

A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture



Final report

Right Honourable Ann Clwyd MP and Professor Tricia Hart

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This report is dedicated to the memory of Owen Dryhurst Roberts

Chapter One:

Introduction

The successes and failures of the National Health Service (NHS) have been debated vigorously in Parliament and elsewhere since its foundation. Aneurin Bevan, the Minister of Health who founded the NHS in 1948, was aware of the need for ways of correcting mistakes. He said, *'The sound of a dropped bedpan in the hospital at Tredegar (in his Ebbw Vale constituency) would reverberate around the Palace of Westminster'*. In today's language it could be translated as a call for transparency; for learning lessons from mistakes; and for continuous improvements in quality.

Sixty five years later the NHS still enjoys wide support as an institution, one of whose basic principles is to treat all patients with compassion and commitment. The rights and responsibilities of NHS staff and patients are listed in the NHS Constitution¹, but unfortunately these are not always evident in practice. Public confidence has been eroded by evidence of poor care and treatment and subsequent failures of the complaints system to acknowledge or rectify shortcomings. Such incidents have had serious and even devastating consequences for patients, their relatives, carers, and friends.

One of the most shocking failures in NHS care was documented on 6th February 2013 when Robert Francis QC published his Public Inquiry into Mid Staffordshire NHS Foundation Trust. He found *"a story of appalling and unnecessary suffering of hundreds of people"* and added: *"They were failed by a system which ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety."*²

He wrote: *"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."*³

"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."

¹ [NHS Constitution](#)

² [Francis Press Statement](#)

³ Public Inquiry into the Mid Staffordshire NHS Foundation Trust, Volume 1, Chapter 3 pp 245-287 [Mid Staffordshire Inquiry Report](#)

It was Robert Francis' report that prompted the Prime Minister and the Secretary of State for Health to commission this review of NHS hospital complaints handling. What follows is a report of the findings and recommendations of the review.

The co-Chairs

This review was co-chaired by the Rt. Hon Ann Clwyd MP for the Cynon Valley and Professor Tricia Hart, Chief Executive, South Tees Hospitals NHS Foundation Trust.

In a radio interview on BBC Radio 4's World at One in December 2012, Ann Clwyd described the way in which her husband, Owen Roberts, had died in the University Hospital of Wales. Ann Clwyd spoke of the "coldness, resentment, indifference and contempt" of some of the nurses who were supposed to be caring for him. She broke down in tears as she recalled his last hours, shivering under flimsy sheets, with an ill-fitting oxygen mask cutting into his face, wedged up against the bars of the hospital bed. She said her husband, a former head of News and Current Affairs for BBC Wales, died "like a battery hen."⁴

Following this programme and others she received letters and emails from hundreds of people who were appalled at such a lapse in standards of basic decency and compassion. Many included accounts of other shocking examples of poor care and of the difficulty people encountered when trying to complain.

Ann Clwyd has long experience as an MP. She was a member of the Royal Commission on the NHS from 1977-1979 during which she became known as, 'The patient's friend'. She was a member of the Welsh Hospital Board from 1970-1974. She also campaigned for many years for justice for pneumoconiosis sufferers.

Co-chair, Professor Tricia Hart has experience of 39 years as a nurse, midwife, community nurse, health visitor and senior executive member of NHS Trust boards. She also has experience as a member of Robert Francis' inquiry team. She spent 18 months as nurse adviser to the first Francis inquiry into the Mid-Staffordshire Trust, which reported in February 2010. She was then asked her to perform a similar role on the full public inquiry.

All the members of the External Review Team are listed at the back of the report.

Terms of reference

This Review was instigated by the Prime Minister to consider the handling of concerns and complaints in NHS hospital care in England and, in doing so:

- consider how to align more closely the handling of concerns and complaints about patient care;
- identify where good practice exists, and how good practice for delivering to those standards is shared and what helps or hinders its adoption;

⁴ [BBC News Wales](#)

- consider what standards might best be applied to the handling of complaints;
- consider how intelligence from concerns and complaints can be used to improve service delivery, and how this information might best be made more widely available to service users and commissioners;
- consider the role of the Trust Board and senior managers in developing a culture that takes the concerns of individuals seriously and acts on them;
- identify the skills and behaviours that staff, including clinical staff, need to ensure that the concerns of individuals are at the heart of their work;
- consider how complainants might more appropriately be supported during the complaints process through, for example, advice, mediation and advocacy; and
- include the handling of concerns raised by staff, including the support of whistle-blowers.

The co-Chairs were encouraged to make recommendations about:

- any aspect of the NHS complaints arrangements and other means by which patients make concerns known;
- the way that organisations receive and act on concerns and complaints;
- how Boards and managers carry out their functions; and
- the process by which individual organisations are held to account for the way that they handle concerns and complaints.”

The co-chairs focused on acute hospitals, although they have taken evidence from and about other care providers. Many of the reflections and comments that follow could be as relevant to primary care, community services and social care as they are for acute hospitals.

Evidence collection

A dedicated postal and email address enabled people to send accounts of their experiences with the complaints system and make suggestions for improvements.

Letters from patients, relatives, friends and carers received before the start of the review were also included in the evidence.

In all over 2500 letters and emails were received. The Department of Health Review Team took responsibility for the analysis of this data.

Seven public engagement events were held in which oral evidence was taken from patients, relatives, friends and carers. These allowed the Review Team to understand how the complaints process is perceived and why people may be discouraged from complaining.

Eight individual meetings were held with people the co-chairs considered to have particular expertise with the complaints process. The names of these participants are listed at the back of the report.

Helped by advisers with experience of patient representation, the review team visited nine NHS hospitals and one hospice, meeting complaints managers, frontline staff and board members.

Meetings were held with 20 leading organisations in the health and social care sector. These organisations are listed at the end of the report.

Discussions were held with leaders of key organisations in the sector to secure pledges of support for the recommendations of the Review. These organisations are listed at the end of the report.

In all the meetings, notes and minutes were analysed by the Department of Health Review Team and discussed by the team.

Chapter Two:

Setting the scene

Annual figures from the Health and Social Care Information Centre show that there were over 162,000 complaints about NHS care in 2012/13. This amounts to 3000 per week. Over a number of years, there have been many official reports which explored what was wrong with the complaints system and made recommendations for change. Unfortunately many of these recommendations have not been fully implemented.

Previous inquiries

Dame Janet Smith reviewed complaints procedures in the Fifth Report of the Shipman Inquiry, published in 2004.⁵ She took account of a series of previous investigations and reports including: the Wilson Report 'Being Heard' in May 1994; the Public Law Project's report 'Cause for Complaint?' in September 1999; and the York Health Economics Consortium's report (the York Report) in March 2001. Dame Janet's review identified:

- A lack of fair procedures;
- Failure to investigate complaints properly;
- Failure to give adequate explanations;
- Failure to take account of the inherent imbalance of power between healthcare professionals and patients, including the patient's fear of retribution;
- Lack of impartiality in organisations investigating their own conduct;
- Absence of accountability to an external body;
- Complaints handlers lack of necessary skills;
- High levels of dissatisfaction among complainants with all levels of the system.⁶

The Government made similar points in April 2003, when it published NHS Complaints Reform: Making Things Right.⁷ The report recorded that patients and staff feel that:

- It is unclear how, and difficult to raise complaints and concerns;
- There is often a delay in responding to complaints and concerns;

⁵ [Dame Janet's Report – section on complaints](#)

⁶ This summary of Dame Janet's concerns was given by Robert Francis in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 1, para 3.6 [Reference to Dame Janet's Report – see page 246](#)

⁷ [NHS Complaints Reform: Making Things Right See para 2.8](#)

- Too often complainants receive a negative response
- Complainants do not seem to get a fair hearing;
- Patients do not get the support they need when they want to complain;
- The Independent Review stage does not have the credibility it needs;
- The process does not provide the redress patients want;
- There does not seem to be any effective way of learning from complaints in order to bring about improvements.

The Health Select Committee

In July 2011, the Health Select Committee published its report on Complaints and Litigation. On complaints, the Committee:

- Supported the current two tier system but noted that it had not been fully implemented across the NHS;
- Noted the importance of PALS for many complainants;
- Recommended that there should be a single local point of access for the entire local resolution of a complaint and that this could be provided by integrated complaints and advice teams;
- Expressed its concerns about the visibility of advocacy services to complainants and recommended more work to improve patient awareness and access; and
- Recommended that a single one organisation should be responsible for maintaining an overview of complaints handling in the NHS, setting and monitoring standards, supporting change, and analysis of complaints data.

The Government rejected the last recommendation but accepted many of the Select Committee's findings.

The Francis report

Despite the implementation of the two tier complaints system, Robert Francis did not feel that it was fit for purpose. He made 14 recommendations on the handling of complaints in his report on Mid Staffordshire. He said the key themes were:

- The reluctance of patients and those close to them to complain, in part because of fear of the consequences. This, and other barriers which prevent organisations receiving complaints need to be addressed;
- Support for complainants, whether or not they are specifically vulnerable, with advice and advocacy still requires development; in particular, it should be clear that advocates can offer advice on the substance of the complaint that is required, and information should be provided on available support organisations;

- The feedback, learning and warning signals available from complaints have not been given a high enough priority;
- Information about the content of complaints should, where permissible, be made available to and used by commissioners and local scrutiny bodies; the Care Quality Commission (CQC) should use material from complaints more widely; and
- There is a case for independent investigation of a wider range of complaints.

Other Reviews

Robert Francis endorsed the Patients' Association's standards for good complaints handling. These standards were developed as part of the Health Foundation funded 'Speaking Up' project. They were aimed at improving the quality of complaints handling at Mid Staffordshire NHS Foundation Trust and elsewhere. These standards were refined over a two year period by a group including clinicians, lay people and complaint managers.

The Ombudsman has also set out principles which are intended to promote a shared understanding of what is meant by good complaint handling, and to help public bodies in the Parliamentary and Health Service Ombudsman's jurisdiction deliver first-class complaint handling to all their customers.

