healthwatch West Sussex

Independent Health Complaints Advocacy Service

Impact & Performance Report

July - September 2024 (Q2)

Supporting residents of West Sussex with their NHS Complaints – providing advocacy in the form of listening to the needs of the client and providing a voice for the individual to be heard.

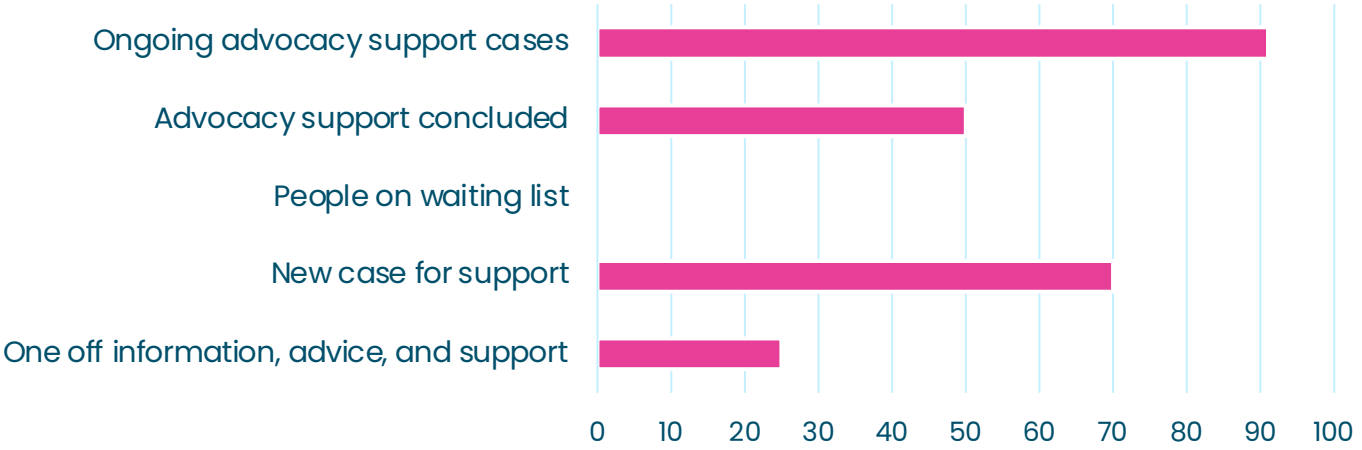
Healthwatch West Sussex is a Community Interest Company limited by guarantee (No. 08557470)

Our service

In recent months, IHCAS has seen a higher demand on the service, with new complaints and requests for support. The one-off information, advice and support has declined as more people have been referred for full advocacy. The service is still seeing increasing delays in getting complaint response letters and resolution meetings from the local Acute hospital Trusts in West Sussex.

IHCAS has seen a rise in complex complaints that require additional time and empathy, especially when supporting clients when their complaint involves the death of a loved one.

For example, two complaint received by the service in April 2021, went through the advocacy process at the local level and are now with the Parliamentary & Health Service Ombudsman and are still in the detailed investigation stage, with one potentially due to complete at the end of the year.



Last quarter comparison

	Key performance metrics for current and previous quarter	
	Q2	Q1
One off information and advice	25	58
New cases for support	70	39
People on waiting list	0	0
Advocacy support concluded	50	18
Ongoing advocacy support cases	91	76

Feedback from people we have supported

"I think your service is brilliant . You helped me clarify what I was actually complaining about and your assistance with the format and advice regarding presentation was really useful, thank you."

"You have given me some trust back and feeling that someone may understand the terribly frustrating and confusing time I have had the past 3 years. I feel a boost of energy, thanks for listening to my concerns. 🙂"

"As I have said on several occasions, I truly believe that I would not have been able to do this without your amazing assistance and advocacy. I really do appreciate it and you"

"I just wanted to thank you for all the work and support you have given to resolve the issues."

"Thank you for all your help and support, it is greatly appreciated and your continued support."

