NHS Complaints Handling: Briefing Note

NHS Complaints Procedure

The standard NHS complaints procedure can be used for most complaints about NHS services.

The legislation governing the NHS complaints procedure[1] sets out various obligations on NHS bodies, GPs and other primary care providers and independent providers of NHS care in relation to the handling of complaints. For example there is a duty on NHS bodies to provide a written response to complaints.

Information about the two stages of the standard NHS complaints process is set out on the NHS Choices website[2]:

1. Ask your GP, hospital or trust for a copy of its complaints procedure, which will explain how to proceed. Your first step will normally be to raise the matter (in writing or by speaking to them) with the practitioner e.g. the nurse or doctor concerned, or with their organisation, which will have a complaints manager. Alternatively, if you prefer, you raise the matter with the relevant commissioning body such as the NHS England or a local CCG. The process is called local resolution, and most cases are resolved at this stage.
2. If you are still unhappy, you can refer the matter to the Parliamentary and Health Service Ombudsman, who is independent of the NHS and government.

The NHS Constitution[3] sets out the following patient's rights concerning complaints and redress:

> You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.
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> You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.
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> You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.
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> You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.
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> You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.
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> You have the right to compensation where you have been harmed by negligent treatment.

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[1] Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
[2] NHS Choices website www.nhs.uk (accessed 10 October 2013)
[3] Department of Health (26 March 2013) The NHS Constitution: the NHS belongs to us all

The NHS also commits:

- To ensure that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely affect your future treatment (pledge);
- To ensure that when mistakes happen or if you are harmed while receiving care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again (pledge);
- To ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services (pledge).

Support in making a complaint can be sought through:

Patient Advice and Liaison Service (PALS) – Most Trusts provide a PALS. They offer confidential advice, support and information on health-related matters to patients, their families and their carers and can provide information and discuss options about how complaints can be resolved. There is some evidence to suggest that where PALS is combined with complaints management there is potential for a conflict of interest and the Clwyd/ Hart Review on NHS Complaints recommends that these roles are separate[4].

NHS Complaints Independent Advocacy Service – from 1 April 2013 local authorities have had a statutory duty to commission independent advocacy services to provide support for people making, or thinking of making, a complaint about their NHS care or treatment. In Nottingham City and Nottinghamshire this service is provided by POhWER. The service is free.

If an individual is dissatisfied with the response to their complaint they can contact the Parliamentary and Health Service Ombudsman (PHSO). The Ombudsman carries out independent investigations into complaints about the NHS when the local resolution has not produced a satisfactory outcome. In 2012-13 the PHSO took a close look at 3770 cases, 377 of which required formal investigation[5].

Figures from the Health and Social Care Information Centre show that over 162,000 complaints about NHS care were made in 2012/13[6].

Parliamentary and Health Service Ombudsman Principles of Good Complaints Handling

First published in 2008, the PHSO sets out principles of good complaints handling[7]:

[4] See (October 2013) A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture
[5] Cited on PHSO website www.ombudsman.org.uk (accessed 31 October 2013)
[6] Cited in (October 2013) A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture
[7] PHSO (November 2008) Principles of Good Complaints Handling

1. Getting it right
    - Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
    - Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
    - Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
    - Including complaint management as an integral part of service design.
    - Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
    - Focusing on the outcomes for the complainant and the public body.
    - Signposting to the next stage of the complaints procedure, in the right way and at the right time.
2. Being customer focused
    - Having clear and simple procedures.
    - Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
    - Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
    - Listening to complainants to understand the complaint and the outcome they are seeking.
    - Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.
3. Being open and accountable
    - Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
    - Publishing service standards for handling complaints.
    - Providing honest, evidence-based explanations and giving reasons for decisions.
    - Keeping full and accurate records.
4. Acting fairly and proportionately
    - Treating the complainant impartially, and without unlawful discrimination or prejudice.
    - Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
    - Ensuring that decisions are proportionate, appropriate and fair.
    - Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
    - Acting fairly towards staff complained about as well as towards complainants.
5. Putting things right
    - Acknowledging mistakes and apologising where appropriate.
    - Providing prompt, appropriate and proportionate remedies.
    - Considering all the relevant factors of the case when offering remedies.
    - Taking account of any injustice or hardship that results from pursing the complaint as well as from the original dispute.
6. Seeking continuous improvement
    - Using all feedback and the lessons learnt from complaints to improve service design and delivery.
    - Having systems in place to record, analyse and report on the learning from complaints.
    - Regularly reviewing the lessons to be learnt from complaints.
    - Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.

