

Spotlight on complaints



A report on second-stage complaints about the NHS in England

February 2009

The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
- Be independent, fair and open in our decision making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission's work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

Contents

Foreword	2
Summary	4
Our service and our success	12
The current process for handling complaints	13
How we have performed	13
Common themes from the review year	16
Main themes in handling complaints	17
Issues raised in complaints	18
Complaints by type of services	20
Types of recommendations made	21
Acting on recommendations	22
Improving local resolution of complaints – a clinical perspective	24
Complaints about GPs' services	25
Complaints about dental services	28
Complaints about nursing care	30
Complaints about accident and emergency (A&E) care	32
Complaints about maternity services	34
Complaints about services for people with mental health needs	37
Complaints involving patients with a learning disability	39
Complaints about palliative care	40
Our legacy of learning	42
Learning from our work	43
Demand for independent reviews of complaints	44
Themes in our reviews since July 2004	45
Recommendations for improved local resolution of complaints	49
Conclusions and next steps	50
References	54

Foreword

Since 2004, the Healthcare Commission has been responsible for carrying out an independent review into complaints that NHS organisations cannot resolve themselves. During this time, we have reviewed more than 30,000 complaints from the public; in each case, the complainant felt that their concerns were not addressed to their satisfaction when first raised with their local organisation.

Complaints are, of course, inherently negative feedback for organisations. However, the process of dealing with them should be viewed as a valuable and positive opportunity for the NHS to learn from mistakes and bring about real improvements in services.

With this in mind, we have worked towards two key goals: to help NHS organisations to improve the way they handle complaints in the first instance, and to ensure that organisations systematically review complaints and learn from them. Our work over the past four and a half years shows that there is much room for improvement in both of these key areas.

NHS organisations receive about 135,000 complaints annually; approximately 7,500 of them are referred to the Healthcare Commission for further consideration. In an organisation the size of the NHS, which provides over 380 million treatments each year, this is, overall, a very small percentage.

However, we remain concerned that patients and the public do not always complain when they do receive poor or even unsafe service. It is vital that patients feel that they can complain to NHS organisations without prejudicing the healthcare they receive. Indeed, our view is that it will be the sign of a healthy NHS when

patients feel able to complain without risk of disadvantage. The NHS will then be an organisation more willing and able to learn from its mistakes. In many cases, patients say that their primary concern is not what gave rise to the original complaint, but how that complaint was dealt with locally. Patients say that they want to be listened to, have their concerns addressed and know that real changes have been made to prevent the same problems happening again to them or to others.

By doing this effectively, public confidence in the NHS can be greatly improved.

This is our third annual report on our review of second stage complaints about NHS services, covering the period from August 2007 to July 2008. During this time, we received 7,827 complaints and, taking account of those arising but not resolved in the previous year, we resolved 8,949.

This reflects the enormous amount of work that we have undertaken to streamline our systems and to get complaints resolved as quickly as possible, particularly in light of the rising number of complaints that we receive. We now resolve 95% of complaints within six months, with each case taking two months, on average.



Of the complaints received in 2007/08, we upheld 30%, up from 19.8% the previous year. In 17% of cases, we negotiated further work between the complainant and the organisation complained about, to resolve the case. Therefore, about 50% of the cases brought to us required further work. This shows that the NHS still has much room for improvement in how it deals with complaints locally. We did not uphold the complaint in 18% of cases and a further 27% of cases fell outside our jurisdiction (for example, because the local trust had not been given an opportunity to review them). These percentages have been broadly similar during the past four years.

Of the complaints that we reviewed in the year, there was an equal split between those relating to acute trusts (43%) and those relating to primary care trusts (43%), with complaints about GPs the most common in the latter sector. We also received complaints relating to dentists, mental health care, ambulance services and healthcare in prisons.

Complaints have generally related to the fundamentals of good healthcare: effective communication with patients, the attitude of staff, record-keeping, privacy and dignity.

However, the issue of concern raised most often was about the initial poor handling of the complaint by the healthcare organisation. For example, letters full of complex medical terms, a lack of a full and unequivocal apology, or the failure to interview members of staff involved in the complaint.

These are all basic issues that NHS organisations can and must address, on behalf of the patients they serve. This will be even more important as we move towards the new system when the Healthcare Commission ceases to exist on 31 March 2009. Our successor, the Care Quality Commission, will not have any role in reviewing complaints about the NHS. Instead, it will become a two-tier process, with unresolved complaints being handled directly by the Parliamentary and Health Service Ombudsman.

Our work over the past four and half years has enabled, for the first time, information about complaints to be collected at a national level. Through this, we have been able to analyse trends and compare the performance of different organisations. In 2007, we published the results of an audit of how complaints are handled in the NHS, which found that standards of handling complaints varied significantly across the NHS and that many trusts did not have adequate arrangements to handle complaints. In this report, we make 12 detailed recommendations to trusts on improving their handling and learning from complaints. We reiterate the responsibility of the board for doing so. It is crucial that this work continues as we move into the new system.

Professor Sir Ian Kennedy
Chairman

Anna Walker CB
Chief Executive

Summary

It is vital that the NHS listens to, and learns from, complaints made by patients and their family and carers. Patients are entitled to this. Moreover, complaints are a valuable source of feedback from patients and an important means of improving services.



At present, making a complaint about the NHS can be a three-stage process, beginning when the patient or their representative complains to the provider involved. If they are not satisfied with the response, they can ask us to review the complaint. Since July 2004, one of our key roles has been to conduct an independent review of these unresolved or 'second stage' complaints made about NHS services in England. If the complainant is still not happy with our decision after we have reviewed their case, they can then contact the Parliamentary and Health Service Ombudsman. Not only is this process lengthy and, at times, laborious and intimidating to patients, it also, by its very existence, allows some trusts the opportunity not to give complaints the importance they warrant because others will deal with them.

In our reviews, we identify the areas where healthcare providers need to improve the way they handle complaints and the problems with services that gave rise to the complaint in the first place. This is not only to resolve outstanding cases, but to ensure that similar complaints do not happen again.

It is therefore disappointing that, while we have seen some improvement in the handling of complaints in the NHS, far too many complaints about the NHS do not receive an appropriate response locally and the same issues continue to be complained about year after year.

During the four and a half years in which we have provided an independent review, the concerns that patients and their representatives bring to us have remained broadly similar, with very little difference in the issues most frequently raised in complaints. Concerns have consistently covered the

fundamentals of healthcare such as communication between clinical staff, privacy and dignity, attitudes of staff, and standards of care and safety for patients.

The types of provider being complained about have also remained consistent. In the primary care sector, GPs tend to generate the greatest volume, though it is important to view this in the context of the many millions of consultations that they deal with each year.

These findings are reflected in this final *Spotlight on Complaints* report, which covers the period from 1 August 2007 to 31 July 2008.

The focus of this report

This report focuses on the areas of both good and poor practice that we have seen in local responses to complaints. As the 'second stage' review of complaints that we conduct will cease on 31 March 2009, and the functions of the Healthcare Commission are taken over by the Care Quality Commission, we wish to provide the NHS with a rich source of information to help providers to improve their services and how they handle complaints locally. We include examples in each of the main areas of clinical practice, drawing on the expertise of our team of clinical advisors who have been involved in reviewing these complaints at the second stage. We also bring together key recommendations for NHS providers and the lessons that we have learned, from our time as the independent reviewer of NHS complaints, as our 'legacy of learning'.

We urge healthcare providers to take account of these recommendations and use them to improve the way they handle complaints in the

future and learn from them to improve services. This report does not include complaints made about independent healthcare providers. We handle such complaints in a different way from those made about NHS services because of differences in the respective legal regimes. Our website provides more information on our role in handling these complaints (www.healthcarecommission.org.uk).

Key findings

In the year 2007/08, we received 7,827 complaints about NHS healthcare in England and reviewed 8,949 complaints (some of which arose but were not resolved in the previous year). The key findings from our work are that:

- In 30% of cases (2,655) we upheld the complaint. This was the most common outcome of our reviews this year (compared with 20% last year) as we now decide whether or not to uphold a complaint in a far higher number of cases. This provides a much clearer outcome for all parties concerned. Where we find that more could have been done locally to resolve a complaint, rather than refer the matter back to the provider for further work, which was the most common outcome in previous years, we now uphold the case.

In the cases upheld, the healthcare organisation appeared to have responded to all of the complainant's concerns, and had usually confirmed to us that it had done all that it reasonably could to resolve the complaint locally. However, when we tested the response to the complaint, usually by obtaining independent clinical advice, we found that the provider could or should have done more to resolve the complaint locally. As

a result, we upheld the complaint and made recommendations to the organisation concerned to help to resolve the complaint or to improve services. Typically, this would involve us recommending that the organisation should:

- Provide an apology to the complainant.
- Hold meetings with relevant staff.
- Offer a clearer explanation of the events leading to the complaint.
- Make improvements to a service to assure the complainant that lessons had been learned to prevent a recurrence of the problem for other patients.
- Provide redress, for example, expenses incurred by the complainant where it is apparent that administrative failings within the trust have unnecessarily prolonged the process of complaining.
- In 17% of cases (1,545) we negotiated further work with the healthcare provider concerned in order to resolve the complaint. This compares to 26% last year, the decrease being due to the higher number of decisions to uphold a case. As regards this group of cases, when we receive a case, we make early contact with all parties to the complaint. Our experience shows that a successful resolution of the complaint can often be achieved by clarifying outstanding concerns early. Our investigators discuss the situation with the complainant and the healthcare organisation concerned, and agree that a complaint can be returned to a local level, but with specific action to be taken, such as:

- Holding a meeting between the complainant and relevant staff.
- Mediation between the complainant and provider.
- Providing clinical advice from a source independent of the trust.
- In a further 18% of cases (1,641) we did not uphold the complaint. We found that the healthcare organisation had provided an appropriate response to the issues raised in the complaint. This proportion is similar to the previous years.
- We found that 27% (2,458) of the complaints brought to us were outside our jurisdiction. This proportion was slightly higher than last year (24%). These were mostly cases where complainants had approached us either before they had complained to the trust or before the trust had come to a conclusion in its investigation.
- Of the remaining cases, 7% (599) were withdrawn, 0.3% (26) were referred to the Parliamentary and Health Service Ombudsman and 0.3% (26) were closed with 'other' or 'not specified' outcomes.

The cases we dealt with this year originated from the following types of healthcare providers:

- Primary care sector (43%).
- Acute trusts (43%).
- Mental health trusts (10%).
- Other trusts (2%).
- Strategic health authorities (1%).
- Ambulance trusts (0.9%).
- Prisons (0.8%).

How should NHS providers respond?

Our findings show that, although there is much good practice on resolving complaints in the NHS, there is much more that healthcare organisations must do to improve how they respond to complaints. As shown in last year's report, these improvements would ordinarily not be difficult or costly for trusts to implement. They are, for the most part, about the fundamentals of healthcare, such as:

- Record-keeping.
- Effective communication with patients.
- Attitude of staff.

Or they relate to the considerate care of a complaint, for example:

- Keeping people informed.
- Understanding what the complainant's concerns are.
- Explaining what went wrong.
- Making a clear apology.
- Providing an appropriate remedy.
- Making improvements so that mistakes do not happen again.

Clinical issues

A team of clinicians from a very wide range of healthcare specialties helps us to improve NHS services by supporting the second stage of the NHS complaints process. During the year of this review, they provided independent clinical advice for around 40% of the cases that we concluded. The following summarises our work in dealing with second stage complaints in the main clinical areas.

General practice

Of the complaints received at second stage this year, 43% were about the primary care sector, and complaints about GPs were the most common type within the sector. A total of 1,018 complaints about GPs were brought to us, though this must be seen in the context of about 290 million consultations made by GPs each year in England. Our clinical advisors provided further advice on 783 cases of the complaints received. The most common outcome of the 1,018 complaints reviewed was 'upheld with recommendations' (45% of the cases reviewed). This was followed by 'not upheld' (43% of cases).

To provide us with a clearer picture of these complaints, one of our most experienced clinical advisors, a practising GP, analysed a sample of 150 consecutive complaints about general practice from the 783 that were reviewed by our clinical advisors at second stage this year. This analysis looked at the trends in complaints about GPs and highlighted examples of good and poor practice in dealing with them, so that they could be used as a tool for learning. As a result, we make a number of recommendations to GP's practices and

primary care trusts (PCTs) to improve their local resolution of complaints about GPs. This is particularly significant as, from April 2009, GP's practices and PCTs will have a much greater role in resolving complaints about primary care locally.

The main issue complained about related to diagnosis (25%). Our recommendations focused on:

- Taking remedial action to resolve the case, taking account of the patient's point of view (15%).
- Ensuring safe and effective clinical practice (14%).
- Improving the way services are delivered to patients (8%).

Dental services

We received 343 complaints about dental treatment during the year, and of these, our dental advisors provided clinical advice on 244 cases. The most common outcome of the 343 complaints reviewed was 'upheld with recommendations' (47% of cases), followed by 'not upheld' (33% of cases).

The main issue complained about related to treatment (36%) for example, delays, incorrect or unsuccessful treatment. Our recommendations focused on:

- Taking remedial action to resolve the case, taking account of the patient's point of view (19%).
- Ensuring safe and effective clinical practice (17%).

