NHS Governance – Clinical Governance

Scottish Public Services Ombudsman

Background

1. The Scottish Public Services Ombudsman (SPSO) is the final stage of the NHS complaints process. In 2016/17, SPSO completed 495 health complaint investigations and made 952 recommendations[1]. 63% of all our investigations last year were about the health sector. We publish the details of our findings on individual cases on our website[2] and each year we also provide an individual letter to each Board with their own individual data. These are also published[3].

2. As well as considering individual complaints, the SPSO plays a key role in supporting improvements in complaints handling. We have worked closely with the Scottish Government and others to develop the new NHS complaints process which came into force on 1 April 2017. We are currently working with the Government to support the implementation of that new process[4].

3. In responding to this call for evidence, we consider our experience is most directly relevant to the fourth question the Committee is asking: "Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong".

Learning from complaints

The importance of learning from complaints

4. The Frances report published in 2013 highlighted that failures to learn from complaints helped to contribute to the poor care experienced at the Mid-Staffordshire NHS Foundation Trust.

[1] All our statistical information from 2016/17 can be found here: https://www.spso.org.uk/statistics-2016-17

[2] Here: https://www.spso.org.uk/our-findings

[3] Annual letters for 16/17 are still in preparation. Annual letters for 15/16 are here: https://www.spso.org.uk/statistics-2015-16

[4] Also on 1 April 2017 new complaints handling procedures were introduced for social work and integrated joint boards. This allows the NHS, integrated joint boards and Councils to align their procedures when they work together. All the new procedures are in line with the SPSO model Complaints Handling Procedures which shift focus to the front-line and encourages early resolution as well as emphasising the importance of recording and learning from complaints. These procedures are available on our valuing complaints site here: http://www.valuingcomplaints.org.uk/handling-complaints/complaints-procedures

> "Trust management had no culture of listening to patients. There were inadequate processes for dealing with complaints and serious untoward incidents (SUIs). Staff and patient surveys continually gave signs of dissatisfaction with the way the Trust was run, and yet no effective action was taken and the Board lacked an awareness of the reality of the care being provided to patients. The failure to respond to these warning signs indicating poor care could be due to inattention, but is more likely due to the lack of importance accorded to these sources of information"[5]

5. Our own work[6] shows that repeat mistakes can occur not only within individual boards but trends across health boards. Good clinical governance plays a critical role in ensuring that the organisation learns from, and does not repeat or miss failures highlighted in complaints. In June 2017 we said:

> We expect organisations to share our findings to enable learning and improvement across the organisation, not just in specific localised settings. Key to this is embedding learning from complaints in governance structures to ensure recommendations are shared with the relevant internal and external decision-makers, for example elected members, board members, audit or quality assurance committees or clinical governance teams.[7]

6. Complaints provide unique insight to the experience of those who use a service, and in many cases to the quality and effectiveness of the service. They highlight what people expect, when they feel they have been let down, and when they have actually been let down. Monitoring complaints and their outcomes is critical, as they can provide early and significant indicators of much bigger problems. Taking action to put them right can be the catalyst to rebuild relationships.

7. In our experience, members of the public are strongly committed to the NHS, as are its hard-working staff. People who complain are motivated by a strong desire to help support improvement and ensure that the same mistakes do not happen to other people. Equally, those delivering services may be let down by the systems in place. Demonstrating good practice in complaints handling is a good way of building trust with patients and staff. Failing to learn from complaints is a significant lost opportunity.

Ensuring learning occurs

8. The (new) NHS Scotland Complaints Handling Procedure (CHP) makes it clear that the most important performance indicator is that Boards demonstrate that they learn from complaints. In accordance with the Complaints Directions,

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[5] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry Executive Summary, p 44, para 1.9

[6] See our recent thematic report which highlighted repeated failures around informed consent: https://www.spso.org.uk/news-and-media/informed-consent-report

[7] https://www.spso.org.uk/sites/spso/files/communications_material/commentary/2017/SPSOCommentaryJune2017FINALVERSION.pdf

Boards have a responsibility to gather and review information on this indicator (and eight other complaints indicators) on a quarterly basis. Each year they must also publish a report setting out their performance in handling complaints, concerns, comments and feedback. This report summarises and builds on the quarterly reports in relation to complaints. The CHP also includes a detailed section on governance which sets out the standards organisations need to meet to ensure their systems are appropriate while allowing flexibility to reflect local structures.[8] We have also developed a simple guide to explain the importance of complaints and their role to board members generally[9]. This Guide "Why do complaints matter to board members"[10] emphasises the importance of:

- setting the right culture;
- ensuring they understand how complaints are being handled and;
- using complaints data as a regular part of performance reporting and assessment.