The Francis Report into Mid Staffordshire NHS Foundation Trust

The inquiries into failures in care at Mid-Staffordshire NHS Foundation Trust found that ineffective action in response to patient complaints was a contributing factor, and commented that failures of a complaints system to acknowledge or rectify shortcomings contributes to an erosion in public confidence in the NHS. The Report published in February 2013[8] stated that

> "A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment… A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service."

The Report made 14 recommendations relating to the handling of complaints. Key themes of the recommendations were:

- Reluctance of patients and those close to them to complain
- Feedback, learning and warning signs available from complaints not given high enough priority
- Information about complaints should be made available to, and used by commissioners and local scrutiny bodies
- There is a case for independent investigation of a wider range of complaints.

In its response in November 2013[9], the Government said that key changes it wanted to see included:

- Trust Chief Executives and Boards should promote a culture of openness and encourage feedback and welcome complaints.
- Every Trust making clear to patients from their first encounter with the hospital:
    - How they can complain
    - Who they can turn to for independent local support
    - That they retain the right to complain to the Ombudsman if they remain dissatisfied and how to contact them
    - Details of how to contact Local Healthwatch.
- Trust Chief Executives and Boards taking personal responsibility for complaints handling.
- Chief Executives ensuring there is greater clinical involvement in handling complaints.
- Directors with responsibility for patient safety being required to give an update on complaints at each Board meeting.
- Boards to see regular data about complaints which means the 'narrative and not just the numbers', so they can identify themes and reoccurring problems, and take action.
- Detailed information on complaints and the lessons learnt to be published quarterly.
- Government to work with NHS England and key partners to introduce a regular and standard way of surveying people who have made a complaint to find out whether

[8] (February 2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
[9] Department of Health (November 2013) Hard Truths: The Journey to Putting Patients First

they were satisfied with the way it was handled and to enable comparison across hospitals.
- Review the patient and advice liaison services service.
- Local Healthwatch scrutinising complaints data across Trusts in an area to spot themes and reoccurring issues.
- Complaints to be a key part of the new Chief Inspector of Hospitals' inspections.
- Work to clarify that threat of future litigation should not delay the handling of a complaint.
- Development of a patient-led vision and expectations for complaints handling in the NHS.

Patients Association Good Practice Standards for NHS Complaints Handling

The Patients Association has published standards for complaints handling[10]. A recommendation of the Francis Report is that Trusts should consider the standards of the Patients Association.

Standard 1: The complainant has a single point of contact in the organisation and is placed at the centre of the process. The nature of their complaint and the outcome they are seeking is established at the outset.

Standard 2: The complaint undergoes initial assessment and any necessary immediate action is taken. A lead investigator is identified.

Standard 3: Investigations are thorough, where appropriate obtain independent evidence and opinion and are carried out in accordance with local procedures, national guidance and legal frameworks.

Standards 4: The investigator reviews, organises and evaluates the investigative findings.

Standard 5: The judgement reached by the decision maker is transparent, reasonable and based on the evidence available.

Standard 6: The complaint documentation is accurate and complete. The investigation is formally recorded, the level of detail appropriate to the nature and seriousness of the complaint.

Standard 7: Both the complainant and those complained about are responded to adequately.

Standard 8: The investigation of the complaint is complete, impartial and fair.

Standard 9: The organisation records, analyses and reports complaints information throughout the organisation and to external audiences.

Standard 10: Learning lessons from complaints occurs throughout the organisation.

Standard 11: Governance arrangements regarding complaints handling are robust.

Standard 12: Individuals assigned to play a part in a complaint investigation have the necessary competencies.

[10] Patients Association (July 2013) Good Practice Standards for NHS Complaints Handling – A Summary

Clwyd/ Hart Review of NHS Hospitals Complaints System

In response to the Francis Report the Government announced a review into the handling of concerns and complaints, including consideration of the Francis Report recommendations. The Review was led by Ann Clwyd MP and Tricia Hart, Chief Executive of South Tees Hospitals NHS Foundation Trust and published its report[11] in October 2013. The review focused on acute hospitals but states that many of the reflections and comments are as relevant to other health and care settings.

