Health and Social Care Board

# THE 11th ANNUAL COMPLAINTS REPORT

# OF THE

# HEALTH AND SOCIAL CARE BOARD

## April 2019 – March 2020

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## 1.0 Summary Position

This is the 11th Annual Complaints Report of the HSC Board and provides a review of events during the year 2019/20, and an overview of complaints activity throughout this period.

The updated HSC Complaints Procedure became effective from 1 April 2019, further detail of which is included in the report. During the early part of the year the HSC Board underwent an internal audit of its handling and monitoring of HSC complaints and as a consequence of this, has made changes to its operational procedures. Of significance, the end of the year saw the dramatic emergence of COVID-19 in the UK and the country placed in 'lockdown'.

- **Position at a glance**

- This year has shown a slight increase in the number of issues of complaint received by the Health and Social Care Trusts (HSC Trusts) at 6,105, compared with 6,049 in the previous year. This figure is in keeping with statistics recorded in 2017/18 (5,814) and 2016/17(6,189).

- The top three categories of complaint remain quality of treatment and care, communication/information and staff attitude/behaviour.

- In relation to Family Practitioner Services (FPS) there continues to be a downward trend in the number of complaints and responses being received by the HSC Board from FPS Practices. In 2019/20 140 local resolution returns were received by the HSC Board. This compares with 177 the previous year.

- In terms of complaints where the HSC Board acted as an 'honest broker' there has been a sharp fall in the number received. In 2019/20 the HSC Board acted as an honest broker in 70 complaints compared to 140 in 2018/19. This is more of a comparison to previous years 2015/16 (79); 2016/17 (43); and 2017/18 (54).

- The number of complaints received by the HSC Board during 2019/20 was 29, a similar figure to that received in the previous year (25). Eleven of these complaints were responded to within 20 working days.

- The HSC Board carried over 4 complaints from the previous year (2018/19); received a total of 82 complaints during 2019/20 (both HSC Board and honest broker complaints); responded to 47 of these complaints within 20 working days and has carried over 4 ongoing complaints into 2020/2021.

- An Internal Audit of HSC Board Complaints Management resulted in a limited assurance being achieved. 14 recommendations were made and a rigorous action plan developed to expeditiously improve this position. The actions taken are highlighted within the report. The subsequent review undertaken by Internal Audit has resulted in satisfactory assurance being achieved with 11 of the 14 recommendations fully implemented. The Complaints Manager will continue to treat the outstanding areas as a priority and would hope to achieve full implementation at the next review.

- Almost 28,000 compliments were received by HSC Trusts in 2019/20, an increase of 11,000 from the previous year. Of note, the top three categories of compliments remain the same as the top three categories of complaint.

## 2.0 Audit on Complaints Management

2.1 During the period the Audit was conducted – unfortunately limited assurance was achieved and 14 recommendations for improvement were made. An action plan was put in place and there has been significant progress. Following a review undertaken by Internal Audit this has resulted in satisfactory compliance.

The following summarises the specific recommendations and the actions taken:-

2.2 Regional complaints learning identified should be disseminated in learning matters newsletters on a more timely basis. While the audit review continued to find this a point of concern arrangements are now in hand to produce a ‘Complaints Special’ edition of Learning Matters in order to address the backlog of complaints, and moving forward ensuring that complaints learning is shared in a more timely manner in future editions.

2.3 To ensure enhanced visibility of the timeliness of the process for disseminating regional complaints learning, the HSC Board developed a table to detail the timeline from identifying learning, confirming the lead professional for development of the article and the date/projected date or edition the article will be included in Learning Matters.

2.4 In light of the consistently poor attendance/cancellation of the Regional Complaints Sub-Group (RCsG), it was recommended that the operation of the Group be reviewed and appropriately strengthened; that the Group meet in line with requirements and that regular non-attendance should be appropriately escalated.

2.5 In response to this recommendation the HSC Board reviewed the Terms of Reference for the RCsG and meetings have been held in line with these. All action logs from meetings held during 2020 were reviewed and no issues with attendance at meetings were noted. In response to a further recommendation the Terms of Reference were updated in January 2021 to include the quorum and detailed staff that should attend.

2.6 It was recommended that the HSC Board should strengthen its formal relationships with HSC Trusts in respect of complaints management either by requesting that nominated staff from HSC Trusts attend the RCsG, or that HSC Board attend HSC Trust meetings in respect of complaints. In response, the HSC Board/HSC Trust Regional Complaints Monitoring and Discussion Group was established and terms of reference and a Monitoring Protocol were developed to reflect requirements. Meetings with representatives from each HSC Trust take place at least on a biannual basis to discuss, themes, trends, issues of concern, and annual learning events.