- Improving the way services are delivered to patients (9%).

Nursing issues

We reviewed 632 complaints about nursing care. The most common outcome of these cases was 'upheld with recommendations' (71% of cases), followed by 'not upheld' (16% of cases). It is important to note that concerns about nursing care are often not the primary issue leading to a complaint. For example, a complaint may have been made about complications that arose during a procedure, but concerns may also have been expressed about the post-operative nursing care.

The main issue complained about related to general nursing care (44%) for example, falls, nutrition, or observation. Our recommendations focused on:

- Ensuring safe and effective clinical practice (30%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (20%).
- Improving the way services are delivered to patients (10%)

Accident and emergency (A&E) care

From a total of 307 complaints about A&E care, we asked for advice from our clinical advisors in 179 cases. The most common outcome of the 307 complaints reviewed was 'upheld with recommendations' (53% of cases), followed by 'not upheld' (22% of cases).

The main issue complained about related to treatment (24%), for example, delays, incorrect or unsuccessful treatment. Our recommendations focused on:

- Ensuring safe and effective clinical practice (22%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (11 %).
- Improving communication with patients (6%).

Maternity services

We received 203 complaints that related to maternity services this year, and our clinical advisors advised on 66 of these cases. The most common outcome of the 203 complaints reviewed was 'upheld with recommendations' (55% of cases), followed by 'not upheld' (25% of cases).

The main issue complained about related to treatment (31%) for example, delays, incorrect and unsuccessful treatment. Our recommendations focused on:

- Ensuring safe and effective clinical practice (25%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (15%).
- Improving communication with patients (10%).

Mental health care

We received 462 complaints about mental health services (of which, 258 cases needed further clinical advice). The most common outcome of the 462 complaints reviewed was 'upheld with recommendations' (50% of cases) followed by 'not upheld' (22% of cases).

The main issue complained about related to general mental health care (47%), for example, appropriateness of treatment, care review meetings, and use of control and restraint. Our recommendations focused on:

- Ensuring safe and effective clinical practice (21%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (18%).
- Improving communication with patients (10%).

Services caring for people with learning disabilities

During the year, we dealt with 24 cases where learning disabilities were an issue in the complaint. These were not necessarily complaints made about learning disability services specifically, but where the patient's learning disability was a factor in the complaint. Our recommendations focused on:

- Ensuring safe and effective clinical practice (29%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (13%).

- Having clear systems of accountability and responsibility (8%).
- Improving the way services are delivered to patients (8%).

Palliative care

We also dealt with 24 cases where palliative care was an issue in the complaint. Our recommendations focused on:

- Taking remedial action to resolve the case, taking account of the patient's point of view (25%).
- Improving learning and innovation (17%).
- Improving communication with patients (13%).
- Improving the way services are delivered to patients (13%).
- Ensuring safe and effective clinical practice (13%).

Our recommendations to all NHS providers

Drawing on our experience as an independent reviewer of complaints, we have set out the following 12 key recommendations for NHS organisations on improving the way they resolve complaints locally.

1. Acknowledge the person's right to complain.
2. Ensure that the complaint is assessed upon receipt, so that any concerns about a risk to the safe care of other patients can be identified promptly.
3. Clarify what the person's concerns are and manage expectations about possible outcomes to the investigation of the complaint.
4. Consider the various options for resolving the complaint – for example, a meeting or reimbursement of costs.
5. Ensure that the person is kept informed of progress throughout the life of the complaint.
6. Confirm to the person what support is available to assist in making a complaint – for example, the Independent Complaints Advocacy Service (ICAS).
7. Take statements from, and interview if necessary, those staff involved in the events leading up to the complaint. This should be done as soon as possible, so that events are still fresh in the memory.
8. Where necessary, obtain clinical advice on the matters raised. This advice must have a high degree of independence – for example, by obtaining advice from the trust's medical director or from a clinician at another trust.
9. Ensure that any letters to the person making the complaint are written in plain English and are as free as possible of clinical or other technical terminology.
10. Offer an apology if appropriate.
11. Ensure that general learning is taken from specific complaints and is embedded into the system of care for the future.
12. Ensure that the boards of trusts are satisfying themselves that all the above are happening.

During the last four and a half years, we have reviewed a total of 30,268 second stage complaints (to 31 July 2008) and made 16,500 recommendations aimed at resolving complaints and improving services. We have improved our own service over those years and have also focused on helping NHS organisations to improve the local resolution of concerns. We, therefore, welcome the new system for dealing with complaints that comes into effect from 1 April 2009, which puts much greater emphasis on resolving complaints locally.

However, the key finding of this report is that there is still much that the NHS can do to improve the way in which it deals with complaints, which is why we make the 12 recommendations above. If NHS organisations draw on the lessons that we have learned as they move into the new system, this can only benefit all, by providing an NHS that is responsive to the concerns of patients and continuously improving its services as a result.

Our service and our success

Over the four and a half years of providing the second stage of the NHS complaints process, we have made great progress in resolving more cases, more quickly, and to high quality standards.



The current process for handling complaints

If someone is unhappy with the treatment or service they have received from the NHS, they are entitled to make a complaint, have it considered, and receive a response from the NHS body or primary care practitioner concerned.

Most complaints are resolved at local level. However, in some cases, the complainant may not be satisfied with this and can approach the Healthcare Commission to request an independent review of their complaint.

The Healthcare Commission reviews the individual case, taking into account the views of both the complainant and the organisation being complained about, obtaining clinical advice where necessary. We then make a decision on whether the NHS organisation could and should have done more to resolve the complaint locally.

If we uphold the complaint, we make a series of recommendations to the healthcare provider on what they must do to resolve it.

If we do not uphold the complaint, we inform the patient or their representative and state the reasons why.

If complainants are still dissatisfied after an independent review by the Healthcare Commission, they can take their case further to the Parliamentary and Health Service Ombudsman, who provides the final stage of the NHS complaints procedure.

The Healthcare Commission will cease to exist on 31 March 2009. From 1 April 2009, our successor, the Care Quality Commission, will not have any role in the complaints process. Instead, the NHS complaints process will become a two-tier process – with the local organisation as the first tier and the Ombudsman as the second tier.

How we have performed

When we started handling complaints at the second stage in July 2004, we faced a much higher demand for the independent review service than originally anticipated. This provided a real challenge for us – and it is one that we have met.

For example, on average, we now resolve cases in around two months. Since the summer of 2007, we have met our target of resolving 95% of cases within 12 months. We have now exceeded that target and are meeting a new, self-imposed target of resolving 95% of cases within six months. In the summer of 2006, we had around 5,000 cases open. Through consistently improving the way that we work, recruiting new staff and expanding our team of clinical advisors, we have reduced our open caseload to around 1,200 – a reduction of 76% in two years.

At the same time, we have ensured that our reviews are completed to high quality standards. We make contact with all parties to a complaint as early as possible, as our experience shows that this increases the chances of a successful resolution. The feedback received from our customers has also improved consistently.

Complainants can currently approach the Parliamentary and Health Service Ombudsman if they are dissatisfied with the way the Healthcare Commission has reviewed their case. It is another indicator of the high standard of our work that in 2007/08, the Ombudsman fully upheld only 178 cases from the 508 that were brought to her at this third stage. From July 2004 to the end of March 2008, the Ombudsman has fully upheld a total of 478 cases about our independent reviews of complaints. During this period, we reviewed 27,354 cases.

Resolving more cases more quickly, while maintaining high quality standards, has been to the benefit of our two key customers – complainants and healthcare organisations.

Common themes from the review year

In this section, we highlight the main themes that we have seen in our independent reviews this year, in particular the need to improve local responses to complaints.



Main themes in handling complaints

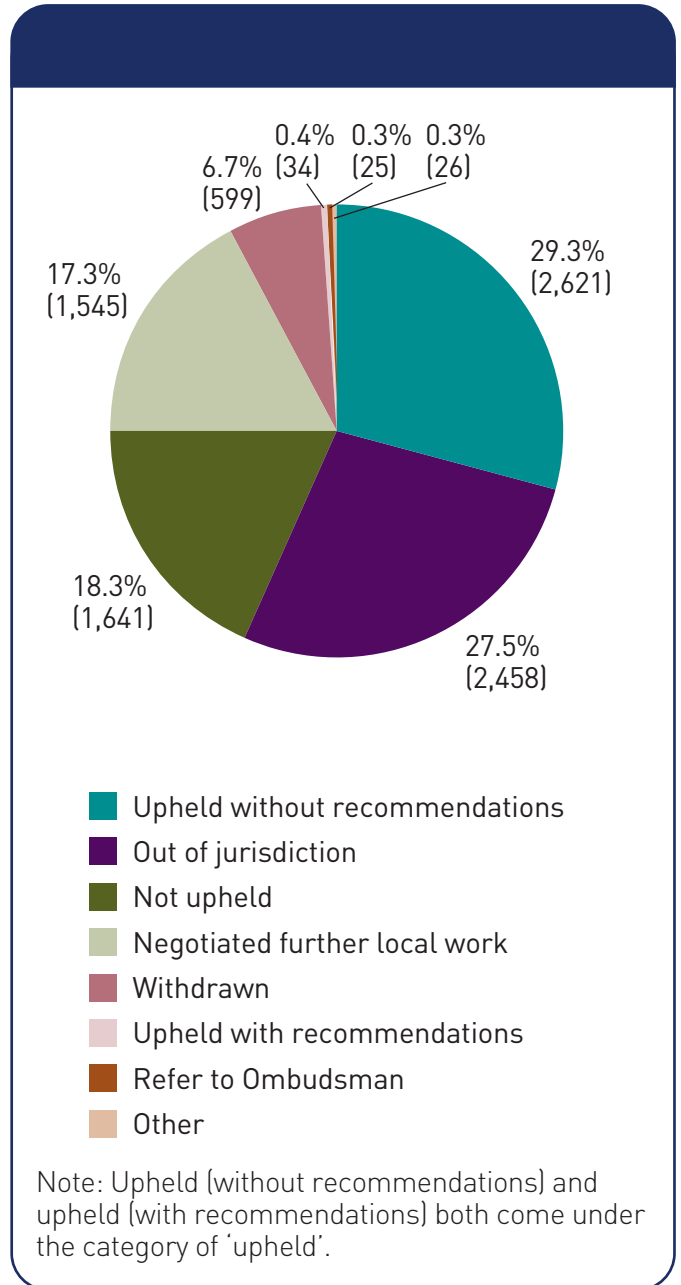
Outcomes of complaints

Between August 2007 and July 2008, we completed 8,949 independent reviews. Possible outcomes after a review are that:

- We upheld the case and made recommendations.
- We negotiated further local work with the trust.
- We did not uphold the case.
- The complainant withdrew the case.
- The case was out of jurisdiction.
- We referred the case to the Parliamentary and Health Service Ombudsman.

The outcomes of the reviews are shown in figure 1.

The most common outcome for the completed reviews this year was that we upheld the complaint (30% of our reviews). In last year's report, the most common outcome was that cases were referred back for further local work (26%). Under our improved ways of working, launched in May 2007, we now make a conclusive decision whether or not to uphold a complaint in far many more cases. When we uphold a complaint, it is because we consider that the provider could, or should, have done more to resolve the complaint locally.



In 17% of our cases this year, we negotiated further local work with the provider concerned. These are cases where the provider had responded to the complaint, but after reviewing the response, our case investigators considered that there was further scope for the case to be resolved locally. Examples of this are where we think that there is an alternative method of resolving the complaint locally – for instance, a meeting between representatives from the trust and the complainant.

A large proportion of cases (around 27%) fell outside of our jurisdiction. These were usually cases where the complainant had not raised their concerns locally and therefore their complaint was not eligible for an independent review by the Healthcare Commission. This shows that trusts still have much work to do to ensure that the public have access to easy-to-understand information about the complaints process, so that they know where to refer their concerns at each stage.

Around 7% of complaints made to us this year were subsequently withdrawn by the complainant. Typically, this was because the NHS complaints process was unlikely to deliver the outcome that the complainant was seeking: for example, compensation resulting from a finding of medical negligence or the removal of a doctor from the list of registered practitioners.

A small number of our cases were referred directly to the Parliamentary and Health Service Ombudsman in the review year, reflecting a protocol agreed between the two organisations. We always ensure that the complainant is informed before making such referrals.

We also refer cases to the General Medical Council, the Nursing and Midwifery Council and other professional regulatory bodies, where we find grounds to suspect that there is evidence of misconduct or concerns about fitness to practise. Such referrals are completed with the consent of the complainant concerned.

Issues raised in complaints

The most frequently raised issue in the cases reviewed this year was how the complaint was handled by the healthcare provider – an issue in 19% of cases compared to 16% last year. This illustrates that, very often, patients and the public are not only concerned about the issue that gave rise to their complaint (for example, the care provided), but also about the way that their complaint was investigated and responded to.

