Parliamentary
and Health Service
Ombudsman

Listening and Learning:

the Ombudsman's review of complaint handling by the NHS in England 2009-10

'The NHS commits, when mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively.'

NHS Constitution

Parliamentary
and Health Service
Ombudsman

Listening and Learning:

the Ombudsman's review of complaint handling by the NHS in England 2009-10

Third report of the Health Service Commissioner for England
Session 2010-11
Presented to Parliament pursuant to section 14(4)
of the Health Service Commissioners Act 1993
Ordered by
The House of Commons
to be printed on 18 October 2010
HC482
London: The Stationery Office
£14.75

© Parliamentary and Health Service Ombudsman 2010
The text of this document (this excludes all departmental and agency logos) may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not in a misleading context.
The material must be acknowledged as Parliamentary and Health Service Ombudsman copyright and the document title specified.
Where third party copyright material has been identified, permission from the respective copyright holder must be sought.
Any enquiries regarding this publication should be sent to us at phso.enquiries@ombudsman.org.uk.
This publication is also available on http://www.official-documents.gov.uk/
ISBN: 9780102969191
Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
ID P002392715 10/10 PHSO-0110
Printed on paper containing 75% recycled fibre content minimum.

Contents

Foreword 4

Our role: listening to complainants; sharing learning with practitioners 7

How we work 11

Health complaints to the Ombudsman 2009-10 13

Putting things right: complainants' stories 22

NHS complaint handling performance 2009-10 29

Looking to the future 47

Appendix: complaints received, resolved and investigated in 2009-10 49

Foreword

This is my first report on complaint handling in the NHS in England. It assesses the performance of the NHS against the commitment in its Constitution to acknowledge mistakes, apologise, explain what went wrong and put things right, quickly and effectively.

The report covers the first full year of the new complaint handling system for the NHS and its scope includes previously unpublished data about the number of complaints we have received in the last year for every trust in England, and the action we have taken as a result. It presents a perspective not seen before; a national picture from the Ombudsman of what happens when mistakes occur and the NHS fails to put things right.

The data published here point to a clear conclusion. The NHS needs to listen harder and learn more from complaints. When it fails to do so, it is missing a rich source of insight and information that is freely and readily available and comes directly from service users.

Failings in clinical care, misdiagnosis or poor communication can all have life-changing consequences for patients. When a complaint is made, delays in responding, or failure to listen, to apologise or to take account of individual needs can make an already difficult situation worse. Many of the lessons that can be learned from complaints are straightforward and cost little or nothing to implement at local level: a commitment to apologising when things go wrong; clear and prompt explanations of what has happened; improved record keeping and better information for patients about how to complain.

The circumstances of the individuals featured in this report are not exceptional. These are everyday stories of people giving birth or caring for children, older people struggling with deteriorating health or individuals seeking diagnosis when they feel unwell. What makes their experiences stand out are the difficulties they encountered when things went wrong. As their experience shows, complaints that are not dealt with properly can escalate, creating unnecessary demands on health practitioners' time and NHS resources.

When things do go wrong, an apology can be a powerful remedy; simple to deliver and costing nothing. If a mistake is not in dispute, the Ombudsman's input should not be necessary to ensure the NHS takes responsibility for the error. Too often it takes the involvement of my Office to secure an apology from the NHS, enabling those affected to move on with their lives.

Offering a full and thorough explanation of what went wrong can help to alleviate distress and to reassure complainants that mistakes will not recur. Inadequate record keeping means such explanations may never be delivered, leaving unanswered questions for patients and their families. As one man wrote to us when he received our report into his complaint: *'I have felt an enormous sense of relief that the findings acknowledge some of the truth of what really happened to me and this has been an important aid to me coming to terms with what happened, and starting to get some closure'.*

The new system for handling health complaints, introduced in April last year, means a quicker, simpler route to resolution for patients and their families. Nevertheless, the high numbers of complaints that reach my Office before local resolution is complete suggests inadequate local information about how to complain or a loss of confidence in NHS complaint procedures.

Poor quality or inconsistent information about complaints and their outcomes diminishes learning

within the NHS and impedes access to choice for patients. The ‘information revolution’ proposed in the Government’s White Paper, *Equity and excellence: Liberating the NHS*, offers a route to redress this. The Government intends that patients should get better access to health information, including on the experience of other service users, to enable them to make more informed choices about their care. Clear and consistent complaint information needs to be part of that revolution.

