# Case Study

## Advocates reflection after 5 years

### Need to introduce compassion and engagement in NHS complaints

An Independent Complaints Advocates reflections authorised by their complaint partner. This has been written to share the complex nature of the processes that have ultimately left the complainant with some reassurance about the potential learning, but huge disappointment over the time it has taken to have his complaint partially upheld.

healthwatch West Sussex

## Case Studies Story

I entered Eric's (name changed) life when he was at his most vulnerable, having watched his wife slowly and painfully die, and as a new advocate for the Healthwatch West Sussex, Independent Health Complaints Advocacy Service (IHCAS). This complaint has taken five years to conclude. It has been valuable to my learning and useful in helping other residents of West Sussex.

The advocate went on a home visit with a colleague to meet Eric and to understand the events that had led up to the death of his wife. Angela (name changed) was taken ill in early 2017 and was transferred to a hospital in London for surgery. Following her discharge, she was due to go back in 4-6 weeks for more surgery. There was an issue with the pre-operative assessment and as a result Angela was never sent an appointment to return to London. All this time her health was declining, and they both felt abandoned by the NHS.

Finally, when the local GP came for a home visit at the end of June, there was realisation that Angela needed urgent support and treatment. A blood test was requested but it would take 14 days for the test to be done by the community nursing team. As a result, the local acute hospital requested Angela attend the hospital that evening, and an ambulance was called. Treatment was provided to stabilise her condition, and the GP contacted the hospital in London and an appointment was made for early August. Angela was discharged home in the middle of July to await her return to London. Her health declined further, and her GP was contacted, and a home visit was requested which took place at the end of July.

Both Angela and Eric felt the right action was to sit it out and wait for Angela to return to London for her surgery (at the beginning of August). During the same evening, Eric witnessed a dramatic decline in Angela, and he called an ambulance, and she was taken to her local acute hospital. She passed away a few days later from multi organ failure and urosepsis. Eric shared his sense of devastation and abandonment by the NHS. He contacted PALs (Patient Advice and Liaison Service) at the hospital and was directed to the Healthwatch West Sussex IHCAS service.

With support from the advocate, Eric was able to explain the events that had led up to Angela's death. A complaint was submitted in the winter of 2017 to the local Clinical Commissioning Group (CCG), to complain about the hospital in London, the acute hospital in West Sussex, the community nursing team, and the GP. The response letters were received in Spring 2018 and after conversations with Eric and the CCG it was felt that trying to have local resolution meetings1 with this many organisations would not be of benefit to Eric.

The advocate requested a copy of the significant Event Report and medical records from the GP. The new GDPR Regulations had come into force which allows people to get copies of medical records, requested without payment. As a result of all the data collection, the advocate made an application to the coroner's office, and it was confirmed they would undertake preliminary enquiries.

Continued...

As the client was not satisfied with the local outcomes, the advocate started to work with the Parliamentary Health Ombudsman Service (PHSO) on his behalf, in the autumn of 2018. The advocate was advised by the PHSO to log the complaint, but at no point were they advised that the complaint could be considered to be out of time. The PHSO stated the complaint could be submitted but they would wait for the outcome of the coroner's investigations. The PHSO application was submitted soon after the initial contact.

The PHSO rejected the application stating the local process had not been completed and the CCG stepped in to confirm that they felt the local process had been finished and the PHSO accepted their letter.

Towards the end of 2018, the coroner confirmed Angela's death would not go to inquest and closed the case. The additional information obtained by the coroner was shared with the PHSO and the advocate requested that the complaint was opened by PHSO. A case worker was assigned in early 2019, and the decision was made by the PHSO that Eric needed to take legal action and the case was closed.

Eric tried to take legal action but due to private reasons he was unable to continue with this route and the advocate contacted the PHSO in May 2019 to ask for the complaint to be re-opened. A new case worker was assigned in the summer of 2019 and a decision letter was received towards the end of 2019. The letter stated that they would not investigate due to the amount of time taken to submit the complaint to the PHSO.

With the advocates support Eric made the decision to challenge the PHSO's decision and a letter was submitted. The PHSO wrote to Eric at the beginning of 2020 to confirm they would uphold his complaint (about their decision not to investigate his complaint) and re-opened it with a different case worker. The scope of the investigation was set out in spring 2020, and the provisional review was shared in late 2020. Each time a provisional review was sent to the parties involved, comments were made to the PHSO, and the investigation continued.

More provisional views were received in early 2022, and with the advocates support, Eric wrote to the PHSO to raise concerns about the investigation and the amount of time taken. Eric received a letter from the PHSO in April 2022, stating "*I sincerely apologise for the delays in our consideration of your complaint and for the impact of this on you*". Finally, the PHSO decided to partially uphold the complaint in Summer 2022. Eric reflected with the advocate during their final telephone conversation, that if he had known how ill his wife was and what he knows now at the end of the complaint's process he might not have submitted the complaint in the first instance.

**Eric needed help and support to navigate the complex NHS complaints process. Reflecting on the length of time and the impact this has had on Eric, we leave the reader with the question: Was it worth this amount of time and effort just to be informed via a letter that the PHSO had partially upheld his complaint, and should the NHS be more open and transparent when a patient is seriously ill?**

## System learning:

Furthermore, a safeguarding referral was made by the ambulance service on Angela's last day at home before she died. As a result, an Adult Safeguarding Review of all the services involved leading up to Angela's death was undertaken.

Learning was first published in Autumn 2019. On behalf of Eric, Katie challenged the report and as a result the report was re-published at the beginning of 2021. The report can be found here. (Please note: - the report has been published with consent to use the full names)

The learning and recommendations for this complaint can now be shared:

- The hospital in London, the PHSO consider they did not ensure the surgery for Angela was scheduled in a timely way. "*Our decision is that this was a failing.*" They recommend the hospital complete an action plan setting out what it will do to prevent a recurrence of the failure to ensure Angela's surgery was scheduled in a timely way.
- The hospital in London, the PHSO consider there was a failing by the hospital to not refer Angela to a nephrologist. Recommending the hospital complete an action plan to reflect on what caused the failings. The action plan should be shared with NHS Improvements and the Care Quality Commission (CQC).
- For the acute hospital in West Sussex, the PHSO consider there was a failing, as it did not take appropriate action in relation to the continual increase in Angela's C-Reactive Protein (CRP) test. They recommend the hospital complete an action plan setting out what it would do to prevent a recurrence of the failure to take appropriate action in relation to the increase in CRP.
- The acute hospital in West Sussex, the PHSO consider there was a failing, by the hospital as it did not refer Angela to a nephrologist. The recommend the hospital complete an action plan and they should reflect on what caused the failing. The action plan would be shared with NHS Improvements and CQC.

## Additional learning was identified during the complaints process:

- The community nursing team recorded they believe that there are lessons to be learnt, that at the time records kept could have been more fully detailed, the care and treatment provided to Angela. The community nurses could have undertaken more detailed assessment of her wounds, this was to be brought to the attention of the team and action will be taken to develop their practice.
- The GP Practice discussed the complaint at the significant event meeting and acknowledge that the care provided had been compromised by the fact that the practice and social service and district nurse boundaries are not the same, the communication between these services was poor and we apparently do not get the pathology results on-line. Therefore, the conclusion was the practice would re-evaluate the boundaries and ask our existing patients who live out of area for the pro-active care team to re-register with a practice within the social services area.