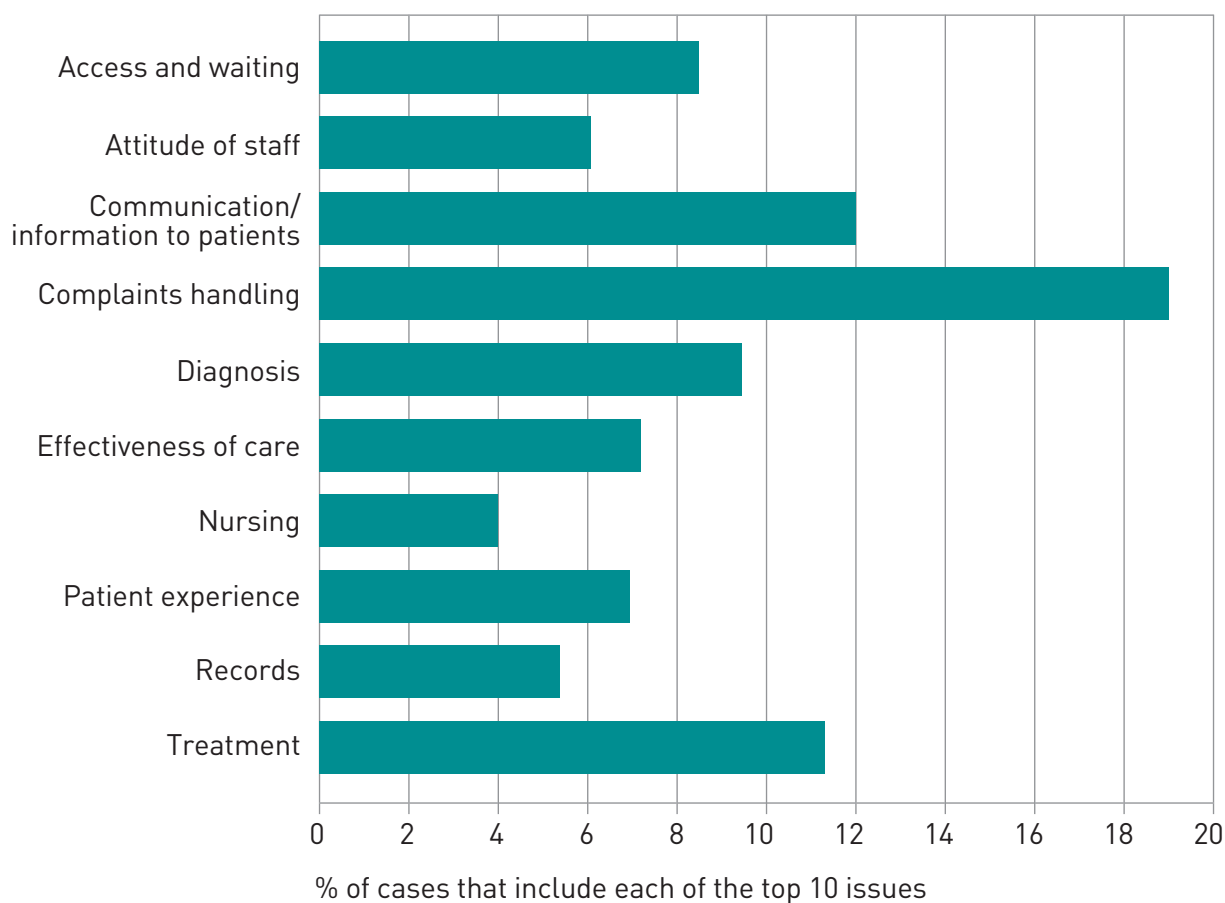
These are typically concerns about the fundamental elements that trusts should include in their response to the complaint, as set out in our *Complaints Toolkit* and highlighted in the clinical case studies later in this report. These elements include: a thorough investigation; flexibility in the methods used to resolve the complaint; ensuring that all issues are addressed; providing a non-defensive empathetic response; maintaining regular communication; and corresponding in plain English. It is clear that many complainants who approach us have concerns that these essentials of the considerate care in response to a complaint have not been met, and our reviews often find this.

As with last year, a large number of complainants (12%) raised the standard of communication that they received from trusts

and about the information provided to them. As the case studies later in this report show, it is vital that trusts communicate openly with patients making a complaint and provide as much information as they can, in order to successfully resolve a complaint at local level. If they do not do this, our experience shows that complainants will often have a lack of trust in the provider's response and seek a more independent view on their complaint.

Concerns about the standards of clinical treatment and diagnosis also feature prominently in the complaints brought to us this year. In 11% of our cases, complainants were concerned about the clinical treatment provided to them and in 9% of cases a delay or failure to diagnose a condition was an issue.

Figure 2: Percentage of issues raised in complaints



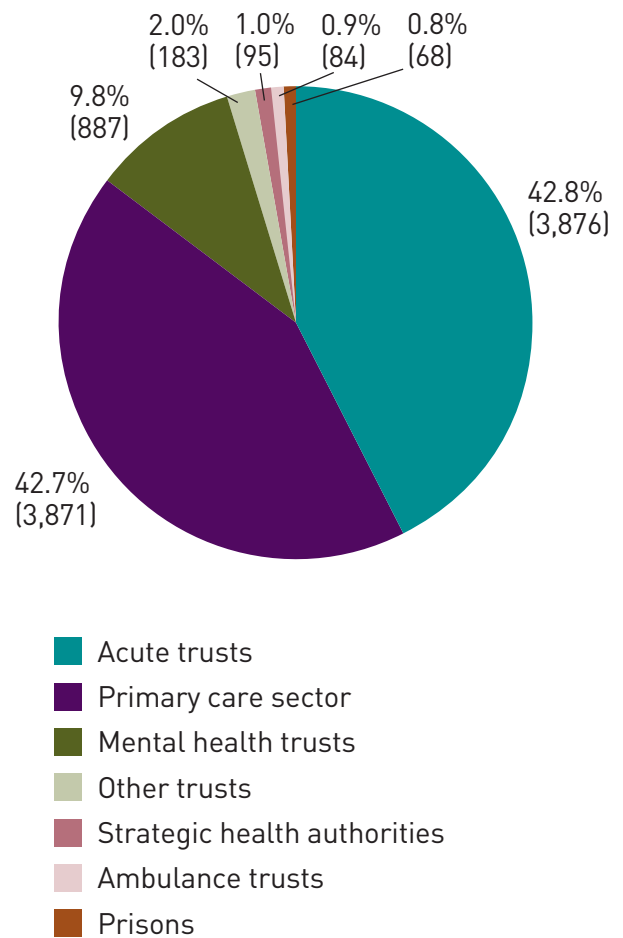
Note: The chart shows that 'complaints handling' was the top issue, compared to 'safe and effective practice' in the last report (24%). This is due to a change in coding, in which elements of what was 'safe and effective practice' were allocated across a number of the issues above.

Complaints by type of services

Each year, we receive complaints about a wide range of NHS organisations (see figure 3), including primary care trusts (PCTs), acute trusts, ambulance trusts, mental health trusts and foundation trusts.

Of the cases reviewed, there was an even split between cases involving primary care trusts, and those involving acute trusts (43% each). We also reviewed cases about foundation trusts (22% of the total reviewed), of which 16% were acute foundation trusts, 5% were mental health foundation trusts and 1% were specialist foundation trusts.

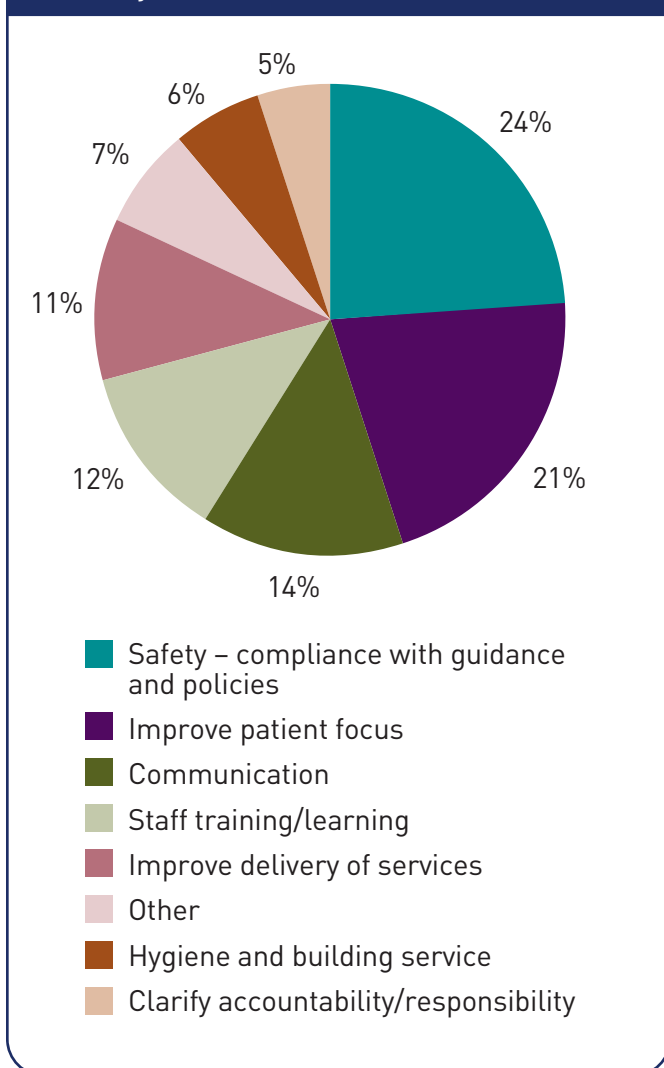
Figure 3: Complaints by type of provider



Types of recommendations made

When we uphold cases, we make recommendations to NHS organisations to help them to resolve complaints and make improvements to their services. Figure 4 shows the types of recommendations that we made at the conclusion of our reviews this year.

Figure 4: Recommendations made in the review year



The most frequently made recommendation (for 24% of our cases) was about safe and effective clinical practice. The following are some examples of recommendations made in this category:

- Review the handover practices between A&E and other hospital wards in order to encourage ongoing improvement in this area.
- Raise awareness among nursing staff of the importance of developing a rapport and an effective collaborative relationship with families and carers of patients.
- Review the management of patients (in a GP's practice) with chronic obstructive pulmonary disease (COPD) to ensure that it complies with guidance issued by the National Institute for Health and Clinical Excellence (NICE).
- Ensure that policies relating to the care of patients with Alzheimer's disease are in accordance with guidelines from the Department of Health and NICE.
- Review the training provided for all staff on eating disorders.

This was closely followed (in 21% of cases) by the following recommendations falling into the category of 'patient focus':

- Review appointment systems to ensure that patients are informed that they may phone in to arrange an alternative appointment if the one offered is inconvenient.

- Review policies regarding communication with patients and carers, in line with the *Essence of Care: Patient-focused benchmarking for health care practitioners* (Department of Health, 2003).
- Refund the complainant for costs incurred in seeking alternative dental treatment. This was because, having received independent clinical advice, we concluded that the dental treatment originally provided fell below accepted standards and that the practice's response to the complaint was inadequate.
- Formally apologise to a patient for misinterpreting scans.
- Apologise to a complainant for providing inaccurate information on the NHS complaints procedure.

Acting on recommendations

Each year, we ask NHS organisations to report to us on their activities in handling complaints, and to tell us what they have done to implement any recommendations we may have made. On 11 September 2008, we analysed 336 annual reports from NHS trusts for the year 2007/08. In 16% of reports, trusts told us that, as result of our recommendations, they had arranged additional training for staff, which included:

- Wound management care.
- Training in eating disorders for all staff at a mental health trust.
- Update training on panic attacks for staff of a walk-in centre.

- Training in customer care.
- Training for healthcare assistants on palliative care at a PCT.
- Training on record keeping in A&E.
- Training on barrier nursing.
- Training on preventing falls.

Additionally, in 14% of the reports, trusts informed us that they had carried out an audit of a service as a result of our recommendations. Examples included:

- A review by a PCT of their approach to complaints about healthcare in prison.
- A review of the policy and procedures for cardiac chest pain.
- A review of the obstetric care pathway.
- A review of the policy and procedures to obtain patients' consent.
- A review of care pathways in nurses' endoscope practice.

Improving local resolution of complaints – a clinical perspective

In this section, we present recommendations for the key ways in which NHS providers can improve the way they resolve complaints locally, shown by examples of good and bad practice from the cases that our clinical advisors saw this year.



A team of clinicians from a very wide range of healthcare specialties helps us to improve NHS services by supporting the second stage of the NHS complaints process. A large proportion of our cases require advice from our clinical advisors – during the year of this review, they provided independent clinical advice for around 40% of the cases that we concluded. A number of these cases were referred to clinical advisors in specialty areas, and it is important to note that, of the cases referred to in this report, some may have involved seeking clinical advice from more than one of the specialties we list here.

Complaints about GPs' services

Approximately 90% of the contact that patients have with the NHS is at primary care level. It is therefore important that GPs listen to, and learn from, their complaints. Complaints about GPs were the most common type received about primary care during the year (a total of 1,018 complaints), though this must be seen in the context of around 290 million consultations they make each year in England.¹ Our clinical advisors provided further advice on 783 cases from the 1,018 complaints received. The most common outcome of the 1,018 complaints reviewed was 'upheld with recommendations' (45% of the cases reviewed). This was followed by 'not upheld' (43% of cases).