We welcome these principles.

A series of other reviews on aspects of NHS care and treatment followed the Francis report and are relevant to this Review. They include:

- Professor Sir Bruce Keogh's, review on the quality of care and treatment provided by 14 NHS hospital Trusts with persistently high mortality rates. The Keogh Review reported on 16th July 2013.⁸
- Professor Don Berwick's review of patient safety in the NHS. Professor Berwick reported on 6th August 2013.⁹
- Camilla Cavendish's review of how the training and support of healthcare and care assistants could be improved so that patients receive compassionate care in both NHS and social settings. Camilla Cavendish published her report on 10th July 2013.¹⁰
- The review of how the Liverpool Care Pathway was being used in practice for people at the end of their lives. The Review, chaired by the crossbench peer Baroness Julia Neuberger, reported on 15th July 2013.¹¹

When someone has a concern the first step should be to discuss the matter with the practitioners concerned, such as doctors, allied health professionals, nurses, or paramedics. At this level problems can be resolved quickly and immediate appropriate action can help avoid

⁸ [Professor Sir Bruce Keogh Report](#)

⁹ [Professor Don Berwick Report](#)

¹⁰ [Camilla Cavendish Report](#)

¹¹ [Liverpool Care Pathway Report](#)

an issue escalating into a more serious problem. Reported concerns or complaints need to be noted in writing by the staff concerned along with any action taken and the outcome.

*'Customer service complaints often can and should be resolved immediately by the person receiving the complaint apologising and rectifying the issue, be they a clinician, a PALS officer or any other employee of the NHS. Due to the nature of these types of complaints, admitting there was a problem, dealing with it and apologising will save time and resources that can be diverted to prompt and effective investigation and resolution of more serious and complex cases.'*¹²

If it is felt that the concern has not been resolved or if a patient feels unable to discuss the problem with the practitioners, there are two options. Either the complaint can be raised, verbally or in writing, with the Hospital Trust or it can be made to the body responsible for purchasing the hospital's services on behalf of the public, the local Clinical Commissioning Group (CCG). The CCG may refer to problem to the Hospital Trust or deal with it themselves in according to regulations.

Complaints made to Hospital Trusts may come through a variety of routes, for example, directly to the Chief Executive, through to a clinical colleague or made through the Complaints' Manager. An investigation then takes place, usually by the Trust itself, although some Trusts use external investigators. This process is described as "local resolution".

The complaint should be acknowledged within three working days, and the hospital trust should offer to discuss with the person making the complaint the manner in which the complaint is to be handled, the period within which the complaint is likely to be investigated and when the response is likely to be sent. Even if the complainant declines a discussion, they should be notified of the timescales above.

The person making the complaint should be kept informed of progress and told the outcome of the investigation into the complaint, including an explanation of the conclusions and confirmation of any action taken or proposed as a result of the complaint.

Many complaints are successfully resolved at this level, by this "local resolution" process.

If the complainant is unhappy with the outcome of their complaint at a local level, their next step is to refer the matter to the Health Service Ombudsman. The Ombudsman is independent of the NHS and government, accountable directly to Parliament.

In 2011-12, the Ombudsman received **16,333** complaints. Of these, the Ombudsman took a closer look at **4,399** complaints and agreed to investigate **400** cases.

Assistance for Complainants

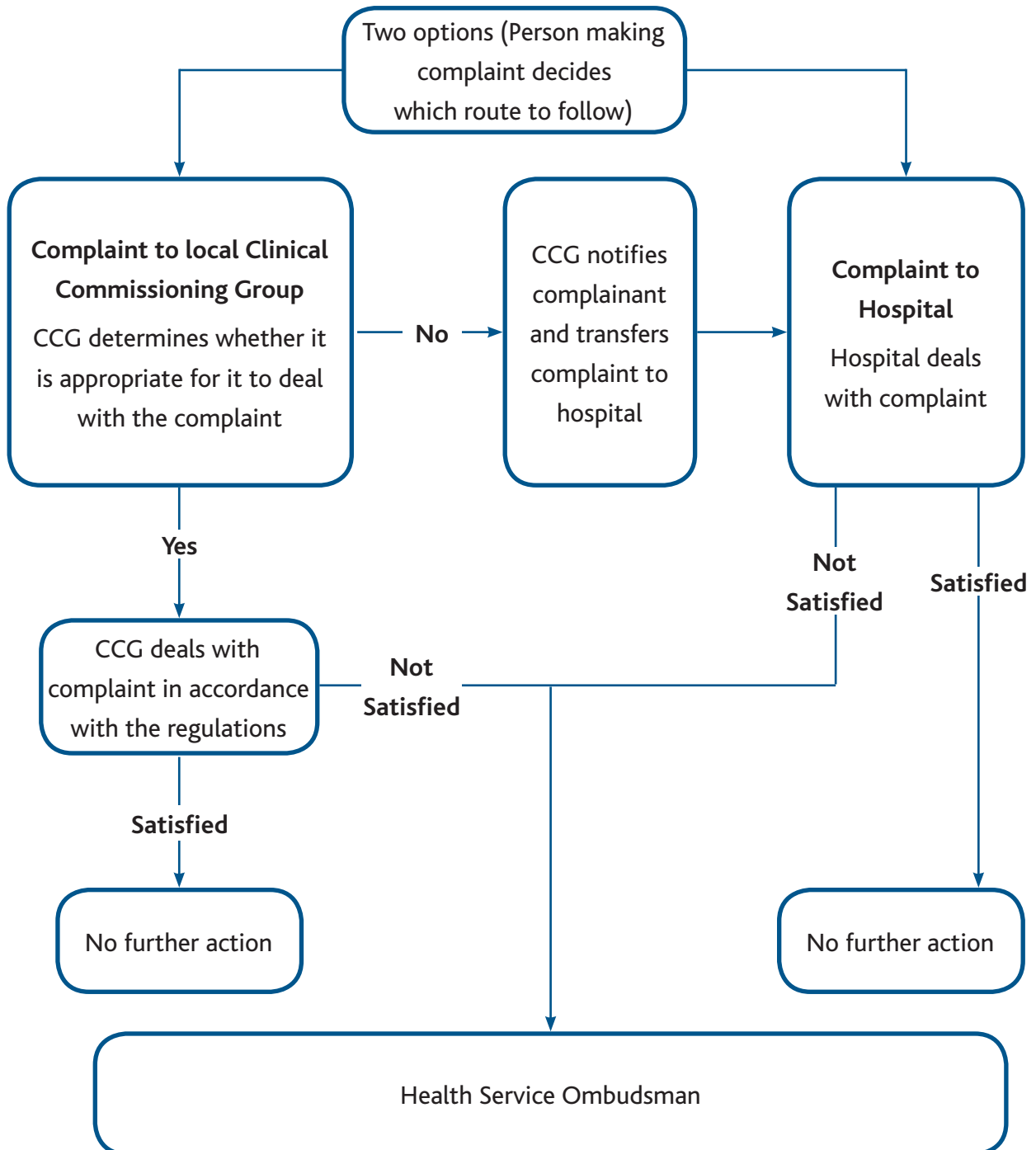
Most hospitals currently provide a Patient Advice and Liaison Service (PALS), which provide general help, support and information to patients. Since some hospitals combine this function with that of complaints management there is clearly a potential conflict of interest. Many respondents to our review said that they found this situation confusing and perceived a

¹² [Select Committee Report on Complaints and Litigation](#)

The Complaints Process

Comments/Concerns may be raised informally with front line staff or PALS

Patient (or relative/representative) makes a complaint (orally, electronically or in writing)



conflict of interest, where the people responsible, for supporting and advising them, were employed by the very organisation against which they were making their complaint.

Independent assistance can also be provided by the Independent Advocacy Services. This service operates outside the NHS, and supports people making a complaint, or thinking of making a complaint, about their NHS care or treatment.

The way in which NHS complaints advocacy services are commissioned was changed from 1 April 2013¹³. These services are now arranged directly by each English local authority, which determines how this advocacy is to be delivered in their areas. Each local authority is obliged to commission a provider of advocacy services for their area.

¹³ [Health and Social Care Act 2012](#)

Chapter Three:

Why people complain

More than 2500 testimonials were received from patients, their relatives, friends or carers. The majority describe problems with the quality of treatment or care in NHS hospitals.

Key points raised:

- **Lack of information – patients said they felt uninformed about their care and treatment.**
- **Compassion – patients said they felt they had not been treated with the compassion they deserve.**
- **Dignity and care – patients said they felt neglected and not listened to.**
- **Staff attitudes – patients said they felt no one was in charge on the ward and the staff were too busy to care for them.**
- **Resources – patients said there was a lack of basic supplies like extra blankets and pillows.**

1. Lack of information

Lack of information was one of the main reasons for dissatisfaction. Patients, their family, carers and friends often felt inadequately informed about the patient's condition, prognosis and expected treatment. Doctors were seen infrequently and nurses were evasive about matters they considered the province of the doctor.

'The process is too complicated, there is a lack of information, it's designed to put people off.' (Patient comment at meeting)

Patients did not know who to ask for information, and often only saw the same member of staff once or twice. There was insufficient communication between staff, so that questions or concerns were not passed on and dealt with, and patients had to repeat the same things several times. Members of staff to whom they did speak were often ill informed about their situation. There were instances where staff did not consult medical notes and others when medical notes were inadequate or missing.

We formed the impression that this sense of confusion caused by lack of information made people fear that they or their relative had not received the right care. As a result, they were more likely to question the treatment or make a formal complaint.

2. Compassion

Many of the people who contacted the Review felt they had not been treated with the level of respect, compassion and sympathy that they expected or deserved. Terms used about staff attitudes and behaviour included “offhand”, “rude”, “impatient” and “callous.” The choice of such words was the consequence of patients feeling they were a problem or a burden, rather than being cared for.

“Care was slapdash, treatment was not given; communication was non-existent.” (Friend of patient who died)

People frequently reported that they had witnessed a lack of compassion from staff towards patients.