2.7 It was recommended that the HSC Board's Complaints Office should monitor the responsiveness of queries raised with relevant health care professionals and that escalation processes be established, as well as a need to strengthen communication and oversight between the Complaints Office and the Quality Safety Experience Group (QSE). In response a spreadsheet was developed to monitor professionals' responses, which was deemed an appropriate method of monitoring responsiveness, and

the Monitoring Protocol updated to reflect that the HSC Board can request further detail on complaints as and when required or deemed appropriate by professional staff.

2.8 It was recommended that HSC Board senior management should intervene and ensure complete and timely complaints information is received from HSC Trusts where information in complaints returns is not of sufficient quality. The Monitoring Protocol which was developed details the timeframes by which monthly reports should be sent by HSC Trusts to the HSC Board; the details that should be included and the escalation process if returns are not submitted. This protocol states that a closed complaints report should be submitted by HSC Trusts on the 7th working day of each month, detailing complaints which have been closed two months retrospectively/closed the previous month.

2.9 Further, to ensure the HSC Board is receiving appropriate and timely information in respect of complaints in HSC Trusts (particularly in respect of learning) it should consider reintroducing the complaints learning template. As a consequence, the learning template was reintroduced, and included within the Monitoring Protocol and is now being used by all HSC Trusts. This was tested and verified by Internal Audit and no issues were noted.

2.10 The implementation of the recommendation that quarterly complaints reports should be provided to the Senior Management Team (SMT) and the Governance Committee on a timely basis, and also report on the number of open HSC Board complaints and FPS complaints, length of time they have been open; and reasons for delays is work in progress and full implementation has been impacted by the COVID-19 pandemic. This area is being treated as a priority for full implementation by the time of the next review by Internal Audit. Full implementation has been impacted as a consequence of COVID-19 priorities.

2.11 It was recommended that annual events covering learning from complaints take place at least once a year. Unfortunately the 2020 Complaints/SAI Learning Event was postponed due to the ongoing response to COVID-19. HSC Trusts have been reminded to continue to complete the complaints Learning Templates as and when significant learning has been identified from complaints. HSC Trusts have also been asked to keep a log of potential complaints which would be applicable for a regional Learning

Event. This recommendation will be taken forward as HSC exits the pandemic.

2.12 It was recommended that management should engage with FPS contractors to gain assurance that all complaints arising in primary care were being appropriately reported to the HSC Board as required. In response a number of actions were taken:

 The Complaints e-learning package for FPS practices was updated to include information in respect of complaints arising in primary care and is available on the HSC Board website.
 The FPS Complaints Information Poster was revised and updated, and is also available on the HSC Board's website and Primary Care Intranet Site.
 Complaints arising in primary care is also now included on the Governance Agenda for Practice Visits and Integrated Care Staff have been reminded of the e-learning and importance of following legislation

2.13 In terms of ensuring that the HSC Board is following all stages of the HSC Complaints Procedure, it was noted in the review by Internal Audit that the Complaints Procedure has been updated to follow DoH guidance as required and a random sample of 4 honest broker cases demonstrated compliance in 3 of these (two recommendations combined).

In response to the recommendation that the Chief Executive has visibility of all responses, the audit review was advised that the new Chief Executive has delegated responsibility for this to Directors. This position is reflected in the revised Policy on the Management of Complaints.

## 3.0 HSCB Monitoring Process for HSC Complaints

The RCsG is a sub-group of QSE. It reviews complaints information received from HSC Trusts and FPS Practices and also any complaints received by the HSC Board and the Public Health Agency (PHA). Membership comprises representatives from the HSC Board, the PHA and the Patient and Client Council (PCC). The HSC Board's complaints staff circulate specific categories of complaint to designated professionals within the HSC Board and PHA for comment at upcoming

RCsG meetings. These include complaints concerning Emergency Departments, maternity and gynaecology, social services, Out of Hours services, allied health professions, and issues associated with patient and client experience. Complaints relating to FPS are reviewed by the Board's respective professional advisers and a summary of all FPS complaints are circulated on a quarterly basis to this Directorate.

A standing item on the QSE agenda requires the RCsG to provide regular updates on complaints issues and/or developments. A quarterly report advising of any key issues or trends arising from complaints and any learning identified from individual complaints is also submitted.