My Office stands ready to assist this drive for change. Over the last year, we have been in direct dialogue with health practitioners and NHS executives, Ministers and Department of Health officials, regulators and patient advocates. As well as helping to resolve individual cases of injustice or maladministration, we have been able to share our expertise in complaint handling at a local, regional and national level to improve customer service and administration for the benefit of patients and their families.

This is the first of what will be an annual series of reports, examining NHS complaint handling. Over the coming years, our data will serve to provide an independent snapshot of NHS performance, complementing local information and national complaint statistics. I hope that it proves to be a useful tool for patients, practitioners and NHS executives in highlighting how the NHS can continue to improve the service it provides for us all.

Ann Abraham
Health Service Ombudsman for England
October 2010

‘She did not feel reassured that the Trust had valued her complaint as a learning opportunity. Instead it was defensive and unwilling to take responsibility for the issues she raised.’

Letter from an ICAS advocate on behalf of a complainant.

‘Please be assured that future complaints will not be subjected to delays such as you have experienced... We are aware that our shortcomings in the administration of your complaint may have caused you unnecessary worry and stress at a time of great sadness, and we do offer you our sincere apologies for this.’

Letter to a complainant from an NHS provider, after our involvement.

‘There was a feeling that we all have a common goal to satisfy complainants’ concerns and this can be achieved by establishing a good understanding of each other’s roles and ways in which we can work together.’

Delegate at our 2009 Complaints and the Ombudsman conference.

Our role: listening to complainants; sharing learning with practitioners

The role of the Health Service Ombudsman is to undertake independent investigations into complaints that the NHS has not acted properly or fairly, or has provided a poor service.

A new system for health complaints

Five years ago, the Ombudsman expressed her concern that some patients and their families were facing severe problems in getting a satisfactory response to their complaints from healthcare providers. In her 2005 report, *Making things better?*, Ann Abraham stressed the need to listen to patients and to offer support and advocacy; for a focus on outcomes not process; for strong leadership and effective governance; and for a simpler, less fragmented system, especially across health and social care. The NHS, she concluded, was not using the information contained in complaints to improve its services. The system needed reform.

In April 2009, a new integrated system for handling complaints within the NHS and adult social care was launched. The Healthcare Commission was disbanded, and the Ombudsman became the second and final point of contact for health complainants, offering a simpler, faster system for resolution.

Patients' right to complain

The right of patients to bring their complaint to the Ombudsman if they are dissatisfied with the way it has been handled locally is recognised in the NHS Constitution. The Constitution, which was launched in the same year that the new system began, outlines a commitment to treat people with courtesy and to provide support during the complaint process; to acknowledge mistakes, apologise and explain and to put things right quickly and effectively. It also commits the NHS to learning lessons from complaints in order to improve NHS services.

People who are not satisfied with the way their complaint has been dealt with by the NHS have the right to bring their complaint to the Ombudsman. By listening directly to complainants, we can help to transform difficult or upsetting situations for individuals, and can share any subsequent learning within the NHS at local, regional and national level. The benefit we bring is recognised within the NHS: in recent independent research into the impact of our work,[1] bodies within our jurisdiction observed that our wider experience in dealing with complaints can bring a fresh approach to resolution, whilst our independence makes our investigation more credible and conclusive than the organisation's own.

Over ten per cent of health complaints that we receive have the support of the Independent Complaints Advocacy Service (ICAS). We have always been a strong supporter of advocacy and our dialogue with, and support, for ICAS includes the provision of a telephone and email enquiry service for ICAS managers and regular liaison meetings with ICAS service directors.

Direct dialogue

Over the last year, we have been talking directly with practitioners and NHS executives at national, regional and local level, and with others who work to ensure the provision of the highest quality care for patients. This direct dialogue has enabled us to share our expectations of complaint handling, and pass on the broader lessons emerging from our casework.

[1] Our 2009-10 Stakeholder Impact Study is available on our website at www.ombudsman.org.uk.

We have established meetings with senior NHS executives and continued those with Department of Health officials. Through this regular contact we can ensure that the ongoing development of NHS policy is informed by complainants' experience and keep check on the implementation of our recommendations to help drive service improvements. We are expecting publication in October 2010 of the Department of Health's progress report on the implementation of the recommendations of the Ombudsman's report *Six Lives: the provision of public services to people with learning disabilities*, which was published in March 2009.

New Memorandums of Understanding between the Ombudsman and NHS regulators, the Care Quality Commission and Monitor, set out our shared commitment to collaboration and co-operation where relevant and appropriate in order to secure high quality healthcare. With a particular focus on information sharing, the Memorandums of Understanding support a strategic alliance which ensures that any recommendations we make for systemic change are followed up in the regulators' inspection and monitoring regimes to achieve service improvements.