“At some of the most important events of the day, meal times, when it should be all hands on deck, the staff are nowhere to be seen. What on earth can they be doing that takes precedence?” (Former nurse)

“The attitude of the consultant varied between pompous, arrogant and condescending. This was a man with a trail of young doctors in tow, moulding them (as I later found) in the same uncaring way.” (Daughter of patient)

3. Dignity and care

We read many accounts of patients not being treated with dignity or respect.

This included neglect of basic comfort, problems with the quality and choice of food and lack of help at meal times. Other problems described to us included: patients not being listened to or being left alone for too long; lack of privacy; lack of respect in the way they are spoken to or handled and lack of compassion.

‘The main complaint from patients of all ages is of poor basic nursing care. No bathing, toileting, ensuring patients are hydrated and nourished, and little sympathy and empathy.’ (Patient)

First time in hospital, mother had two broken wrists. No one would feed her when meals were delivered, despite the fact that she had two arms strapped up in the air! My aunt had to travel over two hours every day just to ensure that she was fed.’ (Son of patient)

We did not form the impression that patients were generally making unreasonable demands or exaggerating minor inconveniences. People were, by and large, describing significant lapses in the standards of care they were entitled to and that hospital managers, clinicians and carers should feel proud to provide.

Many people said that staff frequently did not (or could not) make time to speak to patients in a friendly or concerned way. This was not what they expected from staff providing their care. As a result, minor needs or concerns that could have been resolved promptly or courteously, might be neglected until they turned into major problems or formal complaints.

A common theme was that those who could not speak up for themselves were most likely to suffer from a lack of dignity and care. However, there were also examples of articulate and assertive patients being neglected or treated badly.

"I have long thought those patients in hospital, particularly people without known relatives and friends, the elderly and the confused, need someone to represent their interests – a Champion." (Patient)

There was a particularly powerful concern expressed by the families and friends of patients. They said they could provide care and speak up for a patient when they were on the ward – such as helping a patient to the toilet or demanding more information from a doctor – but, when they went home, the patient was left alone and vulnerable.

Several respondents linked the problem of neglect and advocacy to nurses not having the time, or perhaps the inclination, to perform their role of listening to patients and ensuring their needs were met.

"The nurse is supposed to be the patient's advocate, doing all for the patient that he would do for himself if he were able." (Former nurse)

4. Staff attitudes

Some people shared their positive experiences of treatment and care. However, a significant number (including many former nurses) believed that the quality of nursing care is in decline, because of changes in the role of nurses and in their training and professional ethos. The observations or criticisms included: a belief that nurses are not as disciplined as in the past; are not properly supervised; are not sufficiently compassionate; are too focused on the 'technical' side of nursing; lack a sense of responsibility towards their patients; and are seen not to be prepared to do everything necessary to ensure the right level of care, whatever the lack of resources or competing demands on their time.

One specific perception relating to care was a sense that no-one was 'in charge', particularly on wards, and that as a result, there was no-one to talk to, or raise concerns with, and problems were left to fester.

'I went to the nursing station on one occasion to see the entire team bidding at the end of an eBay auction. I was kept waiting, ignored, until it was ended.' (Relative of patient)

'When visiting my wife... after an operation to mend her broken hip, I asked a nurse for help as she was being very, very sick. She announced, 'I am a graduate. I don't do sick' and left me to deal with the situation.' (Husband of patient)

'If you can't understand that a patient needs a drink, is cold, or needs to go to the toilet, then you shouldn't be in nursing.' (Patient comment at meeting)

Although many of the comments that we received were about nurses, we believe that the issues apply to all professionals, both clinical and non-clinical. Patients, their carers and relatives reflected on nurses because they are the most visible profession in hospitals.

5. Resources

Many people raised concerns over lack of equipment and even of basic supplies, such as incontinence pads, extra blankets or pillows. This echoes concerns noted in the Francis report. However, the main concern about resources concerned the availability of staff. The Review heard that there were not enough staff, or they had too much else to do that took them away from patient care, or that staff were not sufficiently trained or experienced, or that they were under too much pressure.

'The most common term that I heard from nurses in particular was that, 'I am too busy, I will do it later', and later never came.' (Daughter who complained on behalf of her mother)

Chapter Four:

What it feels like to complain

Around 400 people who contacted the Review talked in detail about their experience of complaining, how it felt in practice, and what they went through.

This Chapter explores the themes that emerged and what patients, relatives, friends and carers want to see improved.

Key points raised:

- **Information and accessibility** – patients want clear and simple information about how to complain and the process should be easy to navigate.
- **Freedom from fear** – patients do not want to feel that if they complain their care will be worse in future.
- **Sensitivity** – patients want their complaint dealt with sensitively.
- **Responsiveness** – patients want a response that is properly tailored to the issue they are complaining about.
- **Prompt and clear process** – patients want their complaint handled as quickly as possible.
- **Seamless service** – patients do not want to have to complain to multiple organisations in order to get answers.
- **Support** – patients want someone on their side to help them through the process of complaining.
- **Effectiveness** – patients want their complaints to make a difference to help prevent others suffering in the future.
- **Independence** – patients want to know the complaints process is independent, particularly when they are complaining about a serious failing in care.

1. Information and accessibility

Some people told us that they were unaware how to raise concerns or make complaints, either for themselves or on behalf of friends or relatives. It was clear that many had wanted to complain but did not. They did not know what to expect if they did complain, what would happen, or what rights they might have if they were unhappy with the process.

The lack of information about deadlines contributed to dissatisfaction with the operation of the complaints system. For example, some people had inaccurate information about the process and wrongly believed that they had missed a deadline.

'I had not complained before, as I was well aware that complaints have to be made within six weeks of being in hospital.' (Comment from a patient)

People also said they were frustrated by the way in which their ability to complain successfully was hampered because they had not known what information to record, for example, the names of clinical staff.

Patients, and in particular their relatives, friends and carers, said that when they were in the midst of a traumatic event making a complaint was the last thing on their mind.

"At the time I was too exhausted and traumatised by the experience to do anything about it." (Daughter of father who died)

"I followed all the correct procedures but found the experience very difficult despite my understanding of how the NHS works." (Retired nurse)

'[I] found a confused system where the NHS was judge and jury and where the strategic intent seemed to be to destroy the complaint.' (Family member)

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 in bereavement.

2. Freedom from fear

People expressed their fear that their, or their relative's, care might get worse if they were to complain. They also felt intimidated by the power of professionals or institutions; the complexity of the system and the feeling that nothing will happen – that all their effort will prove to be worth nothing. There is also a strong sense that people who are less able (or feel less able) do not complain.

Some people were left with an overwhelming sense of guilt that they had not complained, feeling that had they done so they might have protected a loved one. This had sometimes haunted people for years afterwards.

"I was frightened to complain and be left with no medical care." (Former patient)

"I did not complain much because I was afraid that my mother would suffer reprisals." (Daughter of patient)

What patients want: 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-judgmental 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 future.

3. Sensitivity

People recalled how hurt they felt when they were trying to make a complaint because they felt that their feelings were ignored during a time of crisis in their lives. For many, this pain and distress had been life changing.

“Complaints procedure attitude is knee-jerk: deny, defend and delay. We don’t need money to change attitudes. What we need is a compassionate, proactive approach.”
(Patient comment at meeting)

“I personally feel destroyed by the whole episode.” (Father of son who died)

“The complaints process is a defensive operation, not an enquiry. No independent forum. No advocate. No investigation. The complaint harmed me. [I am] unable to grieve for my father.” (Family member)

What patients want: Patients want the complaints system to acknowledge the emotional trauma suffered 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 clear about how a complaint will be investigated. They want their feelings respected and not to feel left on the side lines.

4. Responsiveness

People were often unhappy that their concerns were not addressed on the spot by staff. Had they been resolved then, people would not have had to make a formal complaint. People also complained that insufficient attempts had been made to understand their complaint or to assess how serious it was.

“Complaints departments should make early personal telephone contact with a complainant rather than an impersonal letter, and if necessary arrange an early meeting, to ensure a complaint is fully understood. Many complaints would probably be quickly diffused, and those of substance could be quickly structured.” (Friend of patient who died)

“I just wanted to make sure no one else suffered in the same way again. Sadly I don’t believe anything at all was done... In the end I simply gave up.” (Family member)

What patients want: 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.

5. A prompt and clear process

Delays in processing and resolving complaints were a huge source of frustration. There was often no explanation for the reasons for delay and patients were not kept informed about where their complaint had reached in the system. Explanations that were given – such as staff being on leave – were not adequate. Delays were one of the main causes of dissatisfaction. People felt that only their unremitting efforts would keep a complaint from lapsing; and that, whatever the rhetoric the hospital did not welcome the complaint and would prefer it went away.

“I am becoming more and more distressed that this matter has not been resolved almost seven months later.” (Daughter of father who died)

“I have struggled for six years to find out what happened and who is accountable, even to get a proper apology. It has been awful and I have discovered so many others in exactly the same position. There seems to be a culture of concealment and shoulder shrugging.” (Friend of patient who died)

What patients want: 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.

6. A seamless service

One specific concern people raised was the way the complaints system did not deal adequately with issues that were the responsibility of more than one organisation. These involved cases where the substance of the complaint related to different parts of the health and care system, often requiring answers from more than one department or organisation. The problems of managing care across such boundaries (for example, arranging adequate home care for people discharged from hospital) were a source of dissatisfaction.

“We battled for months to get answers as to how and why K died, and after following all of the official enquiry and complaints procedures, being blocked and stalled at every turn by the two NHS Trusts involved, we were left with no choice but to engage solicitors to help us find out what happened to her.” (Parents of daughter who died)

What patients want: 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.

7. Support

People said they felt isolated or ‘out-gunned’ by a powerful and monolithic organisation. Many patients, and some friends and relatives, were so affected by their time in hospital that

they were unable to pursue complaints effectively. People said they wanted help to find their way through the process, and have someone with expertise on their side. Many had not heard of the NHS Complaints Advocacy Service and some felt that it did not offer all the help they needed.