The main issue complained about related to diagnosis (25%). Our recommendations focused on:

- Taking remedial action to resolve the case, taking account of the patient's point of view (15%).

- Ensuring safe and effective clinical practice (14%).
- Improving the way services are delivered to patients (8%).

To provide us with a clearer picture of these complaints, one of our most experienced clinical advisors, a practising GP, analysed a sample of 150 consecutive complaints about general practice from the 783 that were reviewed by our clinical advisors at second stage this year. This analysis looked at the trends in complaints about GPs and highlighted examples of good and poor practice in dealing with them, so that they could be used as a tool for learning.

Example of good practice in resolving complaints locally

This case shows, in particular, a willingness from the practice to be flexible about how the complaint was resolved, the practice ensuring that it responded to all concerns, and the procurement of clinical advice from an independent clinician to review the care provided.

The complainant, Mrs E, raised a number of concerns with her GP's practice about the content of several entries in her records and also about the clinical care provided to her. Mrs E also made a complaint about the recording of telephone conversations at the practice.

The practice provided a number of letters in response and suggested holding a meeting to explain the medical terminology and phraseology. However, Mrs E declined the meeting as she preferred to receive a written response.

The practice responded to each individual point raised about alterations to medical records. At the outset, the practice explained that their computer system permanently records all changes to a patient's clinical record. Mrs E was informed that it is not possible for a doctor or member of staff to make alterations without these being recorded within the clinical software. The practice offered to arrange for the system suppliers to analyse all entries made to the computer record if necessary.

The practice informed Mrs E in a letter that any patient has the right to have a note (an addendum) inserted into their medical record. This note should be written by the patient and should state that they disagree with certain entries made on specific dates in their medical record, listing the entries and the dates. The practice also informed Mrs E that if she still felt that information contained in her medical records was inaccurate, she may wish to contact the Information Commissioner who could look at personal data held about her.

We considered that the practice had provided detailed responses to each point of the complaint about inaccuracies in the medical records. The practice tried to provide clarification and explanations to Mrs E, made extensive reference to her medical records, and made reasonable and appropriate attempts to answer her concerns.

Mrs E raised a number of concerns with the practice about the medical care provided to her. Each concern was answered separately and with appropriate detail. An independent clinician confirmed that the care and treatment provided to Mrs E had been reasonable and appropriate.

Mrs E was also concerned about the recording of telephone calls by the practice. We noted that the practice's recorded telephone message stated that calls may be recorded for training and monitoring purposes. The letterhead paper also stated that telephone calls may be recorded for the same purposes. Our view was that the practice's explanations were reasonable in this respect.

Example of poor practice in resolving complaints locally

This case related to an out-of-hours provider and concerned the standard of care provided to a child. It shows how not being open and transparent with a complainant can lead to significant problems in resolving the complaint.

Child B's mother called just after 8.00pm to request a home visit by a doctor to see her daughter, who was vomiting continuously. She was advised that a doctor should call back within the hour. The out-of-hours provider said that a doctor had called at around 9.25pm, but had found the telephone line engaged. The family refuted this. They stated that a doctor only returned the call at 11.33pm, at which point child B had already been taken to A&E by ambulance.

We found that a letter to the complainant from the out-of-hours service provider was only half complete. The provider informed us that part of the response was mislaid before the letter was sent, although this was subsequently retrieved. In the responses to the complaint, the out-of-hours service provider did not appear to have based its conclusions on the facts that presented themselves during the course of

investigation, nor had there been any substantive attempt to answer any of the questions that were raised.

Our review found that it took one hour and 23 minutes to respond to the original call; our clinical advisor confirmed that this did not comply with the National Quality Requirements. These state that the provider must start a definitive clinical assessment for non-urgent calls within 60 minutes of the call being answered by a person. No attempts were made to contact the caller after the call was made at 9.25pm, and thereby to proceed with triage of the call.

Our clinical advisor reviewed the work logs of two doctors on duty that evening, and noted that it sometimes appeared to take both doctors two hours to reply to the telephone calls that were coming into the base that night. In the Medical Managers' Clinical Review, included within the out-of-hours service provider's complaint file, comments stated that a caller should not have had to ring three times with a sick child. We were disappointed to note that these facts were not communicated to the complainant as part of the service provider's response to the complaint, and further that they proposed no action to learn from or to resolve these issues. The fact that the provider had been overstretched on the evening in question was not communicated to the complainant.

As a result of our review, we recommended that the service provider should:

- Acknowledge the failure of service to the complainant and fully relay the facts of the investigation to her.
- Investigate why there were excessive pressures on the medical staff that led to the delay in responding to the call and to look at what measures were in place to match capacity to demand at busy times and whether these measures failed on the night in question.
- Apologise for being unable to offer clinical advice within an appropriate timeframe and for not attempting to make contact after the 'engaged' call at 9.25pm.

We also recommended that the PCT commissioning the services of this provider should carry out a review of its performance in light of this complaint, along with any others that may have been received about the same provider

Taking an overview of the 150 cases analysed by our clinical advisor, we make the following recommendations to general practices and PCTs to improve how they respond to complaints locally.

Recommendations for PCTs to improve local responses to complaints

1. Ensure that all GPs and practice staff are aware of the requirements of the NHS complaints procedures, providing training and guidance where necessary. Specifically, the cases we have reviewed have revealed scope for improvement in the following areas:
 - Ensuring that responses to complaints are conciliatory in tone and not defensive.

- Making sure that all of the issues in a complaint are addressed.
 - Responding to complaints within the timescales laid out in the regulations – this includes the scope allowed by the regulations to agree alternative timescales with the complainant.
 - Managing complainants' expectations at the outset, so that they are aware of what can and cannot be achieved through the complaints process.
2. Ensure that all general practices are fully aware of the procedures for removing a patient from the list, in accordance with the NHS regulations. Issuing a warning within the 12 months prior to removal, when appropriate, should also be highlighted.
 3. PCTs and general practices should work together to learn from complaints and disseminate the lessons learned. This could be in the format of examples of good and poor complaints handling or clinical scenarios in newsletters or educational meetings.

Recommendations for general practices to improve local responses to complaints

1. Maintain good record-keeping in line with the GMC's guidance *Good Medical Practice*,² including, in particular, telephone consultations and home visits.
2. Ensure that clinical governance systems within practices promote a culture of learning and openness, so that complaints are seen as an opportunity to improve the service provided.
3. Ensure that the information/administration and prescribing systems within practices are robust, in particular the systems for transferring and recording information from outside agencies. This review has highlighted some shortfalls in these areas.
4. The need for independent advice at an early stage is helpful for successful local resolution in many cases, particularly in more serious complaints. This could be provided by an independent GP, recommended by the PCT or a neighbouring PCT.

Complaints about dental services

We received 343 complaints about dental treatment during the year, and of these, our dental advisors provided clinical advice on 244 cases. The most common outcome of the 343 complaints reviewed was 'upheld with recommendations' (47% of cases), followed by 'not upheld' (33% of cases).

The main issue complained about related to treatment (36%) for example, delays, incorrect or unsuccessful treatment. Our recommendations focused on:

- Taking remedial action to resolve the case, taking account of the patient's point of view (19%).
- Ensuring safe and effective clinical practice (17%).
- Improving the way services are delivered to patients (9%).

Example of good practice in resolving complaints locally

This case concerned a patient who had needed an extraction and an urgent temporary denture just before Christmas. His concern was about the poor attention he had received. The practice gave a detailed response, which showed that the extraction had been done in the evening and an anaesthetist employed especially to provide sedation. When the patient said he had difficulty attending the surgery to pick up his denture, two dental nurses had been dispatched to drive a considerable distance to deliver the denture. The practice did, however, apologise that the complainant was unhappy, and offered a goodwill refund of the charges.

Our dental advisor for this case concluded that this was a very appropriate response to the complaint. He noted the considerable efforts that the practice had made to resolve the complaint, particularly in offering a goodwill refund to the complainant when this was not absolutely necessary at the time.

This case highlights the importance of providers recognising where things have gone wrong, demonstrating that lessons have been learned as a result, and, if appropriate, offering recompense to the complainant.

Example of poor practice in resolving complaints locally

This case concerned a patient who visited a dentist with severe pain. The dentist considered that the pain was not dental in nature and advised that the patient should go to her medical practitioner. Nothing could be found

and when the patient returned to the dentist on several occasions, no treatment was provided, except to refer for an opinion to the local dental hospital. The dental hospital found that the patient had an abscess, but it was nearly three months before another dentist performed a simple extraction. In his response to the complaint, the first dentist tried to attribute blame on the patient, and then maintained that, as she was not registered with him, he had no duty to her. When our dental advisor reviewed the case, he found that the dentist should have been able to see the cause of the patient's pain at the beginning. We recommended that the local PCT consider referring the dentist to the General Dental Council.

Both examples demonstrate the importance of effective communication in handling complaints: clear explanations, that address all concerns raised, are essential in resolving complaints locally. The second case also highlights that defensive responses to complaints only serve to entrench views on both sides and make complaints much more difficult to resolve locally. Our dental advisors suggest that the reason why some dental practitioners do not deal with complaints well is because they are often small businesses and, for most, complaints are still relatively rare. Nevertheless, some relatively straightforward steps, such as communicating clearly and providing thorough explanations, could greatly improve responses to complaints in this area.

Recommendations for dental practitioners to improve local responses to complaints

1. Make an apology, where warranted, as soon as possible in responding to the complaint.

2. Where appropriate, offer a refund to a patient when things have gone wrong during care and treatment.
3. Offer thorough, non-defensive explanations when errors have been made during a course of treatment.

Complaints about nursing care

We reviewed 632 complaints about nursing care. The most common outcome of these cases was 'upheld with recommendations' (71% of cases), followed by 'not upheld' (16% of cases). It is important to note that concerns about nursing care are often not the primary issue leading to a complaint. For example, a complaint may have been made about complications that arose during a procedure, but concerns may also have been expressed about the post-operative nursing care.

The main issue complained about related to general nursing care (44%) for example, falls, nutrition, or observation. Our recommendations focused on:

- Ensuring safe and effective clinical practice (30%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (20%).
- Improving the way services are delivered to patients (10%).

Example of good practice in resolving complaints locally

A man in his late 80s was admitted to his local hospital from a nursing home, following a stroke. He had been cared for in the nursing home for four years and on admission he was assessed as "skin intact, independently mobilised prior to the stroke and nutritionally well".

While in hospital, he developed pressure sores, was not eating or drinking, and sadly died within three weeks of his admission. The patient's daughter raised a number of concerns about the poor quality of care her father received. She was dissatisfied with the trust's response to the complaint and asked the Healthcare Commission to undertake an independent review. When we reviewed the case, we found the nursing documentation to be of a poor standard.

Our investigator agreed with the complainant and the hospital that a meeting with senior staff at the trust would be the best way to resolve the complaint. Before this meeting, the trust re-investigated the complaint. The deputy director of nursing led this re-investigation, as she acknowledged that the trust's original investigation was of a poor quality.

During the re-investigation, the trust found poor practice in terms of risk assessment, care planning, pressure sore management and nutritional intake. The patient was not placed on a stroke pathway and was instead inappropriately nursed on a general medical ward.

The trust produced a report, which included a number of recommendations and actions to address the shortfall in nursing care, and

provided an action plan to the complainant and the Healthcare Commission.

At the meeting with the complainant, both the chief executive and the director of nursing attended and offered unreserved apologies for the poor care provided to the patient. They assured the complainant that lessons had been learned from the complaint and that the action plan put in place would ensure that similar events did not happen again.

This action plan included carrying out audits of risk assessments, care planning and evaluation of care, implementing mechanisms to ensure that staff use the stroke care pathway, retraining some staff and introducing a new ward sister. In our review of the trust's final report, we found that the trust had addressed all the issues raised by the complainant, who was satisfied with the outcome.

Our nursing advisor saw the following as the key to successfully resolving this complaint:

- Recognising that the initial investigation was not detailed enough.
- Contribution from senior staff to the investigation and the local resolution meeting.
- A detailed action plan for improvement.
- Showing clearly that lessons had been learned.

Example of poor practice in resolving complaints locally

A female patient was admitted to a trust under the care of the orthopaedic team. Two days later (a Friday) the complainant noticed that the

patient's condition was deteriorating and reported this to staff but nothing was done. The patient deteriorated further over the weekend and sadly died on the following Monday. Over the weekend, nursing staff failed to inform a doctor of the patient's further deterioration and she was not seen at all by the medical team despite her poor condition. Nursing staff also failed to inform the patient's family of her deterioration until the last hour of her life, which meant no member of her family was with her when she died.

The complainant raised a number of concerns with the trust about the poor standard of care provided to the patient. The trust investigated the complaint and, although it accepted that nursing staff should have observed and reported obvious signs of deterioration to medical staff, it attributed the lack of reporting to a "system error" and did not indicate that any action had been taken as a result of the complainant's concerns.

When the complainant brought her case to us, we found that nursing staff had failed to observe the patient sufficiently; that the standard of their documentation was poor; and that they had failed to notify medical staff of the patient's deterioration early enough.