### 3.1 HSC Trusts

In keeping with the requirements of the HSC Complaints Procedure, the HSC Board receives information from all of the HSC Trusts for monitoring purposes. This information is categorised into specific areas of complaint and shared with designated professionals within the HSC Board and PHA, who sit as members of the RCsG. Trends, themes and updates continue to be fed through to the joint HSC Board/PHA QSE via the RCsG. This monitoring process ensures that complaints information is routinely linked into existing work streams/professional groups, for example: -

- Food and Nutrition
- Falls
- Development of Pathways for Bereavement from Stillbirths, Miscarriages and Neonatal Deaths
- Development of Pathways for End of Life Care/Palliative Care
- Maternity Commissioning Group
- Patient Experience Working Group (10,000 more voices)

The monitoring also now highlights specific complaints concerning sepsis and stroke.

Quarterly reports from the RCsG are shared with the HSC Board SMT, and the HSC Board's Governance Committee on a twice yearly basis.

## 3.2 Family Practitioner Services (FPS)

There are in excess of 1500 FPS Practices across Northern Ireland. Under the HSC Complaints Procedure all of these are required to forward to the HSC Board anonymised copies of any letters or statements of complaint together with the respective responses, within three working days of the response having been issued.

From day to day contact with FPS Practices, it is apparent that the process of resolving complaints *'on the spot'* is continuing to flourish across FPS, with Practice staff successfully addressing issues/queries and concerns from patients and families without the need for formal submission of a complaint. This is to be welcomed and the HSC Board would encourage Practices to seek to resolve complaints in this way and effectively de-escalate the situation and reach resolution, provided the complainant is content with this approach. This is in line with the ethos of local resolution within the HSC Complaints Procedure in seeking to resolve complaints as close to their source as possible.

However, the HSC Board also strives to remind FPS Practices of their obligations in terms of the HSC Complaints Procedure, in relation to the requirement to share complaints and responses with the HSC Board. The e-learning package had been updated and re-launched on a new platform last year and all FPS Practices reminded of these requirements.

While many Practices are content to deal with complaints directly, there is an increasing number of Practices contacting the HSC Board complaints staff for 'support and advice' in relation to resolving complaints at local level.

As in previous years, during 2019/20 treatment and care again accounted for the majority of all complaints handled under local resolution. In line with other years, complaints concerning staff attitude/behaviour and communication were the next highest categories.

## 4.0 Complaints Activity

### 4.1 The Year in Detail

**Guidance in relation to the Health and Social Care Complaints Procedure (Revised April 2019)**

Following consultation an updated HSC Complaints Procedure came into effect in April 2019. The key principles of the procedure remained unchanged but the document was reviewed and refreshed in order to bring it up to date for 2019 and the document renamed as above. Updates included: -

- Details on the new government department name introduced under the Departments Northern Ireland Act 2016;
- Details of the role of the Northern Ireland Public Services Ombudsman (NIPSO) known as 'the Ombudsman' further to changes introduced under the Public Services Ombudsman Act (Northern Ireland) 2016;
- Removal on the restriction on providing electronic responses to complainants;
- Removal of the ability for HSC staff to complain to the Ombudsman about the way they have been dealt with under the Complaints Guidance;
- Further clarity on the role and remit of the HSC Board's role as 'honest broker' in complaints handling;
- Updated information on complaints about Independent Sector Providers (ISPs); and
- Process for dealing with complaints and serious adverse incidents that are subject to legal proceedings.

### 4.2 Review of Complaints regarding HSC Trusts

During the period 6,105 issues of complaint were received by the six HSC Trusts. This represents a slight increase from 6,049 issues received in 2018/19 and similar to 6,189 received in 2016/17 and 6,181 issues received in 2015/16.

These figures should be viewed in the context of the considerable volume of interactions between service users and health and social care professionals on a daily basis.

***Number of complaints issues received per HSC Trusts in 2018/19 and 2019/20 and percentage responded to within 20 working days***

| **Trust** | **2018/19** | **% in 20 working days** | **2019/20** | **% in 20 working days** |
|---|---|---|---|---|
| Belfast | 2,356 | 43.2% | 1,646 | 49.7% |
| Northern | 760 | 89.3% | 672 | 77.5% |
| South Eastern | 1,269 | 48.4% | 769 | 43.2% |
| Southern | 850 | 49.0% | 701 | 50.4% |
| Western | 690 | 22.1% | 489 | 26.2% |
| NI Ambulance | 125 | 11.3% | 93 | 6.5% |
| **Total** | **6,049** | **43.9%** | **6, 105** | **49.4%** |