"I no longer had the strength to carry on complaining to [the Trust]." (Former patient)

"For such serious complaints as questionable deaths, at what is a very distressing time, complainants need help to obtain medical records and to access an independent clinician to help interpret them and trace what happened." (Friend of patient who died)

"People hadn't heard of the advocacy service. This should be better publicised." (Patient comment at meeting)

What patients want: 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.

8. Effectiveness

Many people who complain felt that nothing had been learnt or achieved as a result of their complaint. They were disappointed about this because this had been one of their reasons for complaining in the first place. Many people said that an early acknowledgement of fault and a genuine apology would have satisfied them; but that having suffered through a lengthy and taxing complaints system, they wanted the hospital to acknowledge their responsibility and for staff to face appropriate sanctions where necessary.

"I don't and never have wanted compensation, but I do want the fact they let me sister die unnecessarily and the appalling treatment acknowledged." (Sister of relative who died)

"We want a sincere and heartfelt 'sorry' not just a grudging apology forced upon the person." (Wife of patient)

"All I want is answers as to why my husband died, answers to the poor care he received or should I say lack of care." (Wife of patient who died)

"I just wanted to make sure this didn't happen to somebody else." (Patient at meeting)"

What patients want: 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 lessons will be learned and – where appropriate and where 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.

9. Greater independence when there are serious care failings

People said they were disturbed that the NHS is “marking its own homework” and feel scared or upset if they think their complaint has gone directly to the person they are complaining about. Some people said there should be an independent complaints authority, not run by the NHS. Others thought that an independent body would be better able to deal with complaints that crossed over several departments or providers. Some were unhappy with their experience of the Ombudsman.

“The system is biased in favour of the hospital.” (Wife of patient)

“My own thought on what is required is a new agency mirroring the Independent Police Complaints Commission. To ask the hospitals to “police” their own work is just as unacceptable as with the police.” (Former patient)

“The investigation was inadequate and not independent. The person I complained about conducted the investigation.” (Patient comment at meeting)

“My case was proved when I got medical opinion from abroad after the Ombudsman turned down my case.” (Wife of deceased patient)

What patients want: 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.

Chapter Five:

What organisations told us

During this Review we received submissions from organisations working in, and with, the NHS on complaints handling, and supporting patients, their carers and relatives. We received survey data and other evidence about people's attitudes to complaints, and heard views from many organisations on what needs to change to improve the way the NHS handles complaints.

This chapter summarises some of the key pieces of evidence we received, and the main themes that emerged. This augmented what patients told us and helped us build a more complete picture and inform our recommendations.

Key points raised by organisations:

- **Complexity** – vulnerable people find the complaints system complicated and hard to navigate.
- **Advocacy** – action is needed to make the public more aware of how to access the NHS Complaints Advocacy Service.
- **Leadership and Governance** – Chief Executives and Boards must take active responsibility to learn from complaints and to create a culture that is able to take a positive attitude towards complaints.
- **Skills and attitudes** – there is a need for quality, trained staff to deal with complaints effectively and appropriately.
- **Toxic cocktail** – people are reluctant to complain and staff can be defensive and reluctant to listen to or address concerns.
- **Independence** – there is a perceived power imbalance in the complaints system.
- **NHS reforms** – changes in NHS structures may make it more confusing for patients to know how and where to raise their complaint.
- **Whistle-blowing and Duty of Candour** – few organisations provided evidence on whistleblowing, although there was support from some for a Duty of Candour.
- **Lack of compliance** – organisations do not always deliver their legislative responsibilities on complaints handling.

Complexity

Vulnerable people find the complaints system complicated and hard to navigate. The charity Mencap, for example, referred to the findings of its two reports 'Death by Indifference' (2007 and 2012) on unnecessary deaths of people with learning disabilities. It said:

"Both reports stated that the complaints process was slow, bureaucratic and defensive. This not only means that families, who have often been bereaved in traumatic circumstances, may wait years to reach some form of justice for their loved one, but that crucially the NHS fails to learn the lessons and take the steps to prevent further avoidable deaths and serious incidents."

Mencap added: *"On average, it takes between 18 months and two years to complete the local stage ... It is simply not right that some families have been forced to wait years for an apology or an explanation for the death of their loved one."*

The charity Mind reported *"poor record keeping, with correspondence going astray, complaints not being properly registered, long delays in responding or no response at all."* It wrote: *"People told us that it was hard to find out who to complain to, what help they could get and what their legal rights were ... We were also told that people found complaints forms very inaccessible."*

HealthWatch England, the independent consumer champion for health and social care in England, summed up the experience by saying: *"The complaints system can be off-putting, complex and slow... There is limited confidence that making a complaint will lead to learning and change."*

Advocacy

Several organisations called for action to make the public more aware of how to access the NHS Complaints Advocacy (NHSCA), and were unhappy about the recent reforms of April 2013. Others pointed out that it is now operating under different names, in different areas, with different access points. The loss of a "national brand" was causing confusion among the public.

"Patients should have the right to access advocacy services where they receive treatment in their home county. There need to be common approaches among all local authority commissioners." SEAP Complaints Advocacy provider.

"It is important that NHSCA providers, NHS providers, HealthWatch and others, work together to establish a clear identity and brand for the NHSCA service. This has been made more difficult, but far from impossible by the arrangements for the NHSCA to be provided by a large number of locally commissioned organisations." VoiceAbility – complaints advocacy provider.

"The current model of NHS Complaints Advocacy should be reviewed. Locally NHSCA should be available through a local 'one stop shop' (local Healthwatch) which local people can easily identify, and which will also use complaints information to inform its representation of patients and seek improvements." Action Against Medical Accidents (AvMA).

Leadership and Governance

Many organisations referred to the role of leadership and governing bodies in their evidence. There was a strong view that Chief Executives and Boards must take active responsibility for looking at complaints, which should involve examining the narrative, not just the numbers, and ensuring this gets the right level of attention in the organisation. There was also a view that Chief Executives should take personal responsibility for the complaints' process, including signing off letters responding to complaints.

Chief Executives and Boards have a crucial role in ensuring there is the right attitude and approach in the organisation. This should focus on 'learning', to welcome complaints and concerns. The insights they bring should be used to improve patient care.

"To be successful, the drive for change must be owned and led by those who run the service, with the right balance being struck between external pressures and internal ownership." (NHS Confederation)

"The most effective method of using complaints to improve care is to create and support the expectation that providers and their boards take responsibility for monitoring and learning from complaints." (Monitor)

"Supporting Directors of Nursing to take an active role in complaints management can help ensure that a 'ward to board' approach is adopted across an organisation, and as visible members of senior management they can help to model good practice at the organisational level to frontline staff." (RCN).

"NHS hospital boards [to] receive reports on complaints that include: an analysis which enables boards to consider trends and themes as well as responses to individual complaints; assessments on whether real organisational learning and service improvements have taken place as a result of complaints; feedback on patient experience of complaining in order to plan improvements to hospital complaints procedures; and consistent measures to test the effectiveness of complaints handling overall." The Parliamentary and Health Service Ombudsman (PHSO)

"Hospital boards should see complaints as treasure – and get better at handling them" (Prof. Patterson New Zealand Ombudsman)

Staff skills and attitudes

The complaints process relies on the skill of the staff who run it, and the leaders who oversee it. Several organisations mentioned the importance of having good quality, trained complaints managers. AvMA said complaints managers are far too often junior, not sufficiently trained and need proper accreditation. SEAP believe complaints staff should be senior managers who report to a director.

Several organisations agreed that real transformational change depends on improving the attitude and skill of staff who deal with dissatisfied patients. The General Medical Council acknowledged that doctors need better social skills and pledges to address this in training.

However, the organisations responsible for delivering care made little mention of how and when the NHS should say sorry, which is an issue that people care about as described in Chapter Four.

“An apology for a failure must be accompanied with a service improvement outcome. To quote a client: there’s no point in apologising if you’re not going to do anything about it.” (SEAP)

Toxic cocktail

The PHSO told the Review: *“At its worst there is a toxic cocktail that prevents concerns and complaints being heard and addressed. This is a combination of reluctance on the part of patients, families and carers to express their concerns or complaints and a defensiveness on the part of hospitals and their staff to hear and address concerns. As a result opportunities to learn and improve care are lost.”*

PHSO provided information from research conducted in 2012. It showed 18% of patients wanted to complain, but just over half of them did not actually put in a complaint.¹⁴ 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;
- Patients may lack an advocate or need specialised support – 1 in 4 of those in hospital is cognitively impaired.

This analysis of the public’s reluctance to complain was reinforced by research this year for the Care Quality Commission, which found that one in nine people would be reluctant to speak out about poor care.¹⁵ The main reasons people gave for not speaking up were:

- Not wanting to be thought of as a troublemaker (26%);
- Believing that complaining wouldn’t make a difference (25%);
- Thinking that members of staff were so stretched that complaining wouldn’t help (15%);
- Fearing that their care would get worse if they spoke up (11%).

The CQC said that more than half of those who had voiced a concern about poor health or social care felt that their feedback wasn’t welcomed (55%). A similar proportion felt they hadn’t received a satisfactory response (57%). Just over a third (34%) said they didn’t feel they had been treated with respect while their concern was being looked into.

When people were asked what would persuade them to speak out, the CQC said there was overwhelming support for:

- knowing what standard of care they have a legal right to expect (76%);

¹⁴ [Health Service Ombudsman’s submission to the Complaints Review](#)

¹⁵ [CQC research](#) – Full ICM report at: [April 2013 research report for CQC](#)

- being encouraged by people who are providing the care to speak up (75%);
- expecting the service to routinely know what action was taken in response to feedback (70%).