We made a number of recommendations to the trust, and its chief executive wrote to the complainant outlining his intention to carry out a further detailed root cause analysis of the complaint. This took a long time and the trust did not inform the complainant of the reasons for these delays, despite a number of letters from the complainant requesting updates on progress.

Two months later the trust arranged a meeting with the complainant. The chief executive

attended and assured the complainant that an investigation had been carried out and that he would personally respond with the findings in the near future.

The complainant then experienced further delays. When the response to her complaint was concluded, it came from the matron for planned care, not the chief executive as originally promised. The response contained an action plan that lacked timescales; gave no details of staff responsible for taking the actions forward and no information about how the action plan would be reviewed and monitored. The trust refused to give any information about disciplinary action taken against staff, citing reasons of confidentiality. Understandably, the complainant remained dissatisfied with the overall handling of the complaint and the outcome of the investigation. The complainant returned to the Healthcare Commission with her concerns. Our nursing advisors saw this as a very poor example of a local complaint investigation because of:

- Delays in communication with the complainant at various stages of the complaint.
- Poor initial investigation.
- Assurances given by the chief executive that were not delivered.
- A poor quality action plan.
- Insufficient evidence of lessons learned.

Recommendations for providers of nursing care to improve local responses to complaints

1. Ensure that assurances on complaints are provided by senior staff within healthcare organisations.
2. Clearly demonstrate the lessons learned from a complaint in the response to the complainant.
3. Ensure that action plans arising from complaints are robust with regular monitoring of progress.

Complaints about accident and emergency (A&E) care

From a total of 307 complaints about A&E care, we asked for advice from our clinical advisors in 179 cases. The most common outcome of the 307 complaints reviewed was 'upheld with recommendations' (53% of cases), followed by 'not upheld' (22% of cases).

The main issue complained about related to treatment (24%), for example, delays, incorrect or unsuccessful treatment. Our recommendations focused on:

- Ensuring safe and effective clinical practice (22%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (11 %).
- Improving communication with patients (6%).

Example of good practice in resolving complaints locally

An example of good practice in local resolution was a case involving a 68-year-old man who died of respiratory failure secondary to a severe chest infection, which had initially been managed as pulmonary oedema (build-up of fluid on the lungs).

When this complaint was brought to us, our advisors noted that during the local investigation, the trust rapidly identified deficiencies in a number of areas of care and also in the organisational system for the assessment and management of patients.

As a result, the trust made major changes to its whole system of patient management, along with improvements in the individual areas where deficiencies were found as a result of this complaint. Of particular note were the efforts that the trust had made to contact staff who had moved to new places of work since the time of the events leading to the complaint. The trust also involved the local postgraduate medical deanery in following up some of the staff training issues that the complaint had raised.

The trust arranged a meeting where explanations and appropriate apologies were provided to the complainant. The minutes and outcomes of the meeting were well documented – an action plan was put into effect which was to be monitored by the trust's board.

This case is a good example of a complaint that, although it revealed some very serious concerns about systems at the trust, was successfully resolved because the trust

recognised that things had gone wrong, engaged positively with the complaint, and demonstrated that it had learned from events and made improvements as a result.

Examples of poor practice in resolving complaints locally

One case involved an elderly man who presented with a headache and vomiting. He was treated for encephalitis (inflammation of the brain). However, a CT scan carried out later revealed a large brain tumour. One of our A&E advisors considered this case and found that the concerns raised by the complainant were either briefly addressed or not covered at all in what was a very defensive response from them.

The trust's explanation of events was too technical to be understood by the lay reader. The trust only suggested minimal improvements and did not refer to national guidelines. The investigating officer assigned by the trust had been involved in the patient's care and treatment and therefore could not be seen as independent. Important patient documentation was unavailable, no statements were taken from staff involved and documentation of the whole investigation of the complaint was poor.

In the trust's overall response to the complaint, our A&E advisor found little evidence of organisational learning with a focus either on responding to the concerns in this particular complaint or improving standards for other patients.

The second case concerned an elderly woman who had pneumonia and heart failure. She was sent to hospital very ill, but sadly died soon after arrival.

One of our A&E advisors noted that the complaint raised a number of concerns, but the trust's ability to provide a full response was compromised by poor documentation of the events leading to the complaint. The trust developed an action plan covering some of the issues raised and audits were recommended. However, there was little evidence of any implementation of this action plan and planned audits did not happen. Nor were relevant national guidelines referred to in the action plan.

Our A&E advisor commented that, although the trust seemed to recognise that this complaint had revealed problems within its systems of caring for patients, it was clearly having difficulty in making effective changes as a result, and was therefore not using the lessons learned from this complaint to drive improvements in the care of other patients.

Recommendations for providers of A&E care to improve local responses to complaints

From the complaints that we have seen this year, we make the following recommendations:

1. Take statements from doctors and staff who were involved in the events leading to the complaint, rather than relying on consultants or managers at trusts interpreting events retrospectively.
2. Present responses to complaints in plain English, rather than in complex medical terminology, and address all of the complaint's concerns.
3. Show the learning as a result of the complaint and that this is linked to improvements in the care of patients. Refer to relevant national guidelines when appropriate.

Complaints about maternity services

We received 203 complaints that related to maternity services this year, and our clinical advisors advised on 66 of these cases. The most common outcome of the 203 complaints reviewed was 'upheld with recommendations' (55% of cases), followed by 'not upheld' (25% of cases).

The main issue complained about related to treatment (31%) for example, delays, incorrect and unsuccessful treatment. Our recommendations focused on:

- Ensuring safe and effective clinical practice (25%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (15%).
- Improving communication with patients (10%).

Example of good practice in resolving complaints locally

This case related to some aspects of a woman's care in labour, but mostly to her postnatal care. The woman had an uncomplicated labour and was given an early discharge to the community midwives. However, when she returned home she felt unwell. She was readmitted to hospital suffering from puerperal infection (an infection of the genital tract following childbirth) and was treated in intensive care, but made a full recovery. The woman complained that she had not been assessed thoroughly in hospital before being discharged to the community midwives.

Our adviser noted some very positive elements to the trust's local response to the complaint:

- There was evidence of an investigation, with statements taken from the midwives involved.
- The response was honest in that it admitted some shortcomings, and it was factually correct when statements were checked against the written record.
- The trust quoted policies to substantiate some aspects of their response and supplied these policies. They had also supplied them to the complainant.
- The policy documents were referenced to a relevant and suitably well-recognised source.
- The trust had made the offer of a meeting with the complainant, to fully explain some aspects of the complaint and to clarify the issues.
- There was evidence that the trust had changed its practice following the complaint, to prevent a recurrence, and it supplied a new policy that had been implemented as a result of the complaint.

This response included many of the features of a good response as recommended by our *Complaints Toolkit*. The only suggestion we made was for the trust to provide some evidence of how the policy changes had been disseminated to staff, which it has since done. This response included a robust investigation, a clear explanation of what had gone wrong, and substantive evidence of learning as a result.

Example of poor practice in resolving complaints locally

Our advisor had concerns about a healthcare organisation's response to a complaint from a woman who had suffered a massive postpartum haemorrhage that could not be stopped, which resulted in an emergency hysterectomy (removal of the womb).

Having reviewed the relevant information, our clinical advisor concluded that the trust's response to this complaint was of a very poor quality. The response was deficient in the following areas:

- It contained incorrect information, such as using the wrong abbreviation to describe a condition that the trust thought may have affected the woman. If the patient had tried to find out what this abbreviation meant, she would not have found an answer.
- Although the trust said that they believed the patient suffered from this condition, they failed to give an explanation as to what this condition was, how it occurs, or how it would have affected the woman.
- The records of clinical care were of a poor quality.
- The trust did not explain the severity of the haemorrhage well and this was not obvious from the records either.
- Surgical intervention was undertaken, in the form of applying a suture/ligature around the uterus, to try to stem the bleeding, but the trust failed to explain how this worked and why it was attempted.

- The trust stated that drugs had been given to stop the bleeding, but did not say what drugs, how they work, or why they were used.
- The trust stated that uterine atonia (lack of muscle tone in the womb) was the reason for the hysterectomy, but did not explain what this was, why it happens, what the consequence is, or how it can be treated.
- There was no evidence that this case was investigated as a serious untoward incident (SUI), which our advisor would have expected given the serious nature of the complications that arose.

However, when our maternity advisor completed an in-depth review of the clinical notes, she found that the woman's care during the haemorrhage had actually been of an exemplary quality. Midwifery and medical staff had responded speedily and the care provided met all of the standards of well-accepted good practice in the management of massive haemorrhage. Our advisor found that without this intervention, the patient would probably have died.

The most significant learning point from this complaint is that, although the trust had actually provided an excellent standard of clinical care to the patient, its explanation in response to the complaint was so poor that the patient approached the Healthcare Commission for an independent review. The local response to the complaint had led the patient to be mistrustful of the organisation that provided care to her during what was a life-changing event. Our review of this complaint provided explanations of a number of the points above that the trust had failed to adequately address in its local investigation.

What the trust should have provided in its response included:

- Sensitive letters that acknowledged the woman's concerns or her perceptions about her care.
- Non-defensive responses.
- Information shared with the woman if a serious untoward incident (SUI) had occurred and also the findings of this.
- The offer of a meeting to explain or discuss any concerns with the woman.

Recommendations to providers of maternity services to improve local responses to complaints

1. Conduct a thorough investigation into the complaint, and include statements from staff in the file.
2. Give an honest response from the trust, acknowledging any shortfalls in the care.
3. Give a good explanation about the clinical issues.
4. Give supplementary information such as policies in use at the time or an explanation of how the care provided met national guidance.
5. Give evidence of any action taken as a result of the case. For example, an explanation of any training needs identified and how these will be put into place, comment relating to the involvement of midwifery supervision and what this is, changes to practice or the introduction and development of new

policies, and planned audits to monitor whether changes made as a result of the complaint are working.

6. Make sure letters are sensitive and acknowledge the woman's concerns or her perceptions about her care.
7. Give non-defensive responses.
8. Share information with the complainant if a serious untoward incident (SUI) has occurred and also the findings of this.
9. Offer a meeting to explain or discuss any concerns with the complainant.

Complaints about services for people with mental health needs

We received 462 complaints about mental health services (of which, 258 cases needed further clinical advice). The most common outcome of the 462 complaints reviewed was 'upheld with recommendations' (50% of cases) followed by 'not upheld' (22% of cases).

The main issue complained about related to general mental health care, (47%) for example, appropriateness of treatment, care review meetings, and use of control and restraint. Our recommendations focused on:

- Ensuring safe and effective clinical practice (21%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (18%).
- Improving communication with patients (10%).

Examples of good practice in resolving complaints locally

In one case, a man with severe mental health needs complained to the trust about the care he received on a ward. Our advisor noted that it was apparent that some of the complaint was a consequence of the service user's tendency to have some delusional beliefs. However, the trust met with him and tried to go through his experiences.

Our advisor praised the trust's responsiveness to this complaint, as it could have been easy to dismiss the complaint due to the complainant's history. Instead, the trust managed to turn the complaint into a positive and therapeutic experience by helping the service user to formulate his concerns effectively. The advisor noted this as an excellent example of leadership from the trust in dealing with complaints.

A second example was a complaint in which a patient felt abandoned by her community mental health nurse. The healthcare organisation concerned conducted a thorough investigation and offered an unreserved apology for the failings that the investigation had revealed. The tone of the letter was empathetic, it was written in plain English and explained how the trust would improve services as a result of the complaint.

Examples of poor practice in resolving complaints locally

Rather than focusing on individual case examples for poor practice in mental health services, our clinical advisor has described some of the main themes noted in the complaints she reviewed this year.

In complaints about mental health services, it is sometimes apparent that people who use the services feel powerless and controlled by the professions involved in their care. Sometimes, a complaint is one way of exercising some balance in power. Other complaints can be about real and significant failings in mental health services.

Our advisor has noted that some trusts adopt a 'one size fits all' approach to service users who exercise their right to complain. Responses to complaints sometimes reflect this by being somewhat aloof in tone and not offering evidence-based conclusions.

Some examples of poor responses from trusts in mental health cases include:

- A lack of a proportionate internal investigation.
- No offer of a local resolution meeting.
- Apologising for the behaviour of staff without explaining, in particular, what aspects of poor practice warrant the apology. The apology can therefore appear to be a 'token gesture'.
- Providing letters filled with jargon, without answering the complainant's concerns.
- No balance offered in the situation, particularly offering only the trust's version of events without acknowledging the distress caused to the service user.
- Refusal to investigate the complaint due to the service user's 'mental state' (when this may not have been justifiable).

- Admitting some service failings, but making no improvements as a result.

In order to improve responsiveness to complaints about mental health services, we recommend that trusts engage positively with service users so that they do not experience feelings of isolation when making complaints, and that the complaints process feels inclusive rather than defensive. Trusts should see complaints about mental health services as a learning opportunity and should invite service users and carers to be part of the process.