Based on its findings about what it feels like to complain the Report sets out 'what patients want'…

> "Patients want a complaints system that is easy to understand and to use; that is easily accessible and does not require any particular expertise to navigate; and that takes account of the difficulties many people face in expressing themselves or giving evidence, particularly at times of stress, ill health or bereavement."
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> "People who wanted to complain – particularly those worried about the quality of care being provided for a friend or relative – need a guarantee that the complaint will never lead to poorer care or treatment for the patient. Complaining should be penalty free. Patients want staff to be professional and non-judgemental about the way in which they deal with complaints. They do not want to be blamed if they complain but rather, for staff to see complaints as an opportunity to improve the care given to others in the future."
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> "Patients want the complaints system to acknowledge the emotional trauma from poor care, illness and bereavement. The way complaints are handled should be sympathetic and sensitive and not seek to reduce, deny or marginalise people's feelings. Patients want to be included in the process and be clear about how a complaint will be investigated. They want their feelings respected and not feel left on the side lines."
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> "Patients want a complaints system that is flexible and proportionate to the cause of the complaint and provides appropriate remedy. A 'light touch' approach may be more satisfactory than a full, formal investigation in some cases, and as far as possible, the hospital should try and resolve issues and concerns without the need to trigger a formal complaint in the first place. Where an issue becomes a complaint the approach to the investigation should match the seriousness of the issues involved."
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> "Most patients want their complaints dealt with promptly and may suffer if the process is drawn out. Others want the system to recognise that people who are recuperating or bereaved may not be able to bring a complaint immediately or respond to questions within set deadlines."
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> "Patients want a complaints system to cover all aspects of a patient's care, even if this crosses boundaries within the NHS or between the NHS and social care. They want to be able to make only one complaint about their whole experience within the system."
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> "Patients would like to see a service that provides advocacy, representation and support to those who need and want it. They want to know there is someone to speak for them if necessary, and help them to make sense of a complicated system."
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> "Patients want to know that their complaints make a difference. The prime desired outcomes are usually the admission of responsibility, an apology, the reassurance that

[11] (October 2013) A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture

lessons will be learned and – where appropriate and individuals are clearly at fault – some form of sanction. This is particularly important if staff have attempted to cover up their failings. Patients want openness and to know that where staff have done something wrong they will not be allowed to remain anonymous."

"Patients want to know that even if the complaint is handled internally, there is scope for an external review or a further level of scrutiny if their complaint fails or stalls. Some did not feel that the Ombudsman provided the level of independence required in the system, either because cases had to pass too high a hurdle to be considered, or because of the low number of cases upheld."

Other evidence provided to the Review suggested:

- Vulnerable people find complaints systems complicated and hard to navigate.
- People need to be more aware of how to access complaints advocacy.
- Chief Executives and Boards should take active responsibility for complaints, including examining the narrative of complaints and not just the numbers and ensuring it gets the right level of attention within the organisation. Chief Executives and Boards also have a crucial role in ensuring there is the right attitude and approach within the organisation.
- The skill and attitude of staff managing complaints is important.
- There is a public reluctance to complain.
- There is a perceived power imbalance in the complaints system and concerns about internal conflicts of interest.
- It is important to have openness and honesty in responding to complaints – links were made to the proposed 'duty of candour'.

The Report makes a large number of recommendations aimed at a variety of stakeholders including Trusts, Department of Health, professional bodies, Care Quality Commission. Recommendations particularly relevant to this piece of scrutiny include:

Recommendation: Trusts should provide patients with a way of feeding back comments and concerns about their care on the ward including simple steps such as putting pen and paper by the bedside and making sure patients know who to speak to if they have a concern – it could be a nurse or a doctor, or a volunteer on the ward to help people.

Recommendation: Attention needs to be given to the development of appropriate professional behaviour in the handling of complaints. This includes honesty and a willingness to listen to the complainant, and to understand and work with the patient to rectify the problem.