Research for HealthWatch England, found:

- 48% of people do not have the confidence that formal complaints are actually dealt with (rising to 60% among the 55+ age group);
- 54% of people who had a problem with health or social care in the past three years did nothing to report it;
- 49% of consumers surveyed have no trust in the system.¹⁶

Independence

Organisations representing patients told the Review about a perceived power imbalance in the complaints system. Mencap for instance made a series of points on this theme. It reported:

“When complaints are pursued locally with the hospital or GP practice, it is our experience that it is often impossible to find out what really went wrong ... Among the families that Mencap has supported, very few feel that justice had been achieved through the local complaints procedure. A much-cited complaint is the power inequity inherent in the local complaints procedure.

“After a death (or serious untoward incident), most local complaints are investigated by members of NHS staff working within the same Trust. Occasionally, investigators may be drawn from even the same unit (or specialty). Both pose possible conflict of interests. Very rarely, a Trust will bring in an external expert to adjudicate on a complaint, and pay for this to happen. This again calls into question the investigation’s impartiality.”

Consequences of NHS Reforms

Some organisations noted that changes in NHS structures introduced by the Health and Social Care Act 2012 have had consequences for people making complaints. The NHS Confederation noted:

“We have serious concerns that following the NHS reforms the complaints system has become more difficult to navigate and risks leaving patients confused about who to complain to.”

During a face to face meeting with the Review Team, the NHS Confederation suggested that Clinical Commissioning Groups should play a vital role. They should use their leverage to ensure that providers have good complaints systems in place, but there is currently no systematic way for CCGs to look at complaints.

¹⁶ [Healthwatch England research](#)

Although primary care is not the focus of this Review, complaints about acute care may well come through at primary level. People may complain to a GP about poor arrangements for discharge from hospital or relatives may complain after a death in hospital.

Whistle-blowing and duty of candour

Few organisations made references to whistleblowing in their responses to this Review. Some mentioned the proposed Duty of Candour and the LGA made the following points:

“There is a fundamental need for a more open and honest approach to investigating and responding to complaints. This will require a shift in current culture and behaviour which tends to be defensive or not treat complaints seriously enough.”

“The implementation of a statutory Duty of Candour will greatly assist in bringing about this change if it is robust enough to ensure that every organisation and every staff member in it has to take it seriously and is held to account if they do not.”

Julie Bailey of Cure the NHS comments that;

“We must make it safe for doctors and others to speak out when they speak the truth about wrong doing in their Trust.”

Lack of Compliance with legislative duties

As we carried out our review, we were repeatedly told many organisations are not complying with their existing legislative duties with regard to complaint handling.

As an example, there is a legislative requirement on organisations to make information available to the public as to their arrangements for dealing with complaints, and how further information about those arrangements may be obtained¹⁷. Yet, Mind said:

“People told us that it was hard to find out how to complain, who to complain to, what help they could get and what their legal rights were.”

and in their evidence to us, the NHS Confederation wrote:

“...we are calling for CCGs and NHS England to provide clear information to patients and the public about their complaints process.”

We have also been made aware of instances where organisations have not offered to discuss with the person making a complaint the manner in which the complaint is to be handled¹⁸. There is also a legislative requirement, during the investigation, to keep the person making the complaint informed, as far as reasonably practical, as to progress of the investigation¹⁹.

¹⁷ [The Local Authority Social Services and National Health Services Complaints \(England\) Regulations 2009 \[SI 2009 No.309\]; regulation 16](#)

¹⁸ [The Local Authority Social Services and National Health Services Complaints \(England\) Regulations 2009 \[SI 2009 No.309\]; regulation 13](#)

¹⁹ [The Local Authority Social Services and National Health Services Complaints \(England\) Regulations 2009 \[SI 2009 No.309\]; regulation 14](#)

The Health Select Committee, in its 2011 report on *Complaints and Litigation* made the point that “there is still a considerable amount of work to do in order to fully implement the system throughout England”. The Committee further recommended that “...commissioning authorities...should be the engines that drive improvement in complaints handling”. We consider that, whilst individual hospital Boards have an important role to play, so too have commissioning bodies, particularly in respect of NHS hospitals complying with their legislative duties.

Chapter Six:

Recommendations

Although words may inspire change they are not enough to hardwire it into the NHS and this is what our recommendations are designed to achieve. Our proposals reflect the principles in the NHS Constitution and build on those of previous reports. Our recommendations must therefore be read in conjunction with our proposals on implementation in Chapter Seven.

We focus on four areas for change: improving the quality of care; improving the way complaints are handled ensuring independence in the complaints procedures; and whistle-blowing.

1. Improving the quality of care

If standards of care were better and patients felt they could raise concerns on the ward and see them dealt with at the time, many would not feel they have to complain at all.

Recommendations

- Staff providing basic care should be adequately trained, supported and supervised. **Action: Trusts, professional bodies and representative organisations, HEE, clinical leaders and managers**
- There should be annual appraisals linked to the process of medical revalidation which focus on communication skills for clinical staff and dealing with patient concerns positively. This goes hand in hand with ensuring that communication skills are a core part of the curriculum for trainee clinical staff. **Action: HEE, professional bodies and representative organisations, clinical leaders and managers**
- Trusts should ensure that there is a range of basic information and support available on the ward for patients, such as a description of who is who on the ward and what they do; meal times and visiting times; and who is in charge of care for the patient. Care should be taken to ensure that differences in language, culture and vulnerability are taken account of in this. **Action: Trusts, clinical leaders and managers, clinicians and practitioners**
- Patients should be helped to understand their care and treatment. While written information is helpful, it is always important to discuss diagnoses, treatments and care with a patient. Patients frequently need to revisit topics already addressed. Where appropriate, their relatives, friends or carers may be included in discussions. **Action: Trusts,**

professional bodies and representative organisations, HEE, clinical leaders and managers, clinicians and practitioners, patients

- 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. **Action: Trusts, education and training organisations, clinical leaders and managers, clinicians and practitioners, patients**
- Hospitals should actively encourage volunteers. Volunteers can help support patients who wish to express concerns or complaints. This is particularly important where patients are vulnerable or alone, when they might find it difficult to raise a concern. Volunteers should be trained. **Action: Trusts, volunteer organisers**

Recommendations for Trusts and Boards

- Trust Chief Executives and Board members should be supported so they have the necessary skills in effective communication, seeking and using patient feedback, routinely throughout their organisation and are equipped to ensure their organisation learns from that feedback. **Action: NHS Leadership Academy and NHS Confederation**
- PALS should be re-branded and reviewed so it is clearer what the service offers to patients and it should be adequately resourced in every hospital. **Action: DH**
- Every Trust should ensure any rebranded patient service is sufficiently well sign-posted and promoted in their hospital so patients know where to get support if they want to raise a concern or issue. **Action: Trusts**
- The CQC should include complaints in their hospital inspection process and analyse evidence about what the Trust has done to learn from their mistakes. **Action: CQC**

2. Improvements in the way complaints are handled

Too often patients feel uncertain or confused when they feel they have a problem. Some never complain because they feel it may be unjustified or because they think staff are too busy. Others may lack confidence or feel intimidated or find the complaints procedure hard to understand, too complex or tiring. It should not be painful or difficult to complain, and when patients do complain it should not be up to them or their relatives to continually chase progress.

There needs to be a change in the way hospital staff approach dealing with complaints. All feedback, including complaints, offer valuable information which can lead to improvements, but there has to be the right organisational ethos to enable this to happen, so that both patients and their friends or relatives and the staff involved feel supported.

Complaints vary in their seriousness and frequency. Many complaints involve staff who deliver basic patient care and where these are listened to empathetically, immediate appropriate action can be taken to rectify a problem. When action is delayed or mishandled it can cause great distress and a breakdown in the trust between the patient, their family or friends and the hospital.

Recommendations

- Attention needs to be given to the development of appropriate professional behaviour in the handling of complaints. This includes honesty and openness and a willingness to listen to the complainant, and to understand and work with the patient to rectify the problem. **Action: Trusts, professional bodies and representative organisations, clinical leaders and managers, clinicians and practitioners**
- Staff need to record complaints and the action that has been taken and check with the patient that it meets with their expectation. **Action: Trusts, professional bodies and representative organisations, education and training organisations and clinical leaders and managers, clinicians and practitioners**
- 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. **Actions: Trusts, education and training organisations, clinical leaders and managers**
- There should be NHS accredited training for people who investigate and respond to complaints. **Action: Trusts, HEE**
- 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. **Action: Trusts, HEE, clinicians and practitioners**
- It needs to be clearly stated how whistle-blowers are to be protected and gagging clauses should not be allowed in staff contracts. **Action: DH**
- The development of the 'cultural barometer' should continue. This will determine if a workplace is suffering from a problem with staff attitudes or organisational approach. **Action: NHS England and DH**
- The independent NHS Complaints Advocacy Service should be re-branded, better resourced and publicised. It should also be developed to embrace greater independence and support to those who complain. Funding should be protected and the service attached to local HealthWatch organisations. **Action: Local Authorities**
- HealthWatch England should continue to bring together patients and representative groups, and lead the Healthwatch network in the public campaign to improve complaints' systems in health and social care. Some funding should be made available to help organisations to fully participate in this important work. **Action: Healthwatch England, DH.**

Recommendations for Trusts and Boards

- 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. **Action: Trusts**
- 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. **Action: Trust Chief Executives and Boards**
- There should be a new duty on all Trusts to publicise an annual complaints' report, in plain English, which should state what complaints have been made and what changes have taken place. **Action: DH**
- 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. **Action: Trusts**
- Where complaints span organisational boundaries, the Trusts involved should adhere to their statutory duty to cooperate so they can handle the complaint effectively. **Action: Trusts**
- Further work should be done to explore how we look for the right skills in the recruitment of Chief Executives and Board members. They need to be capable of ensuring that their Trust is a learning organisation. **Action: NHS Leadership Academy**
- Commissioners and regulators should establish clear standards for hospitals for complaints handling. These should rank highly in the audit and assessment of the performance of all hospitals. **Action: CCGs, CQC**
- There should be proper arrangements for sharing good practice on complaints handling between hospitals, including examples of service improvements which result from action taken in response to complaints. **Action: DH, Trusts**
- Regulators and the PHSO should work more closely to co-ordinate access for patients to the complaints system, and to detect failings in clinical or other professionals or Trusts. **Action: PHSO**
- We welcome the ongoing discussions on making a Duty of Candour a statutory requirement and recommend that a Duty of Candour is introduced. **Action: DH**

3. Greater perceived and actual independence in the complaints process.

Patients must have confidence in the complaints process. When there have been serious failings, it is particularly important that patients feel the process is independent. Too often hospitals are seen to be 'marking their own homework' and this undermines public

confidence. Much more needs to be done to ensure that there is a level of independence at the local stage which is acceptable to those who complain. Trust Boards should have a duty to offer this and should ensure that this is implemented.