Recommendations to providers of mental health services to improve local responses to complaints

1. Check the detail of any identified failings in the integrated records and compare this against local policies.
2. Invite the service user or carer to discuss their complaint in a safe environment.
3. Keep the complainant up-to-date with changes to services that occur as a result of the complaint.
4. Keep the language used in the response to the complaint as neutral and empathetic as possible and try to not to use defensive language.
5. Offer a proportionate response.
6. Use evidence, guidance or legislation to inform responses where required.
7. Conduct an internal review – the level of the review will be dependent on the issue.

8. Keep response letters free of jargon and write in plain English.
9. Do not dismiss a complaint because of the mental state of the service user – offer an advocate to assist.
10. Offer an apology where appropriate.

Complaints involving patients with a learning disability

Our clinical advisors only saw a small number of cases this year (24 cases) where the complaint concerned people with a learning disability. These were not necessarily complaints made about learning disability services specifically, but where the patient's learning disability was a factor in the complaint. The following are some themes in the complaints reviewed by one of our advisors:

- People with a learning disability had negative experiences in acute hospitals.
- Trusts failed to adhere to the principles of *Valuing People*³ – and to indicate in responses that they will improve training for staff.
- Doctors in an A&E department showed a negative attitude towards a mother's concerns about her daughter who had a learning disability.
- Poor communication between agencies resulted in missing opportunities offered by specialist services and voluntary agencies, such as MENCAP.
- Medical and nursing staff in some hospitals had not read care files accompanying

individuals with a learning disability. These files provide valuable information about the overall care needs for a patient with a learning disability.

Our recommendations focused on:

- Ensuring safe and effective clinical practice (29%).
- Taking remedial action to resolve the case, taking account of the patient's point of view (13%).
- Having clear systems of accountability and responsibility (8%).
- Improving the way services are delivered to patients (8%).

Recommendations to providers of learning disability services to improve local responses to complaints

1. Trusts should consider inviting local voluntary agencies to contribute to a workshop on resolving complaints and improving services. This could be an annual event.
2. Trusts should involve advocacy for the person making the complaint when it is appropriate to do so.
3. Acute trusts should identify an individual to 'champion' the cause of people with learning disabilities. Some acute trusts employ learning disability liaison nurses in this role.
4. Trusts should note the information and guidance provided by the Valuing People website.

Complaints about palliative care

Concerns about end-of-life care feature across a range of cases that our team of clinical advisors have reviewed this year. Palliative care is now increasingly delivered in a number of settings, including hospitals, GP practices and nursing homes. Two of our clinical advisors – a consultant physician and a general surgeon – reviewed 24 cases this year from a palliative care perspective.

Our recommendations focused on:

- Taking remedial action to resolve the case, taking account of the patient's point of view (25%).
- Improving learning and innovation (17%).
- Improving communication with patients (13%).
- Improving the way services are delivered to patients (13%).
- Ensuring safe and effective clinical practice (13%).

Examples of good practice in resolving complaints locally

There were many examples of good practice in palliative care, for instance, trusts using the Liverpool Care Pathway* for the dying. In a surgical case, a trust provided a very open response to a complaint from the wife of a man who had terminal cancer. The patient had asked staff not to inform his wife if a surgical procedure had revealed cancer. It did so. After the patient died, his wife made a complaint that

staff had been obstructive. The trust promptly arranged a meeting and explained that her husband had made the request, but openly accepted that some staff had used this as a reason to block all information to her, not just information about the diagnosis of cancer. The trust offered its sincere apologies for this. Our advisor also noted that there was clear evidence that the surgical team had used this case as a learning tool and had discussed these matters in a full and frank manner.

Examples of poor practice in resolving complaints locally

A man in his late 80s was admitted to hospital as in emergency with a perforated colon, which was due to advanced cancer.

An operation was performed, but afterwards the patient developed septic complications and multi-organ failure and was transferred to the intensive care unit. On reviewing the case, our advisor found that, while the patient was in intensive care, it was not clear who the lead consultant was. A 'Do not attempt resuscitation' (DNAR) form was signed, but this was not fully completed and was not reviewed periodically, which was contrary to the trust's own policy on this. The records from the case showed that it was clear to staff that the chances of the patient dying were very high. However, they did not inform his family about this, who were left with the impression that the patient was expected to recover.

Following the patient's death, a complaint was made to the trust. A report was obtained from the surgeon who operated, but this was then forwarded, unaltered, to the patient's family. It

* The Marie Curie Palliative Care Institute, Liverpool, The Liverpool Care Pathway for the Dying Patient. This is a continuous quality improvement framework for care of the dying, irrespective of diagnosis or place of death.

was written wholly in medical terminology and made no attempt to answer the family's questions. There were no indications that the trust had learned from the complaint or had made any improvements in respect of the issues highlighted. We upheld this complaint against the trust and recommended that they take steps to remedy the shortcomings that our advisor had identified.

The main deficiency in this case was poor communication from the trust with the patient's family. Our advisors recommend that clinical teams are more open and honest with families when a patient's prognosis is poor. When patients are admitted for surgery and there is a high risk of death, this should be discussed and recorded on the form giving the consent for the operation. Trusts should ensure that staff have received up-to-date training on how to break bad news. Hospital doctors should also inform the patient's GP when a decision is taken that the care is to be palliative in nature. Sometimes, when trusts acknowledge that things have gone wrong, the apology provided is evasive.

Our advisors found that the differentiation between active treatment and palliative care was often not clear. They suggest that trusts adopt the Liverpool Care Pathway and provide dedicated teaching and discussion time for staff involved in palliative care.

Recommendations for those providing palliative care to improve local responses to complaints

1. Provide open responses to complainants, that are not full of clinical or technical terminology.
2. Reference relevant care pathways in responses to complaints, in particular the *Liverpool Care Pathway for the Dying Patient*.
3. Ensure that front-line staff have up-to-date training in how to break bad news to patients and their relatives and carers.

Our legacy of learning

In this section, we look at what we have learned from complaints since 2004, and we provide recommendations for NHS organisations to help improve the way they handle complaints and improve their services.



Learning from our work

Before July 2004, if a complaint about an NHS service could not be resolved at local level, a complainant could ask for a review by a panel of lay people. Members of the panel were usually non-executive members of the organisation about which the complaint had been made. A national evaluation of these arrangements found that the public thought that it was not sufficiently independent, took too long, and was inconsistent.⁴ Consequently, the Government introduced a new three-stage complaints system, with the second stage (independent review) provided by the Healthcare Commission.

Our role as independent reviewer has allowed us the unique opportunity to report on the themes and trends in thousands of complaints about the NHS at a national level. We have disseminated this learning to healthcare organisations, with the aim of improving both the way they handle complaints and the services they provide to patients. Since 2004, we have captured and fed this learning back through:

- Three *Spotlight on Complaints* reports on the main themes in second-stage complaints about the NHS in England. The first, published in February 2007, covered the period July 2004 to July 2006. The second, published in April 2008, covered the period August 2006 to July 2007. This, our third and final *Spotlight* report, covers the period August 2007 to July 2008.
- An audit of how complaints are handled in the NHS, published in October 2007.⁵ This found that standards varied significantly across the NHS and that many trusts did not

have adequate arrangements to handle complaints.

- A *Complaints Toolkit*, published in March 2008. This built on the findings of our first *Spotlight* report and our audit, and set out step-by-step good practice guidance for healthcare organisations on handling complaints. It provides tools and templates to help conduct a thorough investigation, with the aim of resolving concerns locally.
- Quarterly reports to strategic health authorities. These detail, for each trust in each region, the outcomes of our cases, with the issues raised and recommendations made.
- A number of engagement events with our stakeholders, focused on improving local resolution.
- Making more than 16,500 recommendations on our cases to resolve complaints and improve services.

Our focus has always been on improving the local resolution of complaints. We firmly believe that complaints are best dealt with closest to the source of the complaint – this strengthens the relationship between the complainant and the organisation complained about. Our experience shows that the steps that NHS organisations need to take to resolve complaints locally are often not difficult or expensive to implement. Rather, they are more to do with changing the culture of how complaints are received within the health sector. It is vital that this change occurs as, under the new system for handling complaints, NHS trusts will have to do far more at a local level to resolve them.

Demand for independent reviews of complaints

The Healthcare Commission took responsibility for the second stage of the NHS complaints process in July 2004. Since then, we have reviewed 30,268 complaints (to the end of 31 July 2008) made by patients and their relatives about NHS services, resolving complainants' concerns and providing valuable feedback to the NHS to improve the care of patients.

It is clear, from the four and a half years that we have provided the second stage review, that many people are dissatisfied with the way that

NHS organisations currently handle complaints. As figure 5 shows, the number of complaints that we have received has remained consistently high, at between 600 and 700 a month. When the Commission took responsibility for the second stage, it was thought that there would be a high initial demand on the system, followed by a fall in volumes. This was not the case. We are strongly of the view that NHS organisations could and should do more to resolve complaints locally – a view that we know the Ombudsman shares.⁶

Figure 5: Volume of cases received

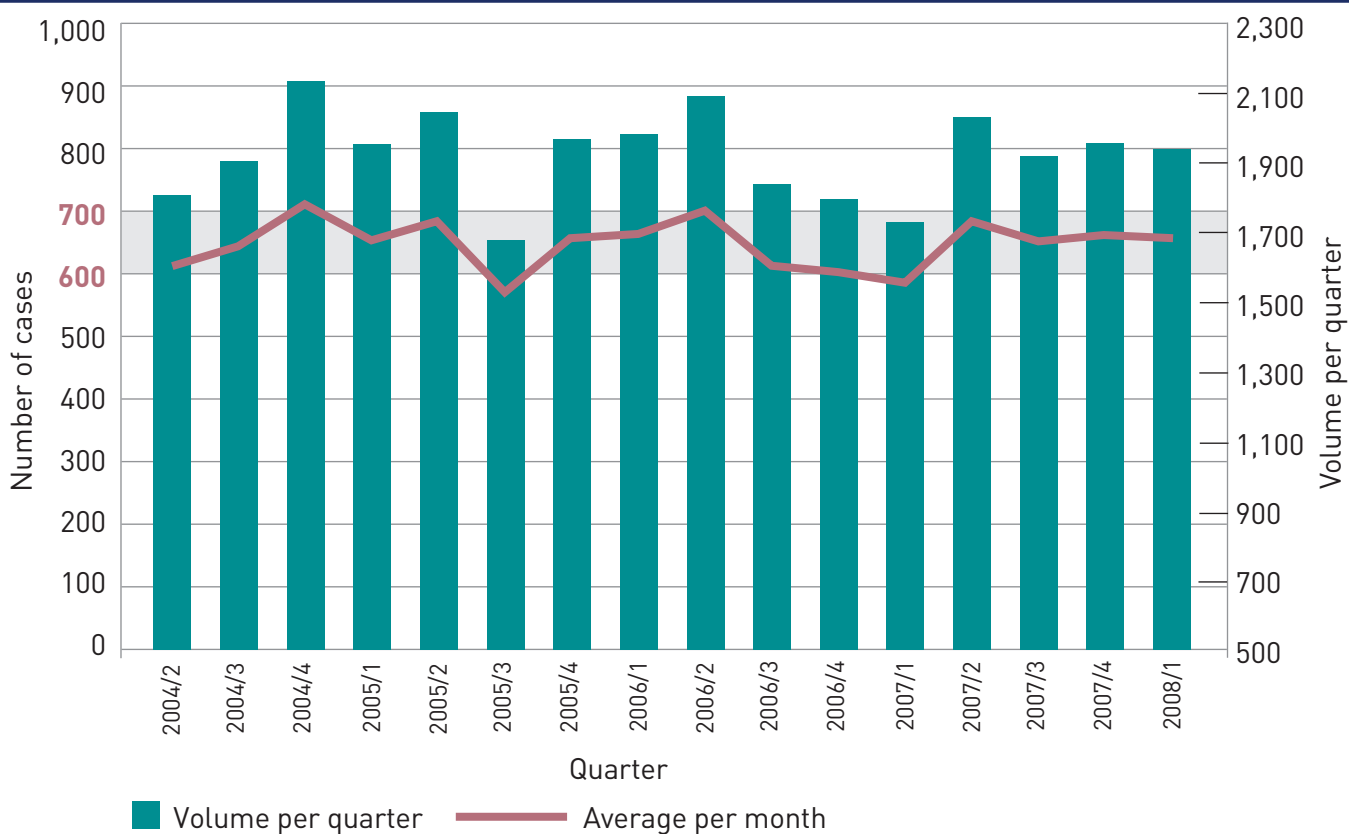
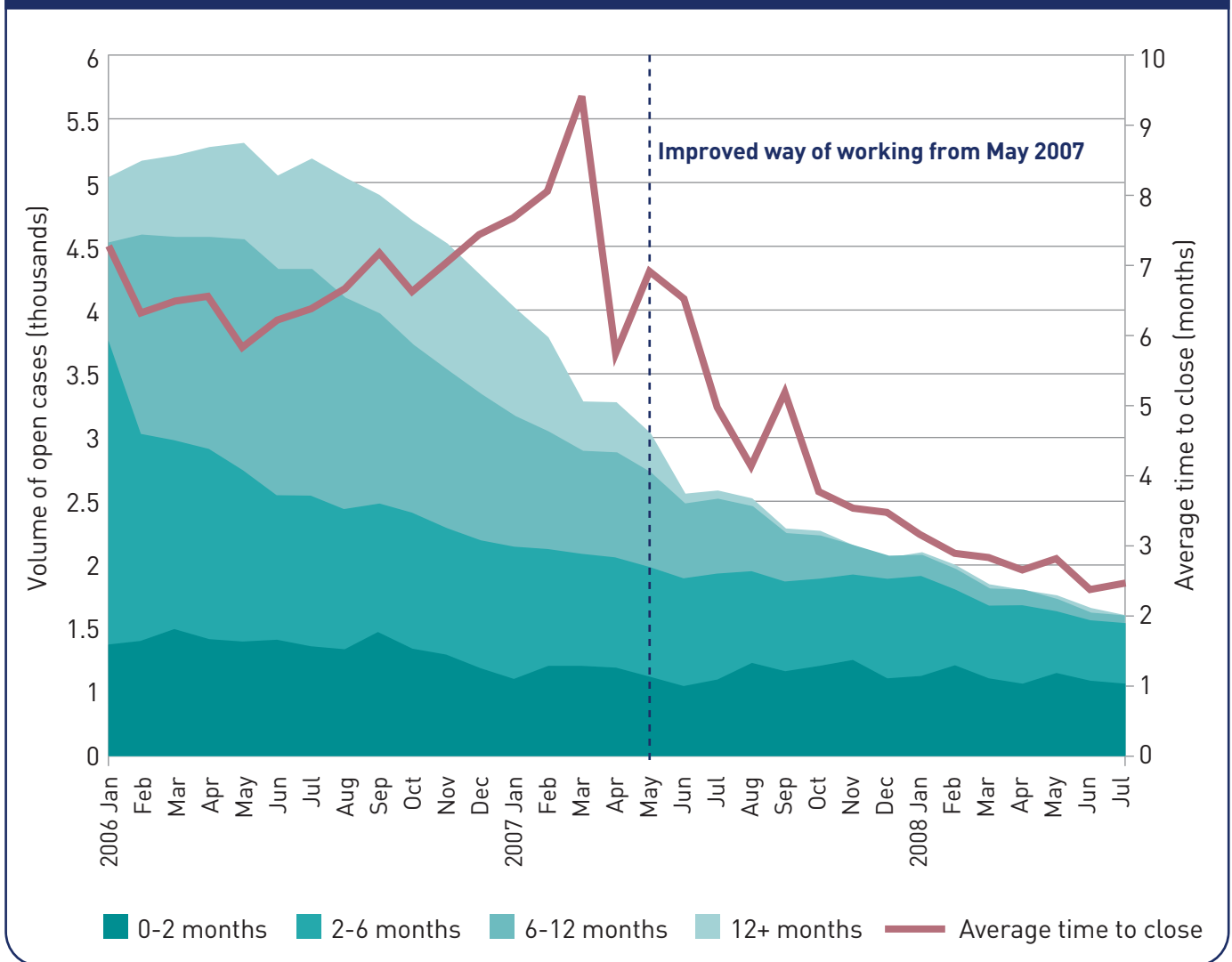