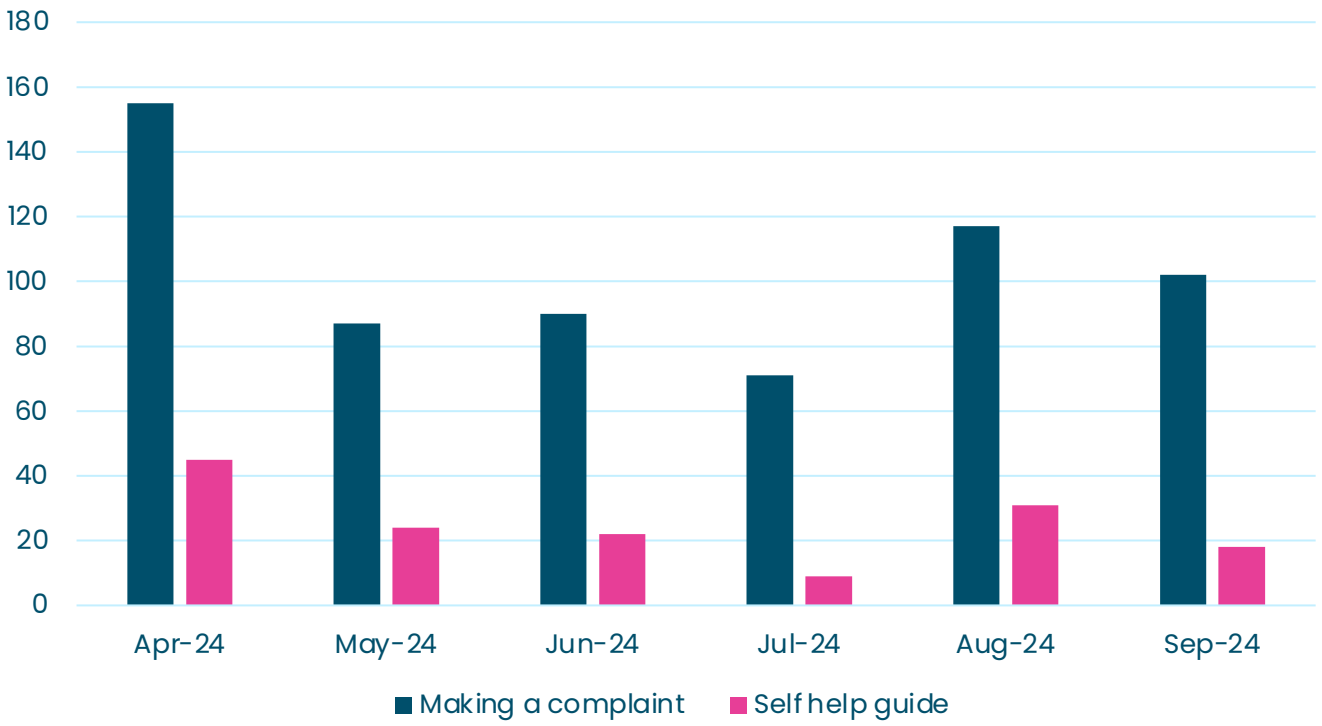
Promoting Advocacy Support for Residents of West Sussex

During this quarter we have been promoting the IHCAS service across social media to ensure the residents of West Sussex are aware, if they need to make a complaint. By using the case study "If you have a cough"