Recommendation: Staff need to record complaints and the action that has been taken and check with the patient that it meets with their expectation.

Recommendation: Complaints are sometimes dealt with by junior staff or those with less training. Staff need to be adequately trained, supervised and supported to deal with complaints effectively.

Recommendation: Trusts should actively encourage both positive and negative feedback about their services. Complaints should be seen as essential and helpful information and welcomed as necessary for continuous service improvement.

Recommendation: Every Chief Executive should take personal responsibility for the complaints procedure, including signing off letters responding to complaints, particularly when they relate to serious care failings.

Recommendation: There should be Board-led scrutiny of complaints. All Boards and Chief Executives should receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals.

Recommendation: Every Trust has a legislative duty to offer complainants the option of a conversation at the start of the complaints process. This conversation is to agree on the way in which the complaint is to be handled and the timescales involved.

Recommendation: Where complaints span organisational boundaries, the Trusts involved should adhere to their statutory duty to co-operate so they can handle the complaint effectively.

Recommendation: Hospitals should offer a truly independent investigation where serious incidents have occurred.

Recommendation: When Trusts have a conversation with patients at the start of the complaints process they must ensure the true independence of the clinical and lay advice and advocacy support offered to the complainant.

Recommendation: Patients, patient representatives and local communities and local Healthwatch organisations should be fully involved in the development and monitoring of complaints systems in all hospitals.

Recommendation: Board level scrutiny of complaints should regularly involve lay representatives.

A Government response to the report and recommendations is expected in due course.

Research on Barriers and Enablers to Making Complaints

A research report commissioned by the Care Quality Commission in 2013[12] found that instances of people making a complaint are low – among respondents who had experienced health and social care service in the past year, 8% voiced a concern to a member of staff about the standard of care and 4% made an official complaint. Conversely 29% of people had provided positive feedback about their time spent receiving care. The PHSO cites research in its submission to the Clwyd/ Hart Review[13] that found 18% of patients want to complain and 54% of these do not. The PHSO says that this is a higher proportion than for public services generally and that the reasons for not complaining include:

- People don't know where or how to complain and fear they won't be listened to or taken seriously
- Some people fear that they will get a worse service if they complain

[12] ICM (2013) Fear of Raising Concerns about Care: a research report for the Care Quality Commission
[13] PHSO (June 2013) Submission by the Health Service Ombudsman for England to the Review of the NHS Complaints System

- Patients may lack an advocate or need special support – 1 in 4 of those in hospital is cognitively impaired.

The CQC research supported this, identifying that the main barrier to making a complaint was not wanting to be seen as a trouble maker (26% of respondents) and a quarter of respondents said that the main factor preventing them from making a complaint was that it would not make a difference and nothing would improve as a result. 11% of respondents said that they would not complain because they would be worried that their care would get worse as a result.

The CQC research found that greater information was the strongest enabler to speaking out, with 76% of respondents saying that knowledge of the standard of care they had a right to receive would encourage them to speak out about poor care. Another strong enabler identified was an open and enabling culture – 75% sad that being told by the provider that they want patients to raise concerns would encourage them to do so. Other key enablers were the provider regularly giving information on the actions they have taken in response to concerns; anonymity in the complaints process; and having an advocate or third party.

Respondents to the CQC research who had made a complaint tended to be negative about the way it was handled:

- 57% said they did not receive a satisfactory response
- 55% said that their concern was not welcome
- 34% said that they were not treated with respect while their concern was being handled.

The PHSO research concluded that there can be a defensiveness on the part of the hospitals and their staff to hear and address concerns and this can lead to poor complaints handling. It says that reasons for defensiveness by staff include:

- Do not have the authority or resources to resolve complaints
- They are on their own when dealing with a complaint
- Fear of disciplinary action/ blame (especially junior staff) if they acknowledge validity of complaint
- Clinicians feel professional pride; see themselves as expert and this is being challenged
- Staff can feel that it would be disloyal to their team or to the organisation to listen and address a patient's concerns
- Complaint handlers don't feel they have the clout to get changes made
- A fear of failure and consequences
- Frightened by patient/ carer/ family behaviour/ threats/ accusations
- They do not understand the complaints process
- They don't know how to support the patient if they have special needs