Figure 6 shows the progress that we have made since January 2006 in consistently reducing our

open caseload and the average time for us to conclude cases.

Figure 6: Profile of open cases and average time to close (January 2006 to July 2008)



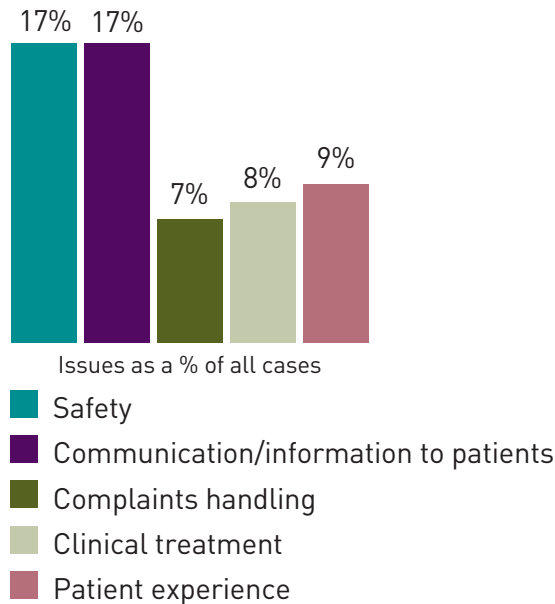
Themes in our reviews since July 2004

During our time as the reviewer of complaints at the second stage, we have seen common themes in the issues raised by complainants and the outcomes of our cases. Figures 7 and 8 show that the issues raised by complainants who

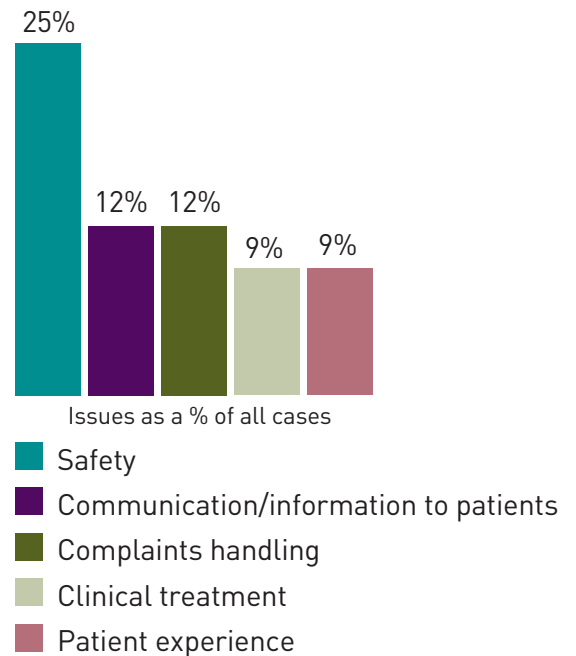
approach us have remained broadly consistent. The main issues concern the fundamentals of healthcare, such as safe care and clinical treatment, and the essential elements of a considerate, customer-focused approach to complaints – such as communication and the way that the complaint was handled overall.

Figure 7: Issues raised by complainants 2004 to 2008 (by financial year)

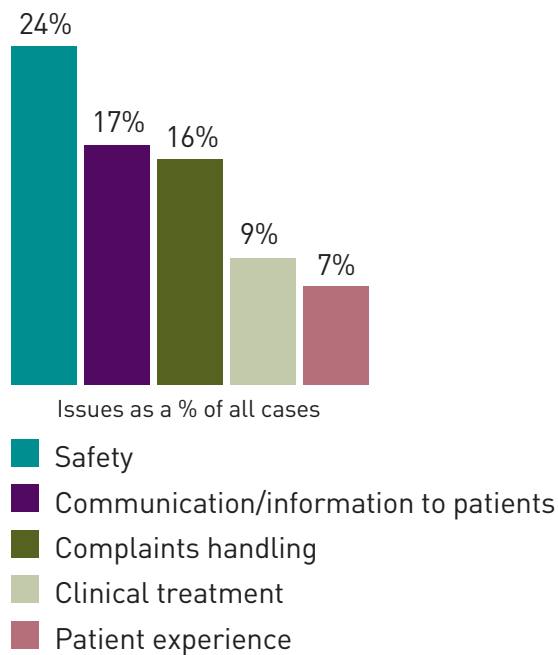
2004/05



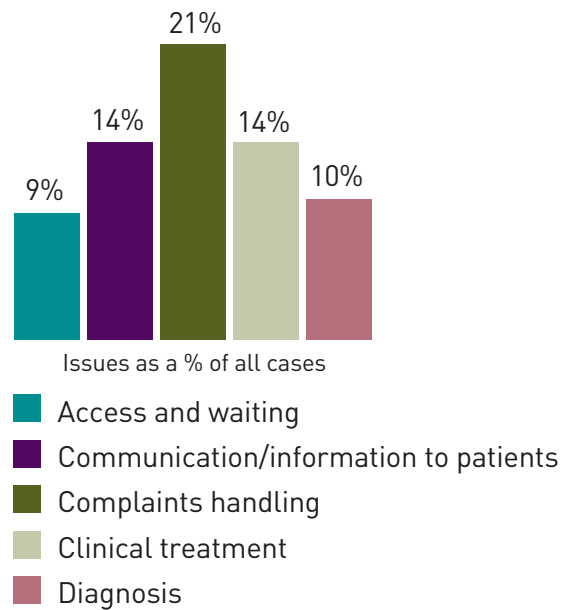
2005/06



2006/07



2007/08

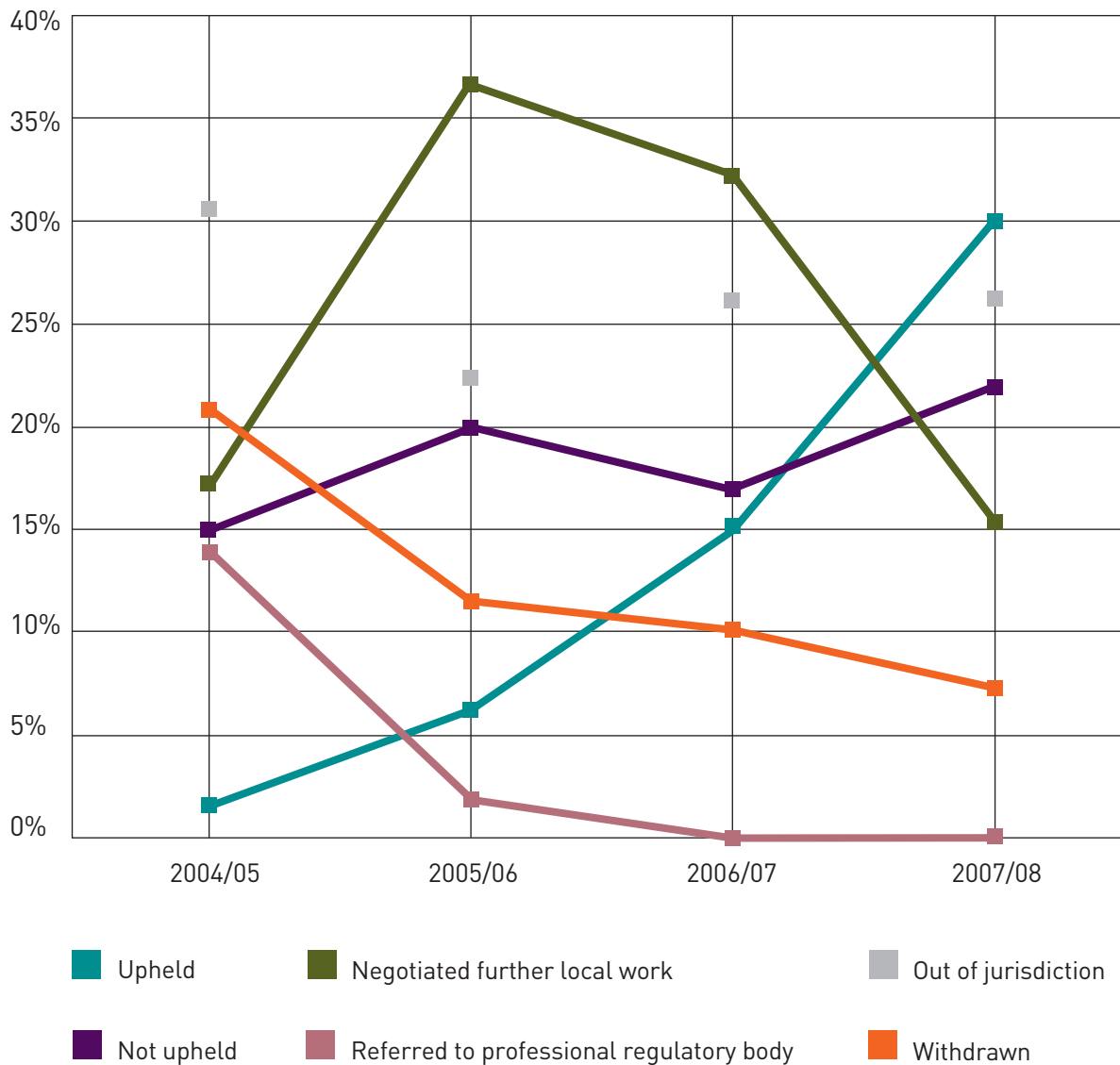


Note: Data for the charts relates to financial years. In 2007/08, 'complaints handling' was the top issue, compared to 'safety' in previous years. This is due to a change in coding, in which elements of what was 'safety' were allocated across a number of different categories.

Figure 8 illustrates the outcomes of the cases that we have reviewed each year since 2004. Some of the varying outcomes can be explained by changes in our processes (for example, we now make a conclusive decision whether or not

to uphold a complaint in far more cases, as indicated earlier in this report), but there has been a clear trend since 2004 that we have upheld far more cases. This demonstrates that, in the last four and a half years, we have

Figure 8: Outcomes of cases handled by the complaints team



consistently found that NHS organisations could and should have done more at a local level to resolve complaints. It is possible that one unintended consequence of the independent review service is that healthcare organisations have become too reliant on the Healthcare Commission to resolve complaints, rather than doing all that they could to resolve the complaint locally.