In terms of programme of care, the top six were: -

| **2018/19** | | **2019/20** | |
|---|---|---|---|
| **1.** Acute Services | (59.9%) | **1.** Acute Services | (58.6%) |
| **2.** Family & Child Care | (7.1%) | **2.** Mental Health | (7.8%) |
| **3.** Mental Health | (6.8%) | **3.** Family & Child Care | (7.5%) |
| **4.** Elderly Services | (5.3%) | **4**. Elderly Services | (7.0%) |
| **5.** Primary Health & Adult Community | (4.7%) | **5.** Maternity/Child Health | (6%) |
| **6.** Maternity/Child Health | (4.6%) | **6**. Primary Health & Adult Community | (1.9%) |

***Composite HSC Trusts complaints by Programme of Care during 2018/19 and 2019/20 were:***

| Programme of Care | 2018/19 | 2019/2020 |
|---|---|---|
| Acute | 3,626 | 3,576 |
| Maternal & Child Health | 281 | 367 |

| | | |
|---|---|---|
| Family & Child Care | 429 | 458 |
| Elderly Services | 322 | 426 |
| Mental Health | 412 | 474 |
| Learning Disability | 93 | 113 |
| Sensory Impairment & Physical Disability | 58 | 40 |
| Health Promotion & Disease Prevention | 4 | 24 |
| Primary Health & Adult Community | 287 | 113 |
| None (No POC assigned) | 498 | 474 |
| Prison Healthcare* | 39 | 40 |
| **Total Complaint Issues** | **6,049** | **6,105** |

***South Eastern HSC Trust only**

## *HSC Trusts complaints by Subject during 2019/20*

| Subject | Belfast | Northern | South Eastern | Southern | Western | NIAS | Total |
|---|---|---|---|---|---|---|---|
| **Access to Premises** | 33 | 0 | 106 | 4 | 0 | 0 | **143** |
| **Aids/Appliances/Adaptations** | 31 | 1 | 17 | 9 | 5 | 0 | **63** |
| **Clinical Diagnosis** | 78 | 29 | 72 | 35 | 26 | 1 | **241** |
| **Communication/Information** | 394 | 66 | 265 | 230 | 49 | 1 | **1005** |
| **Complaints Handling** | 2 | 0 | 7 | 1 | 24 | 0 | **34** |
| **Confidentiality** | 17 | 8 | 13 | 19 | 10 | 0 | **67** |
| **Consent to Treatment/Care** | 4 | 1 | 0 | 0 | 2 | 0 | **7** |
| **Children Order complaints** | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| **Contracted Regulated Domiciliary Services** | 0 | 8 | 2 | 1 | 0 | 0 | **11** |
| **Contracted Regulated Residential Nursing** | 2 | 11 | 5 | 1 | 1 | 0 | **20** |
| **Contracted Independent Hospital Services** | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| **Other Contracted Services** | 3 | 6 | 3 | 4 | 12 | 0 | **28** |
| **Delay/Cancellation for Inpatients** | 4 | 1 | 11 | 1 | 6 | 0 | **23** |
| **Delayed Admission from A&E** | 0 | 0 | 8 | 1 | 10 | 0 | **19** |
| **Discharge/Transfer Arrangements** | 42 | 10 | 15 | 23 | 12 | 0 | **102** |
| **Discrimination** | 5 | 2 | 9 | 0 | 0 | 0 | **16** |
| **Environmental** | 24 | 8 | 33 | 19 | 5 | 0 | **89** |
| **Hotel/Support/Security Services** | 13 | 32 | 2 | 9 | 1 | 0 | **57** |
| **Infection Control** | 2 | 0 | 5 | 4 | 2 | 0 | **13** |
| **Mortuary and Post Mortem** | 1 | 0 | 0 | 0 | 0 | 0 | **1** |
| **Policy/Commercial Decisions** | 9 | 35 | 13 | 25 | 1 | 0 | **83** |
| **Privacy/Dignity** | 5 | 5 | 34 | 15 | 8 | 1 | **68** |
| **Professional Assessment of Need** | 17 | 30 | 8 | 102 | 39 | 0 | **196** |
| **Property/Expenses/Finance** | 29 | 14 | 11 | 12 | 1 | 0 | **67** |
| **Records/Record Keeping** | 13 | 7 | 29 | 21 | 6 | 0 | **76** |
| **Staff Attitude/Behaviour** | 258 | 129 | 223 | 189 | 109 | 24 | **932** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Transport, Late of Non-arrival/Journey Time** | 1 | 1 | 2 | 2 | 47 | 40 | **93** |
| **Transport, Suitability of Vehicle/Equipment** | 0 | 1 | 1 | 1 | 21 | 0 | **24** |
| **Quality of Treatment & Care** | 448 | 211 | 346 | 191 | 148 | 23 | **1367** |
| **Quantity of Treatment & Care** | 158 | 12 | 16 | 19 | 37 | 2 | **244** |
| **Waiting List, Delay/Cancellation Community Based Appts** | 19 | 22 | 18 | 4 | 2 | 0 | **65** |
| **Waiting List, Delay/Cancellation Outpatient Appts** | 243 | 45 | 54 | 26 | 61 | 0 | **429** |
| **Waiting List, Delay/Cancellation Planned Admission to Hospital** | 190 | 15 | 18 | 20 | 8 | 0 | **251** |
| **Waiting Times, A&E Departments** | 15 | 9 | 17 | 19 | 9 | 0 | **69** |
| **Waiting Times, Community Services** | 5 | 1 | 4 | 22 | 8 | 0 | **40** |
| **Waiting Times, Outpatient Departments** | 33 | 7 | 8 | 29 | 8 | 0 | **85** |
| **Other** | 20 | 12 | 17 | 9 | 16 | 1 | **75** |
| **Total** | **2,118** | **739** | **1,392** | **1,067** | **696** | **93** | **6,105** |