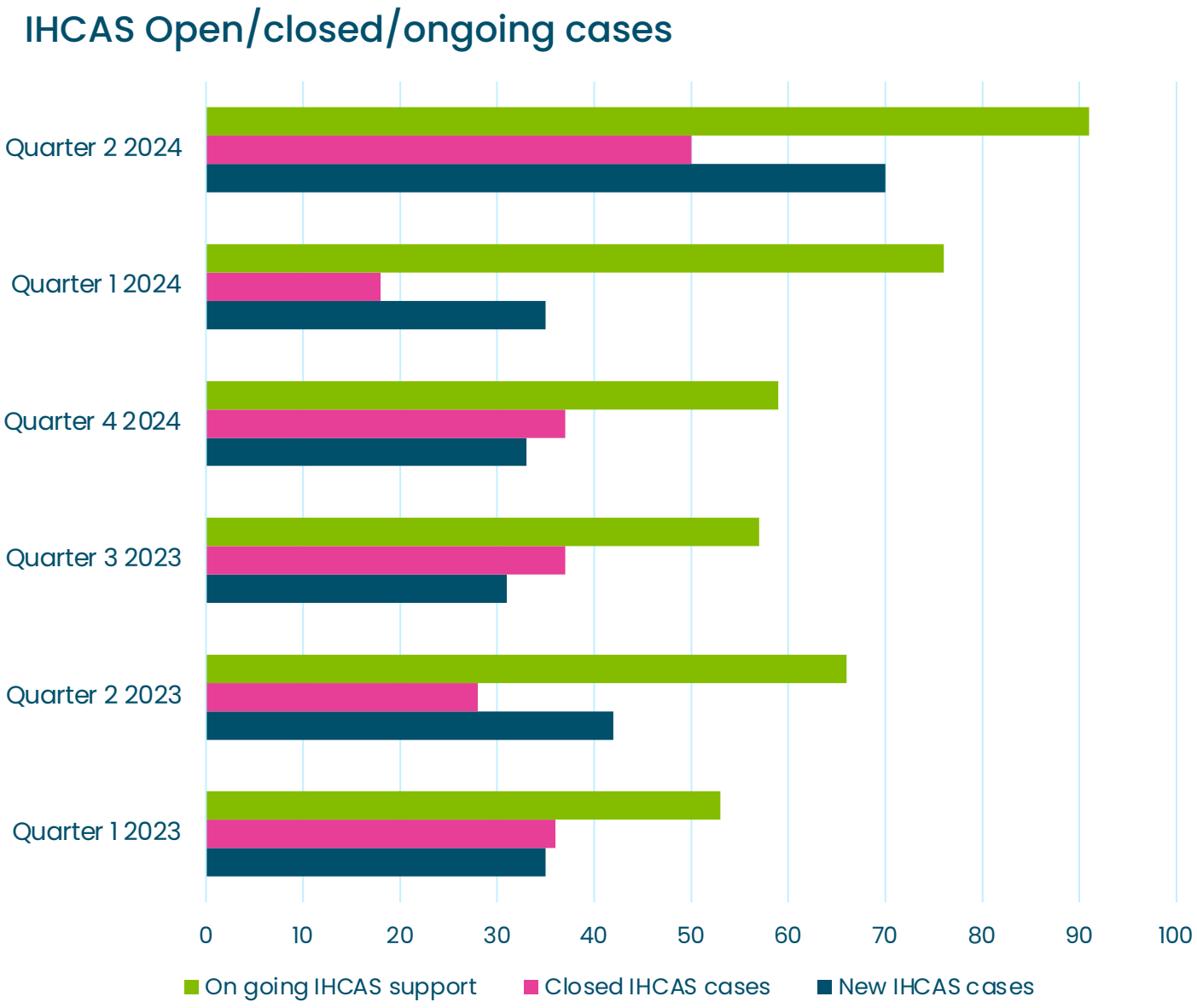
Read the case study

The post on Instagram was the top post for August 2024, and reached 41 viewers, the case study page has also had 33 people view this page in August, as a result we have seen an increase in the number of people access our services either by accessing self-help or direct advocacy support.

Website views in the past 6 month



Annual IHCAS Case Comparison



This charts shows that over the past year the demand for the IHCAS service and access to advocacy support has increased. The social media campaign to promote the service has resulted in an increase of requests to the service over the past quarter. The advocates have seen lots of delays in getting complaint response letters from the organisations the complaint was submitted to. There are delays in getting access to medical files, local resolution meetings are taking longer to arrange. As an example, one IHCAS client is still waiting for a meeting that was requested in December 2023.

Each complaint is unique and the process each complaint undertakes if different depending on the outcome the person is looking for, some just would like an apology, other look for learning to ensure what happened to them does not happen again or some want the evidence to go down the legal route.

Impact & Learning

- Help supporting a family make a complaint to the Integrated Care Board about their GP Practice and local pharmacy following a dispensing error with medication which resulted in an emergency trip to A&E.

- Attended a meeting with a client at a local Acute hospital to support with the reading of a serious incident report (SI) following the death of her partner. This enabled the client to have a voice and for the Trust to personally apologise for the errors in the care provided that contributed to her partners death. The learning from this case is for the Acute Trust to develop IT closed loop system, improve communication between departments, provide awareness training and develop a helpline.

- A family made a complaint to their local Acute hospital following the death of their father at the beginning of 2023. The Trust took 16 months to reply to the complaint and support has been provided to the family to request a meeting to discuss the outstanding concerns the family still have.

- Following an accident, which resulted in a family losing their beloved husband and father, the family submitted a complaint and attended an inquest. Not being able to get a reply to their outstanding concerns, the family approached the IHCAS service and requested a meeting with the Trust. There was a wait for 10 months, but the meeting took place and the family (with support from an advocate), were given answers to the questions that have not been responded to for over 2 years.