We agree with the Francis Report, which recommended that hospitals should always use an independent investigator in circumstances, where:

- A complaint amounts to an allegation of a serious untoward incident;
- Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion;
- A complaint raises substantive issues of professional misconduct or the performance of senior managers.
- A complaint involves issues about the nature and extent of the services commissioned.

We believe that the gap between a local Trust dealing with a complaint by 'Local Resolution' and a patient taking their unresolved complaint to the Health Service Ombudsman is too great. In our view, the PHSO is too far removed from where the actions complained of took place and lacks accountability to local people. We are especially concerned that the PHSO did not act on complaints arriving from the scandal at Mid-Staffordshire Hospital, and we are not reassured by current plans simply to increase the number of complaints the PHSO takes up at a national level. We find the idea of local offices of the Ombudsman service an attractive one.

Our recommendations therefore focus on ways to bring more independence into complaints handling, and complaints advocacy at the local level where there are serious failings in care, how to bring more external patient scrutiny into Trusts, and on ensuring the true interests of patients are represented in several wider reforms which are now needed.

We are not alone in our concern about the independence of the complaints system from the NHS and its organisations.

- the Health Select Committee's recommendation in 2011, that *"one organisation should be responsible for maintaining an overview of complaints handling in the NHS, setting and monitoring standards, supporting change, and analysis of complaints data.*
- Professor Don Berwick's suggestion of *"further consideration of an independent national complaints management system that is easy to access and use, and that would also highlight and promote better practice and improvements in the NHS.*

However, the experience and the evidence that we have received tells us that the creation of a new organisation is unlikely to be the solution to the problems that we have identified. Neither will simply leaving things as they are and hoping that change will lead to the improvements needed. Many of the recommendations of previous reports and enquiries have not been acted upon, hence our proposals on implementation in Chapter Seven.

Recommendations

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

Action: Trusts

- 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.

Action: Trusts

- Patient services and patient complaints support should remain separate so patients do not feel they have to go through PALS first before they make a complaint. **Action: Trusts**
- 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. **Action: Trusts**
- Board level scrutiny of complaints should regularly involve lay representatives. **Action: Trusts**

4. Whistle-blowing

The question of whistle-blowing was raised occasionally by both staff and patients during the course of the review. During our work, the Secretary of State announced change in this area. We were pleased to hear of his decision to ban the practice of so called “gagging” clauses, used where hospitals reach an agreement with disaffected staff to terminate employment in return for a financial payment. Such clauses have in the past obliged clinical and other staff to be silent about practices which endanger patient safety. We support their removal.

However, we have heard in the course of our work repeated concerns about a number of unresolved questions surrounding this issue. These concerns relate firstly to securing justice for past whistle-blowers whose careers have been seriously jeopardised and who have suffered financially as a result of drawing attention to malpractice.

We urge the Department of Health to undertake the review of such cases with a view to both learning lessons for the future and undertaking restorative justice for those individuals affected.

Secondly, there remains disquiet about the opportunities available for staff to be heard, when they believe there is bad practice both within hospitals, and in the wider regulatory system. There is uncertainty too about what employment protection is genuinely to be offered to future whistle-blowers who reveal their concerns externally to regulators, or the press and media, for example.

Future arrangements

We believe that much more needs to be done to avoid the need for whistle-blowing in the future, and to protect those who with justification speak out, where there is no other means of drawing attention to situations where patient safety is threatened.

Recommendations:

- Clear guidance for staff on how they should report concerns, including access to the Chief Executive on request. **Action: DH**
- A board member with responsibility for whistle-blowing should be accessible to staff on a regular basis. **Action: Trusts**
- A legal obligation to consider concerns raised by staff, and to act on them if confirmed to be true.
Action: Trusts
- In assessing the complaints systems of hospitals the CQC should investigate the ease with which staff can express concerns and how whistleblowing is responded to where it has taken place. **Action: CQC**
- The CQC itself should designate a board-member with specific responsibility for whistle-blowing, and ensure that it acts on intelligence received from whistle-blowers. **Action: CQC**

Chapter Seven:

Implementation and pledges to act

The ambition for this review was always that it would lead to real change that is hard-wired into the system. This is not the first report on complaints handling, and as outlined in Chapter 2, a great deal is known about what needs to be done. The challenge however is to ensure the implementation of our recommendations so that they lead to real improvements for patients.

Now, following Robert Francis's investigation, it is clear that the complaints system must be improved if public confidence in the NHS is to be maintained.

We envisage that the drivers for change should be threefold:

- 1. Consumer Power.** Much more needs to be done to encourage patients and the wider public to insist on a better complaints system for the NHS. We are pleased to have been able to meet several consumer and patient bodies in the course of this review. They include HealthWatch England, Citizens Advice, Patients Association, Action for Victims of Medical Accidents, the Consumers Association, National Voices, and others. Between them they are powerful, with impressive contacts and skills, and already doing good work to improve complaints systems for patients. We are delighted they have agreed to work together locally and nationally, to monitor and press for the implementation of many of our recommendations and the pledges below.

We urge however that resources be provided to this grouping to enable them to develop this joint work to the best effect, both nationally and locally, and that the funding for local Healthwatch organisations is protected by ringfencing it in the future.

- 2. A Champion for Complaints Reform.** It is clear from all the evidence that we have heard that the patient who wishes to complain needs a champion, in a health care system which has, over many years, failed to demonstrate that it takes complaints seriously or welcome them as an opportunity to make improvements to the care that it provides.

We considered carefully whether to recommend the creation of a new, time-limited role, to drive the reform of complaints that is so desperately needed. However for the time being we think that the creation of this new role – a Commissioner for Complaints Reform – should be deferred. In discussion with the newly appointed Chief Inspector of Hospitals, Professor Mike Richards, we understand that he sees both the substance of complaints and the manner in

which they are handled by staff and boards, as central to his work and he can help to make progress in the immediate future.

We therefore set out below the key tasks that we believe should fall to CQC, through the Chief Inspector of Hospitals to deliver in the coming year: He should prioritise in his work the examination of the handling of complaints by NHS organisations.

- In doing so, the CQC through the Chief Inspector should:
 - produce and publish a thematic report on complaints, based on the findings of all the hospital inspections that he carries out in the year following the publication of this report;
 - consider the issues set out in our review as part of the thematic report on complaints – the prevention and handling of complaints, independent support for the complainant and the way that hospital boards lead the handling of complaints, and learn from them;
 - consider the sharing of good practice in complaints handling, perhaps through the development of a national resource.
- In the course of his hospital inspections, and as part of a thematic report on complaints, working with others in the health and care system, particularly HealthWatch England, CQC through the Chief Inspector of Hospitals should have due regard to the issues below that we believe remain unresolved, namely the need for:
 - a more localised and accountable second tier complaints review system, capable of analysing and detecting local trends;
 - more, and more effective, independent support for complainants at the local resolution stage;
 - enforceable standards in complaints handling, which can be used by the CQC and the Chief Inspector as well as providing a means of comparing the performance of hospitals; this should include standards governing the ease with which staff themselves can bring forward concerns.
 - commissioners (CCGs and NHS England) to improve their service specification for complaints handling and having access to intelligence about complaints.
- CQC, through the Chief Inspectors of Hospitals, General Practice and Adult Social Care should work in partnership so that lessons from different sectors can be learned and shared, issues relating to complaints along the whole care pathway can be identified and a collective view taken on the issues set out above.
- CQC, through the Chief Inspector of Hospitals should work closely with Healthwatch England, PHSO and patient and consumer groups, to ensure that his report takes account of the views and experiences of those using the NHS and that they help him in his consideration of the four issues set out above.

- These additional functions of the Chief Inspectors need to be properly resourced. The Department of Health should ensure that CQC and, where appropriate, Healthwatch England, is provided with the additional staff and funding necessary to carry out the thematic work and prepare and publish a report. **Action: DH, CQC**
- We will consider the findings of the Chief Inspectors and whether sufficient progress has been made in tackling the issues and problems set out in this report. We recommend that, once the Chief Inspectors' report is published, the Secretary of State for Health seeks our views on the progress made and any further recommendations that we might have to accelerate improvement. **Action: DH**
- We also urge that the Health Select Committee should continue its work on this subject and revisit the question of complaints handling within the same time scale.

With the knowledge that the Chief Inspectors will report on progress within a year, we hope that all involved will wish to be seen to be playing their part in developing a complaints system we can be proud of for the future.

3. Pledges to Act:

The third driver for change is pledges to act. We are grateful to the many organisations who have pledged to take action. We commend them for doing so and look to others to follow suit. The pledges in the following pages largely complement our recommendations, set out in Chapter 6, and focus on the importance of keeping reform of the complaints handling system in the spotlight and sustaining the pressure that will lead to change.

Nursing and Midwifery Council (NMC)

The NMC's Code and education standards include clear duties on nurses and midwives in relation to complaints handling, communication with patients and raising concerns. The NMC will be undertaking a planned review of the Code and other practice standards in the next year as part of the preparation work for revalidation. The NMC will ensure that these duties are highlighted in the revised Code which will form the benchmark for appraisals and revalidation. The NMC plans to publish its new Code and standards by December 2014. The NMC will also take more immediate steps to raise awareness of these duties and their guidance on raising concerns amongst nurses, midwives and the public.