9. The guide contains a simple checklist that board members can use to assess their organisation's complaints culture and governance arrangements. Boards need to have systems in place to allow them to assure themselves about the quality of complaints processes in place. They need to be confident that the investigations that are occurring are sound and that the data being put in front of them is robust, including the evidence about learning.

10. The CHP, therefore, has a system in place which should help to ensure lessons are learned from complaints raised by patients and their families and friends. It is important though to emphasise the role of culture. Without a culture that values complaints, that empowers front-line staff to fix things and that really listens to patients, the system will not be fully effective. Front-line staff in particular need to know that their organisation will support them to highlight problems, to apologise and to be actively involved in uncovering what went wrong and the solutions put in place to make improvements. If they do not, they will resist dealing with, investigating and recording complaints.

Integrating information to support learning

11. Complaints should not be seen in isolation. Best practice in complaints handling uses the information from other sources. For example, from: patient feedback, whistleblowing, Significant Adverse Event Reviews, and, in future the new duty of candour process. We suggest there is significant benefit in streamlining governance reporting in this respect and have had early discussions with the

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[8] http://www.valuingcomplaints.org.uk/sites/valuingcomplaints/files/resources/NHS%20Model%20CHP%20%28March%202017%29.pdf pp 30 onwards.

[9] This guide is not aimed specifically at the NHS but board members generally.

[10] http://www.valuingcomplaints.org.uk/sites/valuingcomplaints/files/resources/1701WhyDo%20ComplaintsMatterToBoardMembers.pdf

Government about the benefit of a single governance report drawing the various sources together.

12. It should be recognised that each of these sources requires administration, monitoring, statistical collection and so on. To minimise the administrative burden, we suggest very strongly that consideration be given to implementing such an approach in a way that uses similar or, ideally, the same systems to record, investigate and report across all of those critical sources of information. This would minimise bureaucracy but also mean that there was a consistent approach to investigating and reporting no matter how the issue was raised.

SPSO's role

13. As an organisation that made over 950 recommendations to the NHS last year, we are mindful of ensuring that our work supports improvement and learning. To do that, the issues we identify and the way in which we make recommendations about them is critical.

14. Last year our Learning and Improvement Unit completed a project in which they reviewed all of SPSO's recommendations and, through contact with organisations under jurisdiction, identified how to make them more effective. This led to a significant change in the way we now make recommendations. The significant majority (over 60%) of recommendations we make are for system improvement. We recognise that although we can identify the failings, the learning and how to address them, is more expertly handled by the organisations themselves. To that end, we now focus on outcomes rather than process. We let the organisation know what outcome we would like to see and also what evidence we need from them to demonstrate that has been achieved.

15. This approach follows direct feedback from organisations and recognises that if a recommendation is to be successful the people who will be responsible for the change need to be at the heart of it.[11]

Scrutiny

16. We are one of a number of organisations, including scrutiny organisations and professional regulators, which regularly receive information about NHS performance.

17. Like the SPSO, each of the other organisations has systems in place to detect practice and service issues (good and poor). The challenge for us all is avoiding duplication for ourselves and the NHS, and co-ordinating responses/ action.

18. A particular area to think about is information sharing. SPSO operates under legislative restrictions on information sharing, but within those restrictions we try

[11] There are practical examples of this approach here: https://www.spso.org.uk/sites/spso/files/communications_material/commentary/2017/SPSOCommentaryJuly2017Final.pdf

to work constructively with others to allow for early identification of problems, and good practice. We recently attended an NHS Intelligence group which features a number of such organisations as members and hope to have closer interaction with them in future.

Conclusion

19. "*Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong".*

20. In terms of what each organisation monitors, records and identifies, the NHS is under considerable scrutiny which we consider is likely to detect poor quality of care and treatment. Each organisation will have different powers to act, or take direct action, in relation to its findings, so it is highly probable that the systems in place (or being put in place) will collectively address care and treatment issues.

21. Where we consider there is an opportunity for improvement across Scotland is in two key areas:

    21.1. NHS organisations themselves need to understand the importance of embedding learning and improvement from complaints (and other scrutiny) into governance and management systems. In particular, and in line with the requirement of the Complaints Directions they need to ensure that learning is identified, acted upon and that staff are supported and trained. This latter point is particularly important as failures in care and treatment can be as traumatic for NHS staff as they are for the service user affected.

    21.2. The various scrutiny organisations, and their systems, should work effectively together. This may require adjustments to what information they can share.