- An advocate was recently contacted by a client to sadly inform them that her father had passed away during an active complaint. Whilst having this conversation, the Client advised the advocate of the new death certification reforms and the delays she had encountered. As a service we were unaware of these reforms and as such have researched this and are now aware of how the new reporting system works, and how this may affect timescales for families we are working with.

- The IHCAS Team are supporting a client that has complex medical needs. The Team has tried to get a complaint submitted to the ICB, direct to the Trust, NHSE and no provider will accept this complex complaint. Finally, the PHSO have agreed to take on this complaint.

- A complaint was made to a GP Practice. As a result, they have confirmed they have taken forward the following learning points: full explanations should be provided to patients when new requests for blood tests are made by the reception team, ensure results are correctly filed on their system to stop incorrect information and results being provide to patients.

Case Study and Learning

Listen to a patient

The sad story of a young person's death after surgery.

Sammy (29 years old) attended appointments at his local Acute hospital Trust over four years, before it was agreed for him to have weight loss surgery. He endured months of injections and a strict diet regime, with lots of side effects.

After lots of planning and preparation, the day arrived and Sammy underwent a 'Roux-en-Y: gastric bypass procedure' and according to the medical team, the surgery went well.

Sammy's fiancée visited in the evening and Sammy reported that he was in a great deal of pain. He was violently vomiting and bringing up blood. Staff said that it was a reaction to the anaesthetic, and that he would feel better in the morning. Although the staff seemed surprised the anti-emetic drugs and pain relief were not working like they would expect. The last text Sammy sent to his family read "worst night and morning of my life, pain is bad, and I can't stop being sick. Too unwell to message further unfortunately."

The same evening, the medical team noted low pain scores.

Early the following morning, Sammy's pain scores were observed as being high, without an immediate response, before he was rushed for an urgent CT scan which showed a haematoma blocking the bypass and was taken into surgery to remove the blockage and then transferred to intensive care, before he sadly died.

The Family's Reflection

Sammy's fiancée is also autistic and felt that she had been dismissed and that her autism played a part in the way the staff communicated with both her and Sammy.

Part of the investigation revealed that a bariatric physician, who was not due to visit Sammy the day after his surgery, having seen Sammy in clinic over the past 4 years went to see him post-surgery and had sufficient concerns to carry out a full examination and wrote in his medical files "NOT RIGHT" and possible CT scan "blockage", she also checked his drug charts and messaged her concerns to the surgeon.

The surgeon did review Sammy but did not do a full examination or check the drugs charts, all of which would have alerted him to the unusual pain Sammy was in, and reported, "nothing out of the ordinary going on at this stage to require further investigation or return to theatre." The family where shocked and dismayed when reading the surgeon's report, he had taken Sammy's autism into account as regards to his ability to understand pain.

The family's view that was accepted by the investigation lead, that had action been taken when the physician raised the alarm about a possible blockage, Sammy would most probably have lived. The family are also astonished that an NHS Trust agrees post the investigation and inquest that nurses are to receive training in monitoring fluids and doctors will be instructed in how to act in a medical emergency and to check drug records.

Investigation

Sammy's death was considered to have met the threshold for the Trust to start a serious incident investigation (SI). The family submitted a complaint to the Trust and requested advocacy support from their local IHCAS team.

After 2 days of inquest, it was found that Sammy died of a rare but recognised complication of a medical procedure.

