI reports or, what they perceived, as 'coldness' they detected in some reports.

*8.5 Delayed SAI outputs*

According to RQIA (2014), depending on the level of the SAI, the Trust should respond within 4 weeks to an Significant Event Audit (SEA). For a more intense or complex investigation, a report is to be submitted within 12 weeks from the incident or from when the SEA was escalated.

Reported delays in the SAI process and in the delivery of SAI reports were a recurring issue, and these delays were often perceived as having been caused by the Trust. In many cases, a delay in the SAI process was the client's main reason for approaching PCC. 42.9% (N=24/56) of clients came to the PCC with an SAI already in progress. Of those 24 clients, eleven (45.8%) were delayed. Delays were also

reported in delivery of the draft SAI report, in sharing notes from meetings with clients and in receiving the final SAI report.

## 9. Key Learning Points

Based on the information from the PCC Complaints Support Service database, further consideration needs to be given to whether current procedures for the investigation of Serious Adverse Incidents, and for engagement and communication with families, are adequate to meet the needs of families in these circumstances.

A major concern is the lack of communication between the Trust and client. In many cases, the PCC has had to communicate on behalf of the client in order to elicit responses from provider organisations. Trusts involved in SAIs should maintain regular contact with the service users and carers involved, updating them on developments and notifying them about any delays and the reasons for such delays.

Trusts should also time their contact with SAI complainants to take account of how recently a person has been bereaved and to ensure that any communication about a SAI happens after a person has been made aware that an SAI is taking place. Trusts should acknowledge the circumstances surrounding the incident to which the SAI relates, and give sufficient time for the relative or patient to process their situation before bringing them into the process.

Delays in SAIs are also an issue and clients have described how these delays add avoidable stress to already difficult circumstances. Trusts should focus on providing more accurate estimates of SAI timescales, and also try to process SAIs more efficiently to relieve some pressure on those involved, while at the same time maintaining the thoroughness of the investigative process.

Issues were also raised around SAI outputs. Some of these concerns reflected wider problems with the SAI process. However, there was a clear finding concerning the use of inaccessible language in SAI reports, making these difficult for SAI clients and their families to understand. These reports should be written using language which is as straightforward and succinct as possible, and avoid the use of technical jargon or acronyms.

## 10. Limitations

This analysis is based on a review of all complaints cases dealt with by the PCC's Complaints Support Service involving SAIs and opened between January 2014 and December 2018. As such, the cases included cover only a proportion of all SAIs declared in Northern Ireland over this period, though information on the number of SAIs declared in Northern Ireland during this period is not available. The figures reported, themes identified and conclusions drawn cannot therefore be considered representative of or applicable to all SAI cases.

It should also be noted that this work was a desk-based exercise; any learning needs to be taken in this context. However, we intend to facilitate workshops with families who have availed of PCC services, to explore in more detail their experience and recommendations for service improvement internally and externally. The content of this report will be applied in planning and delivering these workshops.

## References


[1] *Northern Ireland Statistics and Research Agency (2017), 2016-based Population Projections for Northern Ireland. Accessed 13th March 2019. Available from: https://www.nisra.gov.uk/publications/2016-based-population-projections-northern-ireland*

[2] *The Regulation and Quality Improvement Authority (RQIA) Quality Assurance of the Review of all Serious Adverse Incidents reported between 1st January 2009 and 31st December (2014). Accessed: 25th February 2019. Available from: https://www.health-ni.gov.uk/news/rqia-publish-quality-assurance-report-review-handling-serious-adverse-incidents*

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