We continue to promote good administration and complaint handling to front line staff and managers across the English regions. This autumn we will be hosting a second series of regional conferences on complaint handling for NHS managers and primary care practitioners, providing tailored information about complaint handling performance in strategic health authority regions across England.

Where a high number of complaints received, or accepted for investigation, about an NHS trust or body suggest particular cause for concern, we meet with senior staff to ensure they have a full and thorough understanding of the Ombudsman's expectations and our processes for investigating and responding to complaints. Where we become alert to any real or potential threat to the health or safety of patients, we share that information with the relevant authorities. For example, information that calls into question the fitness to practise of an individual clinician will normally be disclosed to the relevant professional body.

Working with the regulators

The Care Quality Commission (CQC) and Monitor are reviewing the progress of a trust's action plan following failings in the care of an elderly patient.

Ms H, an 86 year old patient who had a history of cerebrovascular disease (which affects blood supply to the brain) with mild dementia, diabetes and recurrent urinary tract infections (UTI) was admitted to hospital for treatment of a UTI. Ms H died 12 days later. Our investigation found numerous failings regarding the treatment of her UTI, the management of her renal failure, the gaps between medical reviews and her nursing care.

We upheld a complaint from Ms H's family about her treatment and, alongside an apology and financial compensation for distress, we asked the trust to prepare an action plan describing how they would ensure that staff had learnt lessons from the failings identified and setting out how they would avoid similar failings in future. Copies of the plan were sent to the regulators, CQC and Monitor, so that they could monitor progress.

Publishing and sharing information about complaints

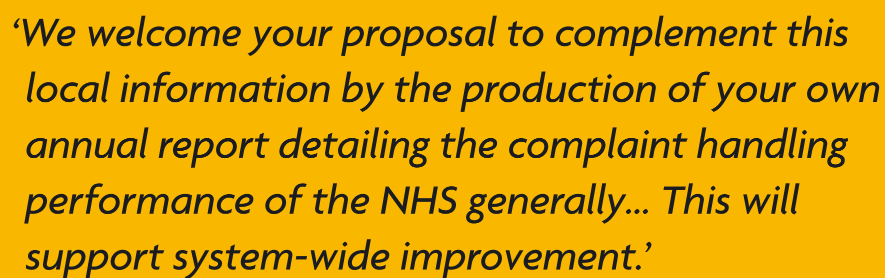
NHS providers are required to produce an annual report on their complaint handling performance and make this available to any person on request.[2] This must include the number of complaints received and the subject matter; the number which were considered well-founded; and the number referred to the Ombudsman. It must also summarise any action which has been taken to improve services as a result of those complaints. Because there are no clear requirements about how the summaries will be reported and presented – and no requirement even to publish these reports on the website – service users can be at a disadvantage when they are seeking to make informed choices about their care. Such inconsistencies also make it difficult for NHS managers to identify and track learning from complaints across the NHS; and for service commissioners and regulators to compare the complaint handling performance of one NHS body with another.

The Ombudsman, in partnership with the Information Centre for Health and Social Care and supported by the Department of Health, has established a dialogue with NHS executives, the regulators and service user groups to tackle the issue. The aim is to identify how information about complaints can best be captured and shared to support effective learning within and across the NHS and to help patients make informed decisions about their care.

The Ombudsman has recently undertaken a public consultation on our own approach to sharing and publishing information about health complaints and we reported on the outcome of that consultation in April 2010.[3]

As we said in the consultation document, *'the Ombudsman wants to share the learning from complaints with those who are likely to benefit from having access to that information'*. Our challenge is to do so in a way which is compatible with the legislation which governs our work, balancing the need to protect the privacy of personal and other information given to us in confidence with the potential benefit of sharing more widely information that can help to improve everyone's healthcare. The consultation responses made it clear that there is enormous interest in learning from the complaints that people bring to the Ombudsman and we have been reviewing our policy in this area over the past six months with the aim of sharing and publishing as much information as possible. The policy that the Ombudsman has adopted as a result of this consultation will be published shortly.

[2] *Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.*
[3] The report of the Ombudsman's consultation on sharing and publishing information about complaints is available on our website at www.ombudsman.org.uk.



Response from Sir David Nicholson, NHS Chief Executive, and Sir Hugh Taylor, Permanent Secretary, Department of Health, to the Ombudsman's consultation on sharing and publishing information about complaints, 22 March 2010.