The three most common 'subject of complaint' issues continue to be quality of treatment and care (1,367); communication/information (1,005); and staff attitude/behaviour (932).

## 4.3 Review of Family Practitioner Services (FPS) Complaints

### *4.3.1 Complaints handled under Local Resolution*

| Subject | GP | Dental | Pharmacy | Ophthalmic | Total |
|---|---|---|---|---|---|
| Treatment & Care | **53** | **8** | **0** | **0** | **61** |
| Appointments | **19** | **0** | **0** | **0** | **19** |
| Prescriptions | **12** | **1** | **0** | **0** | **13** |
| Communication/Information | **10** | **0** | **0** | **0** | **10** |
| Staff Attitude | **8** | **0** | **0** | **0** | **8** |
| Confidentiality | **2** | **0** | **0** | **0** | **2** |
| Clinical Diagnosis | **2** | **0** | **0** | **0** | **2** |
| Policy/Commercial Decisions | **2** | **0** | **0** | **0** | **2** |
| Administrative Errors | **2** | **0** | **0** | **0** | **2** |
| Medication | **4** | **0** | **0** | **0** | **4** |
| Removals | **5** | **0** | **0** | **0** | **5** |
| Registration | **1** | **0** | **0** | **0** | **1** |
| Failure to Follow Procedures | **1** | **0** | **0** | **0** | **1** |
| Other | **9** | **1** | **0** | **0** | **10** |

| | | | | | |
|---|---|---|---|---|---|
| **Total** | **130** | **10** | **0** | **0** | **140** |

Following on from the slight decrease in the number of complaints and responses being received by the HSC Board from FPS Practices in 2016/17 (206), this trend has continued with 177 in 2018/19 and 140 in 2019/20.

| Local Resolution | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| **GP** | **194** | **192** | **171** | **151** | **131** |
| **Dental** | **15** | **13** | **10** | **26** | **9** |
| **Pharmacy** | **1** | **1** | **5** | **0** | **0** |
| **Ophthalmic** | **0** | **0** | **0** | **0** | **0** |
| **Total** | **210** | **206** | **186** | **177** | **140** |

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### *4.3.1 'Honest broker' complaints*

| Subject | GP | Dental | Pharmacy | Ophthalmic | Total |
|---|---|---|---|---|---|
| Treatment & Care | **28** | **4** | **0** | **0** | **32** |
| Appointments | **1** | **0** | **0** | **0** | **1** |
| Prescriptions | **1** | **0** | **1** | **0** | **2** |
| Communication/Information | **6** | **0** | **0** | **0** | **6** |
| Staff Attitude | **8** | **0** | **0** | **0** | **8** |
| Clinical Diagnosis | **1** | **0** | **0** | **0** | **1** |
| Policy/Commercial Decisions | **3** | **0** | **0** | **0** | **3** |
| Administrative Errors | **1** | **0** | **0** | **0** | **1** |
| Medication | **5** | **0** | **0** | **0** | **5** |
| Removals | **3** | **0** | **0** | **0** | **3** |
| Warnings | **1** | **0** | **0** | **0** | **1** |
| Other | **4** | **1** | **2** | **0** | **7** |
| **Total** | **62** | **5** | **3** | **0** | **70** |

On occasions where complainants do not wish to approach the FPS Practice directly, the HSC Board's complaints staff can act as an 'honest broker' between both parties. This intermediary role may arise due to a patient's or relative's concern about the impartiality of the FPS Practice to investigate the complaint, or because of a breakdown in the relationship between the patient and the practitioner. However, for the HSC Board's complaints staff to act in this role, with the aim of assisting local resolution and/or in helping restore relationships (where possible), or reaching a position of understanding, both parties must be in agreement to this occurring.