The NMC will improve the experience of patients and other complainants who become involved in their fitness to practise proceedings by providing more information and support throughout the process. The NMC plans to have their new arrangements in place by April 2014.

The NMC will work more closely with other regulators and healthcare organisations to share data and intelligence including, where appropriate, complaints information and patient feedback, in order to enable them to better protect the public. The NMC plans to have a new operational protocol and data sharing agreement in place with the Care Quality Commission

by December 2013 and to develop similar arrangements with other regulators during 2014/15.

Royal College of Nursing (RCN)

The RCN will host a workshop with nurses to consider the report after its publication, and will produce a short guide/advice sheet for nurses by spring 2014.

NHS Trust Development Authority (NHS TDA)

The NHS TDA's Accountability Framework for NHS Trust Boards highlights the centrality of patient experience, with a clear focus on complaints. The NHS TDA will take into account the message and recommendations of the Clwyd/Hart complaints review, as it further develops its approach to holding Trusts to account for providing patient-centred care. The NHS TDA will align its approach with that of Monitor, CQC and NHS England to ensure Trusts are being given consistent messages.' NHS TDA will consider any changes needed to the Accountability Framework and will reissue it by the end of April 2014.

Health Education England (HEE)

HEE will develop an e-Learning resource for complaints handling, with modules specific to complaints staff, and also modules to raise awareness of the importance of, and process for dealing with patient feedback and complaints. Work to create the specification for the e-learning resource for complaints handling will be completed by December 2013 (subject to agreement by all parties). A procurement process for the resource will then take place with the intention that it will be widely available in 2014.

HEE will work with regulators and other key partners to review training, education and CPD programmes to include and give greater emphasis to developing student and staff awareness of a positive attitude to hearing, accepting and responding to patient concerns, complaints and compliments. A review of the provision of training, education and CPD programmes will take place by LETB education commissioning leads (in partnership with regulators such as the NMC etc and HEIs) to include and give greater emphasis to developing student and staff awareness of a positive attitude to hearing, accepting and responding to patient concerns, complaints and compliments. This review will be completed by May 2014 and include a clear action plan for delivering recommendations.

Local Government Association (LGA)

The LGA will support councils by focusing on the role of councillors as advocates for their communities.

Working with the Centre for Public Scrutiny, by April 2014, the LGA will provide information and learning about public feedback, complaints and insight about NHS services to lead councillors for adults and children's services; health and wellbeing boards; local HealthWatch commissioners; and council scrutiny.

NHS Confederation

The NHS Confederation pledges to hold discussions with its members about the review's recommendations at two regional events by spring 2014. These discussions will be used to identify and share good practice about complaints handling in hospitals and to inform the NHS Confederation's response to the review.

NHS Employers

NHS Employers will promote the outcomes from the National Complaints review through engaging and working in partnership with NHS employers and staff-side through a 12 month work programme through existing networks and forums of HR Directors, Workforce Leaders/ partners and Regional Social Partnership Forums and will provide feedback to the DH.

General Medical Council (GMC)

The GMC's core guidance for all doctors, *Good medical practice*, sets out what is expected of doctors, including in communication and partnership working with patients. Its guidance emphasises the need to listen to patients, provide the information they need, be polite and considerate as well as treat patients fairly and with respect. The GMC is examining how these skills can be better reflected in postgraduate training and also promoted as part of continuing professional development for all doctors. The GMC plans to consult patients and others on this work early in 2014. Guided by the work of an independent review of post graduate medical education, jointly sponsored with the Academy of Medical Royal Colleges, by September 2014, the GMC will be working with the medical Royal Colleges and other key interest groups to embed the generic professional competences outlined in *Good Medical Practise* in postgraduate training.

The GMC will also look at how well prepared medical graduates feel to deal with patient concerns and complaints in a positive way. They will do so as part of their review of the impact of Tomorrow's Doctors 2009, which sets out the outcomes and standards for undergraduate medical education. This research will be received in the second half of 2014 and work will have begun to identify any changes that may need to be made.

The GMC believes there will be increasing use of instant patient feedback and welcomes the greater transparency and patient involvement this brings. The GMC also believes patient feedback in general is vital for professional development and it has produced guidance for best practise for patient feedback as part of the revalidation process, which requires doctors to go through a series of annual checks. As part of the evaluation of revalidation, the GMC will look at the role of patient feedback and how it can be further developed. By September 2014, a research partner will have been commissioned to undertake this work.

The GMC will act to support patients through fitness to practice cases, undertaking to take tailored face to face opportunities to explain the process and outcomes. Interim findings from the pilot programme have been positive and the GMC will receive the final evaluation at the end of 2013. Subject to favourable findings and agreement of the Council, the GMC expect to have established the essentials of this programme in all four countries by mid-2015.

Monitor

Working with partners, Monitor will make sure foundation trusts understand what best practice in complaints handling looks like and what Monitor expects of them. For example, as part of their quarterly monitoring process during the summer Monitor have asked foundation trusts to explain how their Boards use complaints in their assessment of quality performance and how they assure themselves that they comply with Monitor's *Quality Governance Framework* in relation to complaints and whistleblowing. During the autumn, Monitor will analyse their responses to identify any issues that might require us to take further action.

Monitor will continue to work closely with the CQC during the autumn as it develops its new inspection and assessment regime relating to leadership, governance and culture to ensure that we are clear how CQC concerns relating to complaints could trigger further investigation or regulatory action in foundation trusts by Monitor.

Monitor will share information about complaints quickly and effectively with our partners, and already does so with the CQC.

Care Quality Commission (CQC)

CQC is committed to putting people who use services at the centre of their work, and including people's experiences as a core focus of their inspections. CQC has recently announced their intention to gather and use a much wider range of information from patients and the public, and CQC will use the outcome of this review to inform their regulatory assessment of the NHS and other health and social care services where relevant. In particular over the next year CQC will improve how they are looking at leadership, governance and culture, and will:

- develop the way they use CQC complaints information as well as other views and feedback from people who use services in their surveillance model to ensure they are embedded consistently and given significant weighting (winter 2013/14);
- analyse the number and themes of complaints and feedback they receive directly;
- work closely with and share information with their regulatory partners about complaints;
- strengthen how they consider complaints as they develop their approach to assessing quality and safety of hospitals and other services (Autumn/Winter 2013).

NHS England

NHS England will review the role of commissioners, including their own, in holding providers to account for a positive attitude towards patient feedback, concerns, complaints and compliments, with specific reference to using the standard contract and quality accounts as relevant existing tools. NHS England will undertake this work by March 2014.

NHS England is supporting the piloting of the cultural barometer, and in the evaluation, revisions and potential rollout of the barometer, will consider the content and

recommendations of the Complaints review. NHS England will undertake this work by March 2014.

The Parliamentary and Health Service Ombudsman

The Ombudsman is independent of the NHS but has committed to do the following:

- The HSO wants to participate actively in discussions on whether an NHS vision for excellence in complaint handling can be developed along with ways of measuring individual hospital level performance against that vision.
- The HSO will regularly share insights from the complaints that they see with Parliament, the Department of Health, regulators and the NHS itself. Reflecting one of their core strategic aims, they will collate and provide this information in the way which it can be most useful in showing key learning (both of good practice, and learning from things that have gone wrong) and so support improvement in the complaints system.
- The HSO will support organisations such as NHS England and the Foundation Trust Network in the development and embedding of good board practice.
- The HSO will contribute to work by the NHS to define the competencies for complaint handlers and develop a suitable accreditation framework.
- The HSO will also contribute to the definition of competencies required on the ward to handle expressions of dissatisfaction before they turn into complaints.
- The HSO will work with others to develop and promote good practice from ward to board using our experience and the findings from our research.

Even if recommendations for improvements are implemented, there will still be occasions when something will go wrong. In the most serious of those cases, HSO hopes that NHS Trusts will use the option of self-referral to the Health Service Ombudsman for independent investigation; and so allow HSO to play their part in delivering justice, finding out what went wrong and ultimately helping the NHS to restore public trust in what is such a key public service.

Chapter Eight:

Good Work

During the Review we found good work in the NHS.

In this Chapter we highlight some examples from around the country showing how patients are being encouraged to provide feedback about their care, how some organisations provide additional support when they complain, and what organisations do with the insight they get from patients who raise concerns and complain.

Case study one: The critical friend

Central Manchester University Hospitals NHS Foundation Trust

Patients or relatives complaining about services at Central Manchester University Hospitals NHS Foundation Trust may be pleasantly surprised by the tone of the response. In the most serious cases, they are offered direct personal support from a senior executive. Cheryl Lenney, Director of Nursing (Adult), said a director or deputy director is assigned as a “critical friend”, acting as an independent advocate on behalf of the complainant. That might involve helping people to navigate a way through the organisation to find out whether mistakes were made, why things went wrong and what will be done to provide better care in future.

Ms Lenney said:

“We tell them: I am your one point of contact in the organisation. They value the fact that we are very senior. We will see them through to the end result of an investigation. That may mean helping a family to get further information that they hadn’t asked for at the start. And sometimes a bereaved family may want this help to continue through to an inquest.

“The family may be satisfied with the result of an investigation, when they have an explanation of what happened. Or they may not. If a member of staff has been investigated in a disciplinary procedure, we share the outcome. We can’t make right what went wrong, but we can signpost complainants to legal services or the NHS Litigation Authority. We are not defensive. We are supportive.”

‘Critical friends’ are assigned only for complex cases when there has been a suspected serious untoward incident and a patient has been harmed or has died. But the Trust has been putting a lot of effort into answering all complaints fully, openly and in plain English. The letter responding to a complaint is regarded as a ‘final product’ that has to meet certain quality standards. Ms Lenney said it should demonstrate:

- robust investigation;
- clear awareness of the issues;
- knowledge of what the individual has experienced;
- a strong feeling of empathy in the apology; and
- saying what the Trust will do to prevent that happening again.