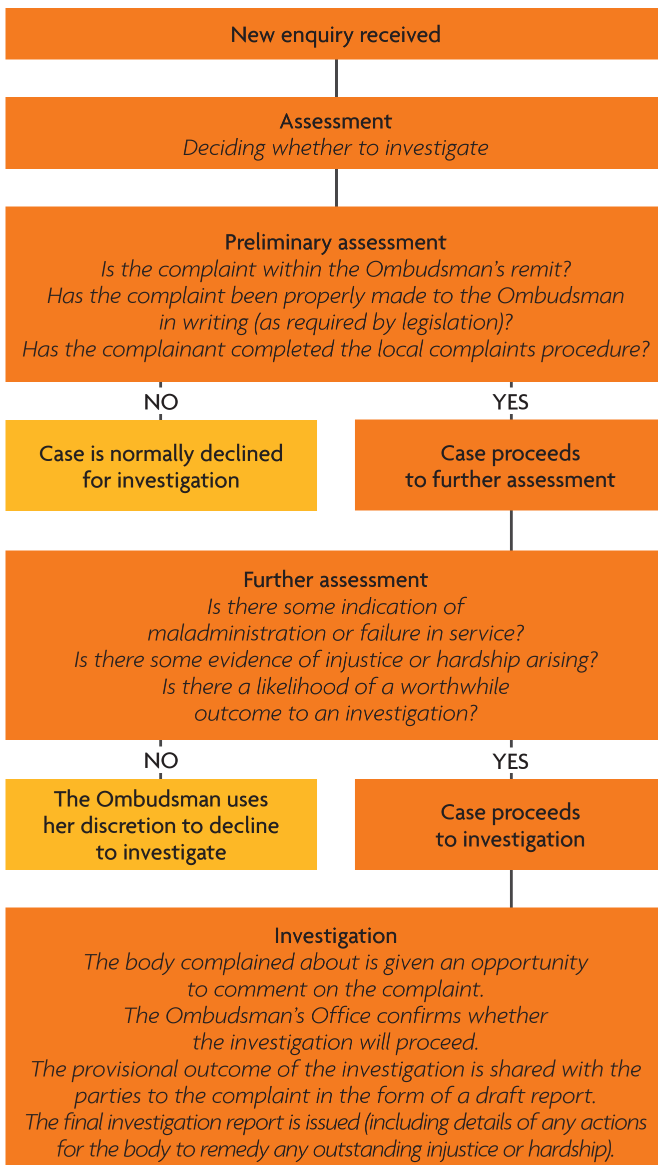
How we work

We receive many thousands of enquiries about the NHS every year (an enquiry is a request to investigate a complaint). We thoroughly assess each one to decide how we can best resolve it.

If local resolution has been completed, the assessment involves checking the quality of the NHS response to the complaint, testing the evidence supporting the response and comparing any clinical issues against relevant accepted good practice using our team of independent clinical advisers.

The flowchart below explains our process in more detail. We take decisions based on the individual circumstances of the case and after a careful examination of all the evidence.

Our complaint handling process



Resolution through intervention
At any stage of the assessment process the Ombudsman's Office may attempt resolution through intervention. *The body complained about is asked to provide a remedy which resolves the complaint without the need for an investigation.*

The Ombudsman's Principles

We judge complaints against the framework for good administration, complaint handling and remedy set out in the *Ombudsman's Principles*, available on our website. The Principles outline what we expect when public bodies deliver services and the questions we ask in deciding whether maladministration and service failure have occurred.

There are six Principles:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right, and
- Seeking continuous improvement.

Health complaints to the Ombudsman 2009-10

In 2009-10, the first full year of the new system for health complaints, we received 12,889 enquiries, covering 14,429 health complaints[4] – more than double the number of enquiries and complaints received the previous year (6,229 enquiries and 6,780 complaints). We closed 15,579 complaints successfully: this is higher than the number of complaints received during the year because the resolution of some complaints was carried over from the year before.

Over half the complaints we closed (58 per cent) were not properly made (as required by our legislation) or were premature. Complaints may be classed as premature if the complainant has not made a complaint to the NHS body concerned, or if more needs to be done to resolve the complaint locally. Sometimes the complainant may be unsure of the status of their complaint and in these cases our involvement can clarify the situation and ensure that further work is done locally to provide a satisfactory conclusion.

If a complaint has come to us in good time and has been properly made, we may decide not to accept it for investigation for a variety of reasons. We may conclude that the NHS body has acted correctly or reasonably or, where there have been errors, that the complainant has already been offered appropriate redress.