Not all complaints can be resolved by an exchange of written communication and on occasions this can involve meetings with the complainant to discuss the issues involved, the response subsequently received and what further action can/should be taken; as well as meeting separately with the Practice being complained about, or facilitating joint meetings of both parties.

While the HSC Board may become involved as an 'honest broker' the responsibility for investigation of the complaint lies with the Practice. In this regard, there is an option for the Practice to respond directly to the complainant, or via the HSC Board.

In the period 2019/20 the HSC Board acted as an 'honest broker' in 70 complaints concerning FPS Practices compared to 140 in 2018/19. This substantial differentiation has potentially been affected by the pandemic.

The total for 2019/20 is more in line with the numbers received in previous years: 2015/16 (79); 2016/17 (43); and 2017/18 (54).

| Honest Broker | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|
| GP | 66 | 34 | 44 | 101 | 62 |
| Dental | 11 | 7 | 7 | 34 | 5 |
| Pharmacy | 2 | 2 | 3 | 5 | 3 |
| Ophthalmic | 0 | 0 | 0 | 0 | 0 |
| Total | 79 | 43 | 54 | 140 | 70 |

Of the 70 'honest broker' complaints received, 29 were responded to within 20 working days. Regrettably in each year only about 50% of the complaints are responded to within the timescale: - 67 out of the 115 in 2018/19 and 17 out of 43 in 2016/17. However, this is better than 2015/16 and 2014/15 when 79 and 96 complaints were received and 26 and 30 responded to within 20 working days. While it is regrettable that more complaints were not completed within the DoH target timescale, the role of 'honest broker' demands continued contact and liaison between the relevant parties and this ensures that timely and accurate updates are provided.

FPS Practices themselves can request the services of the HSC Board to act in this role and while the complainant must also be in

agreement, these instances may often involve complex complaints.

## 4.4 Complaints concerning the HSC Board

The HSC Board received 29 complaints in 2019/20 a slight increase from that received in 2018/19 (25). These numbers are greater than those received in recent years, 9 in 2017/18, 12 in 2016/17 and 8 in 2015/16. However, the largest annual figure of 35 in 2014/15 was attributed to a commissioning decision to 'pause' treatment due to financial constraints.

In relation to the 29 complaints received in 2019/20 the vast majority of these related to decisions taken by the HSC Board in respect of Extra-Contractual Referrals, with others concerning applications in relation to EU directive, rises in Care Home costs, GP Practice boundaries and the availability of cannabis oil.

In terms of response times for HSC Board complaints – 11 of the 29 complaints were responded to within 20 working days.

## 4.5 Independent Lay Persons

The involvement of an independent Lay Person is one of the potential options available within the HSC Complaints Procedure to resolve complaints at local resolution. This year the HSC Board nor any of the HSC Trusts involved an Independent Lay Person in any of their complaints.

## 4.6 Independent Experts

Similarly, the acquiring of an independent medical opinion/professional is a further option available under the HSC Complaints Procedure as a means of seeking to resolve complaints under local resolution.

During the period 2019/20 the HSC Board did not seek independent expert opinions in any complaints.

However, two complaints from 2018/19 in which an independent expert had been used reported during the year. Unfortunately, neither of these complaints was successfully resolved with one progressing to the Ombudsman.

In 2019/20 the HSC Trusts involved independent experts opinions as follows: -

| HSC Trust | Number of Opinions |
|---|---|
| Belfast | 2 |
| Northern | 5 |
| South Eastern | 2 |
| Southern | 0 |
| Western | 2 |
| NI Ambulance Service | 0 |
| **Total** | **11** |

## 5.0 Other Issues

Initial discussions took place with the Ombudsman's office to agree a mechanism where anonymised executive summaries/Investigation Reports of the Ombudsman's investigations, where regional learning or suggested changes to local/regional services has been identified, should routinely be made available to the Board.

Most investigation reports are currently available on the website, but this would negate the current practice by complaints officers of having to search the Ombudsman's website.