The Trust tries to pre-empt people's need to complain by facilitating meetings with the clinical teams who were involved in any case that has caused concern. It also collects data about complaints that have arisen in a particular clinical setting or ward, feeding the information back to the teams involved and requiring a response.

Other initiatives include a complaint review group, chaired by one of the trust's non-executive directors and 'Feedback Fridays' when middle managers spend time on the wards listening to patients to gather information about how services could improve.

Case study two: Customer focus

Birmingham Heartlands Hospital

Patients and relatives arriving at Birmingham Heartlands hospital are left in no doubt that senior NHS managers treat their opinions seriously. On the front door of the main entrance is a "Tell us what you think" poster. Inside in the foyer there is a Patient Services desk, giving the organisation a customer-focussed feel. It displays colourful, eye-catching booklets seeking opinions about how the hospital is doing. One is "*Tell us what you think about our services – a guide to giving feedback or reporting a concern.*" Another is: "*How are we doing? Compliments, comments, concerns.*"

The booklets, which are also displayed in outpatients, on the wards and in the discharge lounge, explain in user-friendly language what is involved in raising a concern or complaint, and give advice on independent advocacy. There are forms for completion by a complainant, or for comment. The hospital website has a direct link to Patient Opinion feedback on its home page.

The hospital standard is for complaints to be acknowledged within a maximum of three days, when the complainant is given a named case manager who becomes responsible for overseeing resolution. The standard is for every complaint to be answered within 25 days, except in the most complex cases.

Recent examples of changes in clinical practice as a direct result of complaints/feedback include the redesign of the patients' care pathway in A&E and new procedures in the Gynaecology department for women suffering miscarriages.

Board members take part in a sub-group that reviews stories of individual patient experiences. It provides a monthly report to the Board and to the meeting of Executive Directors, giving patient feedback, including signed or anonymous comments on the Patient Opinion and NHS Choices websites. The Trust takes a monthly snapshot of performance by

asking 15 patients' on each ward to complete a questionnaire about their experience. It compares this information with results from the Friends and Family Test, staff sickness returns, complaints data and reports from unannounced visits by members of the consultative Healthcare Council. On the wards in Heartlands, each patient has a folder beside the bed with information about visiting hours, who's who among the staff and how to give feedback or make a complaint. A recent audit identified missing folders from various areas and a new replacement order has been organised with updated information. The policies are being extended to the Trust's other hospitals at Solihull and Good Hope.

Case study three: Using patients' experiences to build better services.

Royal United Hospital, Bath.

Staff and management at the Royal United Hospital (RUH), Bath, know that by listening to feedback and being open to making changes, they can improve their patient services. Both during and after their time in the hospital, patients and relatives have many options for commenting on their experiences besides using the traditional PALS and Complaints routes. For instance, patients and relatives who want to give more immediate feedback are invited to meet for a cup of tea with the ward sister on a weekly basis on the wards. Other methods of feedback include the "Friends and Family Test" at the point of discharge. Patients and carers can also use the in-house real-time patient feedback system, which can also be accessed on line from the patient/carer's own computer.

Another way that RUH ensures they focus their services around the patient is through the Patient Experience Group (PEG). This group comprises administrative and clinical staff together with representatives from community organisations including previous patients, senior citizen organisations, Carer Support Wiltshire and other carer groups. The PEG is invited to give feedback on changes to the patient services within the hospital or to suggest how these services could be improved. The composition of this group is regularly reviewed to ensure it reflects the broadest possible cross section of service users with its aim to focus on any Trust-wide strategic issues for service users and to drive and support a Trust wide approach to improve the experience of patients and carers.

One of the ways that the RUH works with patients, families, carers and staff is by presenting their stories at 'See it my way' events. Patient focused events such as these allow staff to reflect on the hospital experience from the patients perspective and staff agree from the feedback collected after these events, that it provides real value in terms of their overall understanding of how patients and their families lives are affected due to specific conditions and also how they can adapt their own working practises to benefit patients in future. "See it my way" has broached a number of topics ranging from "living with learning difficulties" to "being deaf.

These many and varied approaches to receiving and using information from patients, relatives and staff helps to create a responsive flexible culture of learning and therapy within RUH. As

Medical Director Tim Craft says “*the patients’ experience is inseparable from the staff and family experience*”.

Case study four: Easy and practical steps to put confidence in your complaints system.

St. Christopher’s Hospice, London.

St. Christopher’s Hospice in South London have a number of sensible practices in place which gives confidence to the patient and relative who may wish to make a complaint or give feedback. Upon first booking an appointment, the hospice issue an information book which explains services and includes information on how to make a complaint. This encourages the patient, who may otherwise feel daunted at complaining, to do so. It also makes the complaints process easy to understand and more accessible.

Front line workers, from porters to clinical staff, are given induction training in which they are encouraged to respond openly to patients’ and relatives’ questions and concerns. Staff are encouraged to deal with the situation immediately if this seems appropriate, and to alert their manager to situations that may develop into a complaint. The aim here is to pre-empt complaints, perhaps by giving people the opportunity to talk to a manager and resolve potential misunderstandings and issues.

The senior management team (SMT) at St. Christopher’s manage the complaints process and deal with most complaints. Written responses to complaints are scrutinised by at least 2 members of the SMT. They avoid jargon wherever possible and apologies are readily given when warranted. When complaints are upheld, complainants are advised how practice will change as a result.

An internal review of responses to complainants by clinical managers, the senior management team and the Board takes place every 6 months. This ensures that any learning points are disseminated and required actions have been taken.

Case study five: Training the NHS staff of the future

University of Southampton

The Faculty of Health Sciences at the University of Southampton has a very impressive approach to training their students to be receptive of patient feedback, and in handling complaints effectively.

For example, pre-registration nursing students and those undertaking physiotherapy, occupational therapy and podiatry programmes are explicitly taught about the handling of complaints and the raising of concerns in their practice placement briefing sessions, and they are further developed within subsequent placements in the NHS.

Nursing and midwifery students have opportunities to practice their skills through scenarios simulated with patient actors, and through an innovative and award winning teaching

method called Forum theatre, in which staff actors and student audiences review a range of strategies, and communication skills required to manage challenging situations as they escalate.

Within the Faculty, an enhanced specialist support service was established for students who either wished to raise concerns about suboptimal care (whistleblowing), or who were involved in adverse events. With regard to supporting patients and raising concerns, the support service includes preparing students for, and accompanying them through, the experience of giving evidence to investigating officers or disciplinary panels.

All students reporting significant concerns are assisted in the construction of a detailed and robust witness statement which aids the investigation process.

The service achieved national recognition by the Nursing and Midwifery Council (NMC), and in 2011 was cited as an 'outstanding' provision, and 'unique within Higher Education Institutions within the UK'. It was recommended by the NMC reviewer to be rolled out as a national model, and is featured on the NMC website as an example of best practice.

Annex A:

Thank you and acknowledgements

We would like to thank everyone who contributed to this Review. It would not have been possible without the openness, commitment, engagement, and support of many individuals and organisations. Nor would it have been possible without the input from patients, members of the public, NHS bodies, organisations and voluntary groups who provided written evidence or attended regional events.

Thanks to over 2500 people who cared enough to share their concerns

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NHS and hospice staff

Barts Health NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Central Manchester Universities Hospitals NHS Foundation Trust
Heart of England NHS Foundation Trust
Nottinghamshire Healthcare NHS Trust
Royal United Hospital Bath NHS Trust
Salford Royal NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
St Christopher's Hospice

Universities

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Southampton
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Key Partners Group in the health and care system

Action against Medical Accidents
Care Quality Commission
Foundation Trust Network
General Medical Council
Health Education England
Healthwatch England
Local Government Association
Monitor
National Voices
NHS Confederation
NHS Employers
NHS England
NHS Trust Development Authority
Nursing and Midwifery Council
Patients Association
Parliamentary and Health Service Ombudsman
Professional Standards Authority
Royal College Nursing
Royal College Physicians
Royal College Surgeons

Patient Groups

Action against Medical Accidents

Citizens Advice Bureau

Consumers' Association

National Voices

Patients Association

Patient Opinion

Department of Health Review Team

Annex B:

the evidence

The Review received over 2,500 individual submissions or comments from members of the public, including patients, their families and friends, and former members of staff. Some were hand-written letters, others sent in detailed dossiers on their own experiences, and there were also many hundreds of emails and telephone calls. All were reviewed and assessed and helped to build a picture of people's experiences when things went wrong in hospitals and when they used the complaints system to try to put it right.

The majority of submissions were about people's experiences in hospital: nearly 2,000 in total. This evidence has been invaluable in exploring the underlying reasons why people were unsatisfied and why some of them went on to complain.

A smaller number – around 400 – went on to comment specifically about the complaints system, and of these around 150 made suggestions about how the system itself could be improved. Again, all were reviewed and all those that made substantial comments or suggestions were coded to indicate their areas of interest and concern, to help with our analysis. Further, we selected representative comments from a range of contributions and a number of these are included word-for-word in this report to illustrate and support the analysis and conclusions.

Finally, it is worth noting the significant number of former nurses, doctors and other health professionals who took the trouble to write in to the Review. These contributions were particularly valuable, as there were very few submissions from current members of staff.

The co-Chairs of the review were supported by a team of eight external members. The members were from a range of backgrounds in the health, private and voluntary sector – all of whom had an interest in improving complaints handling for the benefit of patients and the NHS.

The Review team:

- visited nine hospital trusts across the country and a non NHS organisation in order to meet with staff and discuss their current approach to handling complaints.
- held three regional events in London, Birmingham and Newcastle. During these events, the team heard the views and experiences of voluntary organisations who represented patient groups, with a particular focus on access and support issues.
- held four patient events, during which individual patients who had had personal experiences of using the complaints procedure were invited to provide their views.

- had face to face meetings with eight prominent UK and international individuals all of whom had expertise in complaints handling, use of information or representing patient views.
- Held two workshops, one in May and one in June, with around twenty key partners in the health and care system.

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