Drawing on our experience as an independent reviewer of complaints, we have set out 12 key recommendations for improving the local resolution of complaints in the NHS.

1. Acknowledge the person's right to complain.
2. Ensure that the complaint is assessed upon receipt, so that any concerns about a risk to the safe care of other patients can be identified promptly.
3. Clarify what the person's concerns are and manage expectations about possible outcomes to the investigation of the complaint.
4. Consider the various options for resolving the complaint – for example, a meeting or reimbursement of costs.
5. Ensure that the person is kept informed of progress throughout the life of the complaint.
6. Confirm to the person what support is available to assist in making a complaint – for example, the Independent Complaints Advocacy Service (ICAS).
7. Take statements from, and interview if necessary, those staff involved in the events leading up to the complaint. This should be done as soon as possible, so that events are still fresh in the memory.
8. Where necessary, obtain clinical advice on the matters raised. This advice must have a high degree of independence – for example, by obtaining advice from the trust's medical director or from a clinician at another trust.
9. Ensure that any letters to the person making the complaint are written in plain English and are as free as possible of clinical or other technical terminology.
10. Offer an apology if appropriate.
11. Ensure that general learning is taken from specific complaints and is embedded into the system of care for the future.
12. Ensure that the boards of trusts are satisfying themselves that all the above are happening.

Conclusions and next steps



Conclusions

Since we assumed responsibility for the second stage of the NHS complaints process in July 2004, we have reviewed 30,268 complaints about the NHS made by patients and their relatives, and made 16,500 recommendations to resolve complaints and improve services. We have also shared what we have learned from these reviews in a number of different ways (see page 43).

Over this period, as highlighted by the examples of good practice in this report, we have seen some improvements in the way that the NHS responds to complaints. But, as the outcomes of our reviews from this year show, there is some way to go before the NHS can confidently say that there are robust arrangements for handling complaints across its providers in England. This will be a big challenge for trusts under the new arrangements for handling complaints, which are due to come into force in April this year.

The types of complaints that we have seen have not changed substantially over the four and a half years that we have provided the independent review. They have mostly related to the fundamentals of good healthcare: communication, the attitude of staff, record-keeping, and privacy and dignity.

Many complaints have also been about a poor standard of handling complaints by the organisation concerned – this was the issue that complainants were most concerned about this year. For example:

- Letters which do not empathise with the circumstances of the complaint, or are full of clinical or other technical terminology.

- Some issues raised by the complainant not addressed in the response.
- A failure to interview or take statements from members of staff involved in the complaint.
- A lack of flexibility in the trust's approach to the case, for instance, not offering the complainant the opportunity to meet with representatives of the trust to discuss their concerns.

We have also seen cases this year where trusts have apologised for things that have gone wrong, but have expressed this in equivocal terms. For example, chief executives who say to complainants: 'I am sorry if you feel that way'. We strongly recommend that trusts provide a full and unequivocal apology when shortcomings in care and treatment have been identified.

As we emphasised in last year's report, it is crucial that NHS organisations get the customer service aspects of a complaint right at the first time of asking. Complaints and feedback from patients are likely to play an increasingly important role as a mechanism to improve the care of the patients in the NHS. The framework set out in the final report of the NHS Next Stage Review, *High Quality Care for All*⁷, sees far greater choice for patients and more personalised services. Advances in technology mean that there are now more different ways for the public to provide feedback to NHS organisations. In this context, it will be even more important for NHS organisations to listen to, and learn from, complaints to ensure that the quality of services meets the increasing expectations of patients and the public.

We have always believed, and this is reflected in our previous reports on NHS complaints, that complaints are best resolved by the local provider without the need for involvement of an outside agency. Improving the way that complaints are responded to locally has always been the focus of our work. We call on NHS organisations to use all the good practice guidance available to improve the way that they handle complaints, including our *Spotlight* reports, our *Complaints Toolkit* and the Ombudsman's *Principles of Good Administration*⁸, *Principles for Remedy*⁹ and *Principles of Good Complaints Handling*.¹⁰

We know that patients and their representatives make complaints to healthcare organisations for three major reasons:

- They want an explanation of the events leading to their complaint.
- They want an apology.
- They want an assurance that the same mistakes will not be made in the future.¹¹

We urge NHS organisations to ensure that they give active consideration to these three crucial components when responding to a complaint.

The key finding of this report is that there is still much that the NHS can do to improve the way that it deals with complaints. It is essential that there is a change of thinking throughout healthcare organisations – that they view complaints positively as a learning experience, rather than adopting a defensive approach. This is even more important with the increased emphasis on providers getting their responses to complaints 'right first time' under the new arrangements. We have done a great deal of

good work on complaints and we are proud of our achievements as the independent reviewer. We call on NHS organisations to build on our legacy of learning to continuously drive improvements in complaints handling.

Next steps

We have provided a successful independent review service, which has identified key themes in complaints and has shared these with the NHS. As a result of a number of reports, including previous publications of *Spotlight on Complaints*, the NHS complaints system is being reformed, together with the system to handle complaints about social care. From 1 April 2009, a single, simpler process will be introduced for all health and social care services in England. Under this new system complaints should be made first to the NHS or social care provider and, if the complainant remains unhappy with the outcome, to the Health Service Ombudsman (or Local Government Ombudsman where that is appropriate). The Health Service and Local Government Ombudsmen will work together in a coordinated way on complaints that cross the boundaries between health and social care. Our focus has always been on improving local resolution of complaints – so we welcome these reforms, which put much greater emphasis on resolving complaints locally.

We trust that NHS organisations will draw on the lessons that we have learned from complaints as they move into the new system. As this report shows, there are considerable challenges facing the NHS to bring the standards of local complaint responses up to one where patients are much less likely to seek a second, independent view on their concerns.

It is vital that trusts' boards show clear leadership on complaints and challenge some of the areas of poor practice that we have highlighted. Poor complaints handling can cause damage to the reputation of NHS providers so it is essential, in a more commercially competitive healthcare environment, that boards listen to, and learn from, complaints. Commissioners too need to make clear that they will follow up any failings on complaints handling with vigour.

We will do all that we can to make the transition to the new arrangements as smooth as possible – so that no complainant is disadvantaged. We will work closely with the Ombudsman to ensure that all work that we have in hand at the end of March 2009 is moved across in a way that maintains a high level of customer service to both the public and healthcare providers.

On 31 March 2009, the Healthcare Commission's functions will be taken over by the Care Quality Commission, the new health and social care regulator. Although the new regulator will not review unresolved complaints, it will have a key role to play in ensuring that all healthcare organisations have appropriate arrangements for handling complaints. We believe that the new regulator should work in partnership with the Ombudsman to exchange information on trends in complaints, and to act on concerns that arise from investigations into individual complaints.

To underpin the new approach to complaints, the Ombudsman's *Principles of Good Complaint Handling*, published in November 2008, aims to complement her previously published *Principles of Good Administration and Principles for Remedy*. These *Principles* seek to establish a

framework of standards for the NHS to complement the work being done through reforms such as the NHS Next Stage Review, the NHS Constitution and the World Class Commissioning agenda.

All those reforms seek to make clear the importance of designing and delivering services around the needs and wishes of the people who use those services and making them more responsive to the feedback provided, especially through complaints. In particular, the NHS Constitution, will also make clear people's rights when it comes to making a complaint – including the right to have a complaint efficiently dealt with, to have it properly looked into and to be told of the outcome. People should also expect things to be put right if they have been disadvantaged. The new complaints system and the Ombudsman's *Principles* are all intended to support these rights and build on the valuable work that we have done in providing the independent review service.

This report shows that, although much progress has been made on handling complaints about the NHS, there is much work to be done to achieve these aims and that there are many challenges in doing so for NHS organisations and the Ombudsman. However, we trust that the new arrangements will meet these aims. An NHS that is locally responsive to the concerns of patients and that continuously improves as a result of complaints is something that would be universally welcomed.

References

1. NHS Information Centre for Health and Social Care, *Trends in Consultation Rates in General Practice 1995-2006*, July 2007
2. General Medical Council, *Good Medical Practice*, 2006
3. Department of Health, *Valuing People, A New Strategy for Learning Disability for the 21st Century*, 2001
4. Department of Health, *NHS Complaints Procedure, National Evaluation*, March 2001
5. Healthcare Commission, *Is anyone listening? A report on complaints handling in the NHS*, October 2007
6. Parliamentary and Health Service Ombudsman, *The Ombudsman's role in a reformed complaints procedure*, speech at the Making Experiences Count Conference, 2 April 2008
7. Professor the Lord Darzi of Denham KBE, *High quality care for all: NHS Next Stage Review final report*, June 2008
8. Parliamentary and Health Service Ombudsman, *Principles of Good Administration*, March 2007
9. Parliamentary and Health Service Ombudsman, *Principles for Remedy*, October 2007
10. Parliamentary and Health Service Ombudsman, *Principles for Good Complaint Handling*, November 2008
11. BMRB Social Research, *Evaluating the Healthcare Commission's Complaints Handling Function*, April 2007

If you would like this information in other formats or languages, please telephone 0845 601 3012.

Albanian

Ky botim gjendet në gjuhë dhe formate të tjera. Ju lutemi telefononi në 0845 601 3012.

Arabic

هذه الإستمارة متاحة بلغات وبأشكال أخرى عند الطلب
نرجو الاتصال على الرقم 0845 601 3012.

French

Cette publication est disponible dans d'autres formats et d'autres langues. Merci d'appeler le 0845 601 3012.

Gujarati

આ પ્રકાશન બીજા પ્રકારો અને ભાષાઓમાં વિનંતી
પર મળશે. કૃપા કરીને આ નંબર 0845 601 3012
પર ફોન કરશો.

Kurdish

ئەم بڵاوکراوەیە بە شێوە و زمانەکانی تر دابین کراوە.
تکایە تەلەفۆن بکە بۆ ژمارە تەلەفۆنی 0845 601 3012.

Pashto

دغه خپرونه په نورو بڼو او ژبو کې هم تر لاسه کېږي.
هيله ده چې 0845 601 3012 لمبرته ټيليفون وکړئ.

Polish

Niniejsze wydanie jest dostępne na prośbę
w innych formatach i językach. Proszę
dzwonić pod numer telefonu 0845 601 3012.

Punjabi

ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਮੰਗ ਕਰਨ 'ਤੇ ਦੂਜੀਆਂ ਫਾਰਮੈਟਾਂ ਅਤੇ ਜ਼ਬਾਨਾਂ ਵਿੱਚ
ਉਪਲਬਧ ਹੈ। ਕਿਰਪਾ ਕਰ ਕੇ 0845 601 3012 'ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ।

Serbian

Ova publikacija je dostupna i u drugim
formatima i jezicima. Molimo Vas pozovite
0845 601 3012.

Somali

Daabacaaddan waxaa lagu heli karaa qaabab
iyo luuqado kale. Fadlan soo dir taleefoonka
0845 601 3012.

Spanish

Esta información se encuentra también
disponible en otras lenguas y formatos.
Llame al: +44 (0) 845 601 3012.

Sylheti

এই তথ্যপত্রটি অঙ্ক এবং বধির লোকদের পড়ার ও বোঝার
উপযুক্ত নমুনায় এবং অন্যান্য ভাষায় পাওয়া যায়।
অনুগ্রহ করে ফোন করুন: 0845 601 3012 ।

Traditional Chinese

這份刊物提供有其他格式和要求的語言版本。
請致電 0845 601 3012。

Urdu

یہ پبلی کیشن طلب کرنے پر دیگر زبانوں اور وضع میں دستیاب ہے۔
براه کرم 0845 601 3012 پر ٹیلی فون کریں۔

Vietnamese

Ấn bản này được cung cấp ở những định dạng
khác và bằng ngôn ngữ khác theo yêu cầu.
Hãy gọi điện tới số 0845 601 3012.

Yoruba

A ti ṣe iwé yi ni oríṣíríṣí èda ati ède mírán.
Ẹ kàn si wa lori 0845 601 3012.

© February 2009 Commission for Healthcare Audit and Inspection

This document may be reproduced in whole or in part in any format or medium for non-commercial purposes, provided that it is reproduced accurately and not used in a derogatory manner or in a misleading context. The source should be acknowledged, by showing the document title and © 2009 Commission for Healthcare Audit and Inspection.

ISBN: 978-1-84562-211-4

Concordat gateway number: 159

Photos from John Birdsall/PA Photos

Healthcare Commission

Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Maid Marian House
56 Hounds Gate
Nottingham
NG1 6BE

Dominions House
Lime Kiln Close
Stoke Gifford
Bristol
BS34 8SR

Kernel House
Killingbeck Drive
Killingbeck
Leeds
LS14 6UF

5th Floor
Peter House
Oxford Street
Manchester
M1 5AX

1st Floor
1 Friarsgate
1011 Stratford Road
Solihull
B90 4AG

Telephone 020 7448 9200
Facsimile 020 7448 9222
Helpline 0845 601 3012

E-mail feedback@healthcarecommission.org.uk
Website www.healthcarecommission.org.uk

This publication is printed on paper made
from a minimum of 75% recycled fibre

ISBN 978-1-84562-211-4



9 781845 622114



Corporate Member of
Plain English Campaign
Committed to clearer communication.

341