A number of measures have been identified for implementation next year, such as: -

- Assisting in the scheduling a joint complaints/SAI learning event, COVID-19 permitting.

- Continued meetings with the joint Regional HSC Board/Trusts Forum.

- Meeting with the newly appointed Ombudsman.

- Liaison with the Chair of the RCGP(NI) in identifying designated General Practitioners to act as independent experts.

## 6.0 NI Public Services Ombudsman

The NI Public Services Ombudsman 2019/20 report outlined that this was its 50th year and coincided with an unprecedented demand for its services. The Ombudsman's office received 1,043 new complaints, a significant increase of 37% from the previous year.

Of the complaints received and considered by the Ombudsman's office, 36% related to Health and Social Care – 377 complaints. The vast majority of these concerned HSC Trusts (298) and GP Practices (33). There were 6 complaints concerning the Board.

The Ombudsman has the authority to recommend financial recompense where maladministration has been found. In one complaint, where a patient had died of multiple organ failure, given the serious failings, the Ombudsman recommended that the Trust concerned provide a payment of £10,000 to the family in recognition of the upset, frustration and distress caused.

The NI Assembly in the 2016 Act provided for the Ombudsman to hold a role as Complaints Standards Authority (CSA), a role held by the Ombudsman in Scotland and Wales. This role has not yet been commenced by the Assembly. As part of the NI Ombudsman's work into improving complaints handling, they met with the families of the residents of Dunmurry Manor Care Home to understand their difficult experiences in complaining about failing in the social care system. The Ombudsman refers to these issues being highlighted prominently in the Commissioner for Older People's Home Truths report in 2018.

The Ombudsman highlighted in the report that it would continue to address these issues through its forthcoming role as a Complaints Standards Authority.

Further information on the NI Public Services Ombudsman can be found on the website: -

nipso@nipso.org.uk

**Annex (1)**

***Local Learning***

**A complainant raised concerns regarding the poor care her son with a disability received when attending the Emergency Department for treatment of a wound.**

The Trust apologised that the treatment provided by the Urgent Care Centre was less than expected. The consultant apologised on behalf of the Emergency Department and the service manager and ward manager also apologised for the distress caused.

The Trust identified learning for the Urgent Care Centre and Emergency Department in relation to patients with disabilities - engaging with additional teams regarding the provision of 'Fast Track Cards' for patients with special needs when they present to the Emergency Department.

If the patient is known to learning disability services, staff have been educated to ask for the HSC Hospital Passport, which directs how each individual should be managed. Further information is available at: -

https://www.publichealth.hscni.net/publications/hsc-hospital-passport-and-guidance-notes

**Regional Learning**

**Example of regional learning which resulted in an article being included in Learning Matters:**

A patient attended the ED with acute chronic back pain. She had a one year history of chronic back pain and no other co-morbidities of note. On the day of presentation she experienced a sudden onset atraumatic exacerbation of her back pain, experiencing 10/10 pain, which radiated down the left leg to the knee, with associated paraesthesia over the left leg.

The patient was assessed with the left knee being the focus of the pain, therefore a knee X-ray was undertaken to exclude a bony injury. Documentation from this assessment describes sudden onset left knee

pain with paraesthesia. The patient's power and reflexes were normal. There was no documentation of bowel or urinary symptoms, and no PR was performed.

The patient was handed over to another clinician and following discussion with the Emergency Medicine Consultant, she was informed that there was no injury to her knee, and explained to her that it may be a 'bulging disc' in her lower back. She was referred for an MRI scan. The patient was discharged pending an outpatient MRI. No clear safety net or discharge advice was provided.

Four days later and still experiencing severe pain, the patient sought medical advice in the private sector. An MRI was subsequently performed which indicated spinal cord compression at the height of L5/S1. The patient was urgently transferred to the RVH for spinal surgery following a diagnosis of Cauda Equina Syndrome. Ten months post discharge the patient continues to experience ongoing pain, left leg weakness, bladder dysfunction and other associated symptoms.

**Key Learning:**

Cauda Equina Syndrome (CES) is a relatively rare, but very disabling condition and can be a source of significant morbidity as well as litigation.