Recommendations Following Investigation

These are some of the recommendations from the Acute Trust: -

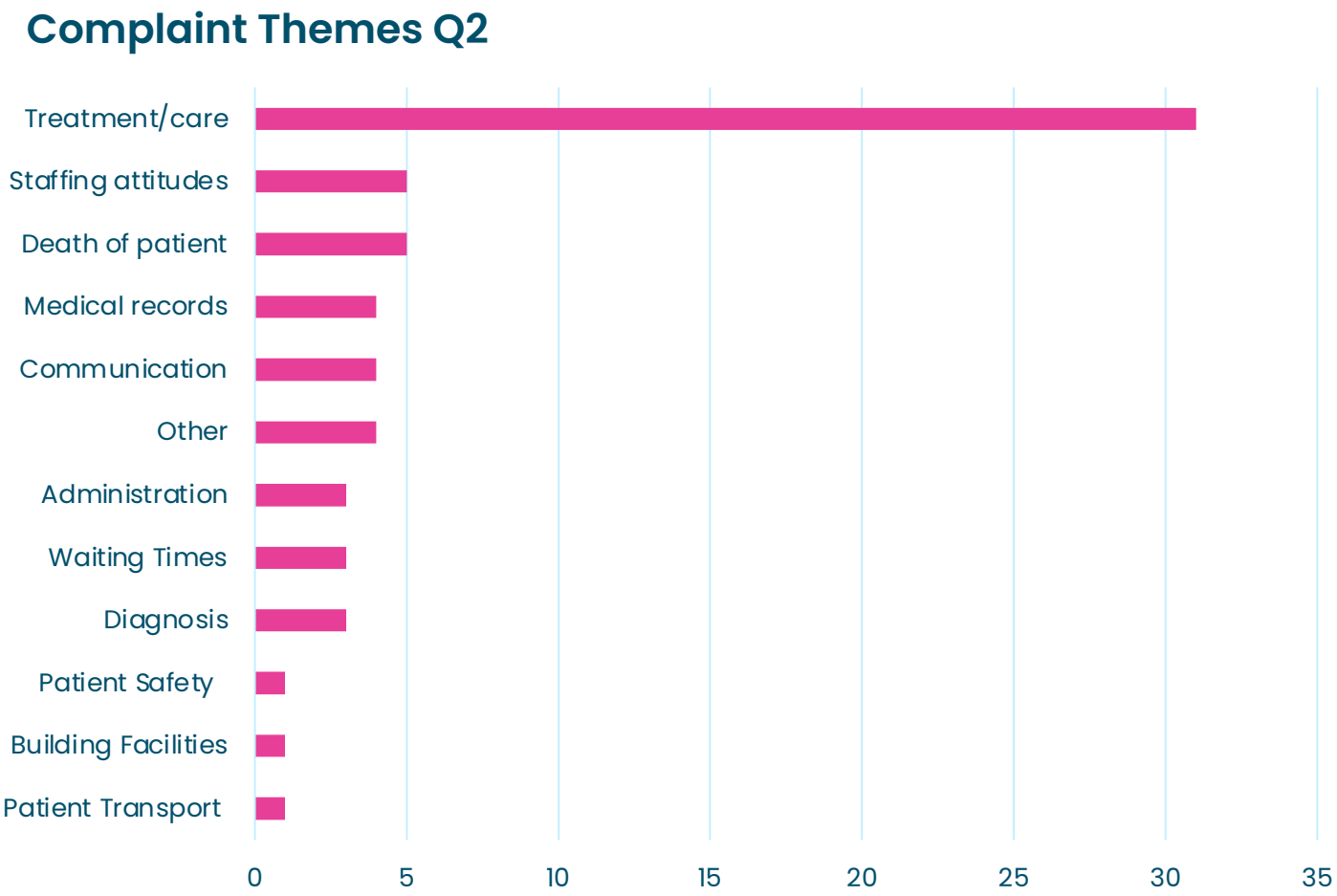
- Consider early CT scan in the presence of clinical concern regarding unresolved pain and nausea.
- Training for staff to implement MET calls when there is a sudden deterioration in NEWS2 scores.
- Improve documentation.
- Education in the bariatric medical team to specifically assess the anti-emetic drug use as potential markers for the presence of an obstruction.
- Recognition of autism as a part of a holistic assessment and how it may impact upon an individual's recognition and response to pain from the beginning of the patient's journey.
- Importance of asking whether reasonable adjustments might be required to support individuals while they are receiving our care.
- Communication training for nursing staff to ensure time is taken to listen to concerns and when to respond in an effective manner, reassure patients and loved ones that we are listening and taking action.

IHCAS Advocate

The IHCAS Advocate was by the side of the family throughout the process.

"Whilst we thanked you after the inquest for all the help and support you gave us, we both felt we had not thanked you enough. We like many before us, were left disillusioned and feeling let down by the system. That does not take away from our appreciation of the support and guidance you gave us. Without your help the entire process would have been far more distressing and intimidating than it was."

Q2 Complaint Themes



Treatment and Care is the most complained about subject area in quarter 2, followed by staff/staffing attitudes and death of a patient.

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