The British Association of Spine Surgeons and the Society of British Neurological Surgeons joint 'Standards of Care for Suspected and Confirmed Compressive Cauda Equina Syndrome (Dec 2018) available at link below:

https://www.spinesurgeons.ac.uk/resources/Documents/News/Cauda_Equina_Syndrome_Standards_SBNS_BASS%20-%20Dec%202018.pdf

- A patient presenting with acute, or exacerbation of back pain or leg pain, with a suggestion of a disturbance of bowel/bladder function OR saddle sensory disturbance should be suspected as having CES;
- Suspected cases of CES should be urgently investigated, if imaging is not requested it should be clearly documented why;
- MRI scanning should be available on an emergency basis for cases of suspected CES, it should not be delayed unless there is a clinical reason for doing;
- Normal bladder function does NOT rule out CES;

Normal anal tone does NOT rule out CES

***Learning from FPS***

As part of the monitoring process, complaints concerning clinical/professional/regulatory issues are shared with respective professional staff in the Directorate of Integrated Care.

The complaint below outlines learning from a particular complaint, but also the involvement of the HSC Board professionals.

A lady raised a complaint regarding her GP Practice that her 22 month old baby, who has complex needs and suffers from epilepsy, had been prescribed the wrong dosage of medication (400% more than the required dosage) over an eight month period. On a number of occasions this resulted in her being admitted to hospital which required invasive treatment.

**Practice response:**

The Practice noted that given the patient's complex medical needs, she was under the care of a number of consultants including a Paediatric Neurology Consultant.

On review of the medical records, the Practice confirmed that it had a copy of the Epilepsy Emergency Care Plan which had been countersigned by one of the GPs as required. However, it acknowledged that there was no record of this being shared with the complainant by the Practice and apologised for this.

The Practice explained that one of the GPs had taken a call from a Community Paediatric Nurse who had been concerned with the labelling of the patient's medication. The nurse explained that the patient had two pre-filled syringes of medication, one of which had contained the wrong level of medication. She explained that this had resulted in the incorrect dose having been given to the patient over an extended period of time. The GP agreed to follow this up and come back to her.

The GP confirmed that the medication on the most recent hospital discharge letter did not specify a particular brand. The Practice concluded that one of the GPs, when adding this medication chose the drug from the 'pick list' and under dose entered 'use as required, repeat

after 10 minutes if required'. The Practice stated that had the complainant made contact to discuss the dosage and had spoken with a different member of staff, the prescribing GP could have made a follow up call to ensure the complainant understood what was required.

The Practice concluded that the GP had followed the exact instruction on the discharge letter, but accepted that the exact dose could have been entered to prevent an error at the Pharmacy or in administration.

The Practice apologised unreservedly that the care had fallen short of the standard they wished to provide.

Practice-based Learning:
The Practice carried out a Significant Event Analysis to identify the issues and to take action to prevent a recurrence. As a result an audit of all patients prescribed this medication was undertaken to ensure that no further similar incidents had occurred.

It reported that the Guidance (NI Medicines Matters (February 2018)) and NI Formulary, advised that buccal Midazolam should be prescribed by brand to avoid medication errors; that the brand of Midazolam be specified in the patient's care plan and that the carer be trained to use this; and that prescriptions comply with Controlled Drugs Regulations as Midazolam is a Scheduled 3 drug.

The Practice acknowledged there should have been more awareness by the clinicians to prescribe buccal Midazolam by specific brand to avoid the error that occurred and that the carer should have been counselled about this specific brand.

Additional action: In line with the HSC Board's monitoring processes this complaint was shared with one of the HSC Board's Medical Advisers to review. While they had no issues of patient safety, they updated pharmacy colleagues and suggested that the Practice submit an Adverse Incident form. As a result of this and a number of other incidents submitted by other Practices, a Best Guidance Reminder was issued to Practices and an article regarding this medication was included in a Pharmacy Newsletter.

**Annex (2)**

***Complaints Contact Points:***

**HSC Board**
Tel: 028 95 363893
Email: complaints.hscb@hscni.net

**Belfast Health and Social Care Trust**
Tel**:** 028 95 048000
Email: complaints@belfasttrust@hscni.net

**Northern Health and Social Care Trust**
Tel**:** 028 94 424655
Email: userfeedback@northerntrust.hscni.net

**South Eastern Health and Social Care Trust**
**Tel:** 028 90 561427
Email: complaints@setrust.hscni.net

**Southern Health and Social Care Trust**
Tel: 028 38 614150
Email: complaints@southerntrust.hscni.net

**Western Health and Social Care Trust**
Tel: 028 71 611226
Email: complaints@westerntrust.hscni.net

**Northern Ireland Ambulance Service Trust**
Tel**:** 028 90 400 999
Email: complaints@nias.hscni.net

**Patient and Client Council**
Freephone: 0800 917 0222

Complaints.PCC@hscni.net

**NI Public Services Ombudsman**
Freephone: 0800 34 34 24
nipso@nipso.org.uk