During the year we accepted 346 complaints for investigation and resolved a further 219 complaints by intervening directly with the body complained about, without the need for a full investigation.

Resolving complaints through intervention

If a complaint is within our jurisdiction, has been properly made and the local complaint process has been completed, we will conduct a detailed further assessment of the issues raised. If we identify some indication of maladministration, service failure or evidence of injustice, we may be able to resolve the complaint quickly and effectively by adopting a more informal and flexible approach than a full investigation. This involves asking the body in question to provide an appropriate remedy, such as an apology and/or explanation, or compensation for clear or admitted errors. Not all complaints are suitable for interventions of this type, but those which are generally present a clear, simple and achievable remedy.

The 219 interventions made in 2009-10, resulted in 246 outcomes for complainants[5] including payments for financial loss or inconvenience and action by the body concerned to put things right. This action might involve securing a hospital or GP appointment for a patient or asking for a more detailed explanation about their care and treatment. As figure 2 shows (see page 16), 25 per cent of the outcomes we achieved through intervention in 2009-10 resulted in an apology for the complainant. When mistakes have been made, apologies cost the NHS nothing, are simple to deliver and recognise the value of the patient as a person and the impact their experience has had. This simple act can often make a significant difference to complainants, allowing them to put the matter behind them and move on with their lives.

[4] An enquiry is a request for us to investigate. Enquiries can contain more than one complaint. For example, an enquiry may consist of complaints about two separate bodies.

[5] A single intervention can result in more than one outcome.

Key figures

2009-10

15,579

health complaints closed by the Ombudsman in 2009-10

58%

of complaints closed were premature or not properly made

219

complaints resolved by intervention

63%

of complaints investigated upheld or partly upheld

25%

of intervention outcomes included the NHS agreeing to apologise

Poor explanation or an incomplete response were the most common reasons recorded for dissatisfaction with NHS complaint handling.

The attitude of NHS staff was the second highest category of complaints recorded by subject.

Figure 1: Types of closed health complaints

2009-10

Outside our remit
351

Not properly made*
4,496

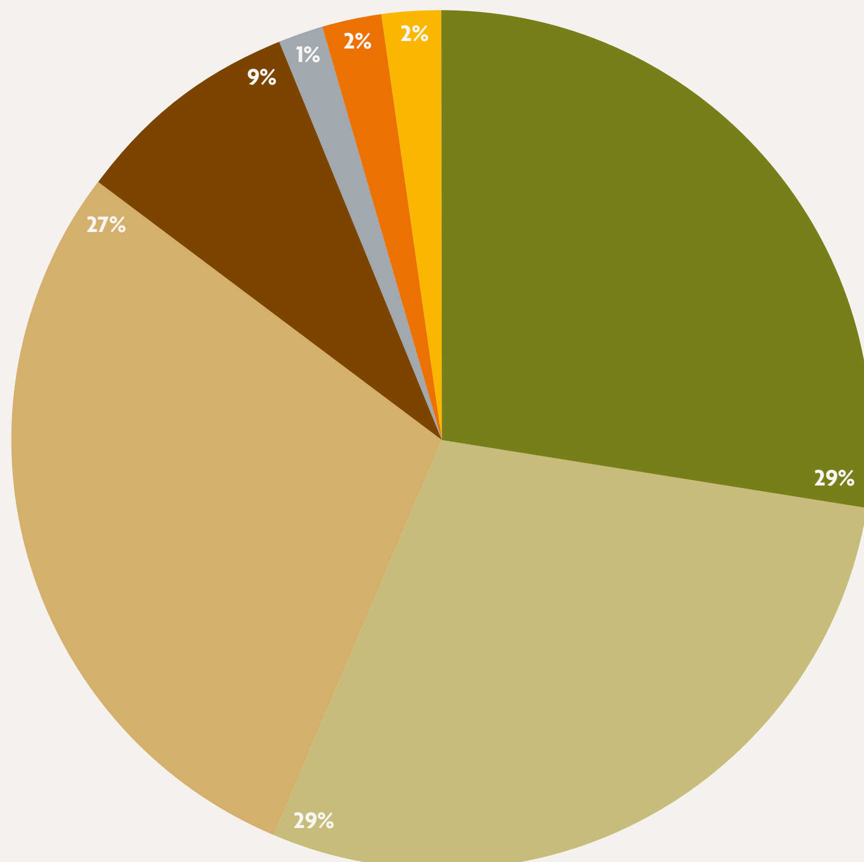
Premature**
4,515

Discretionary***
4,279

Withdrawn by the complainant
1,373

Intervention
219

Accepted for investigation
346

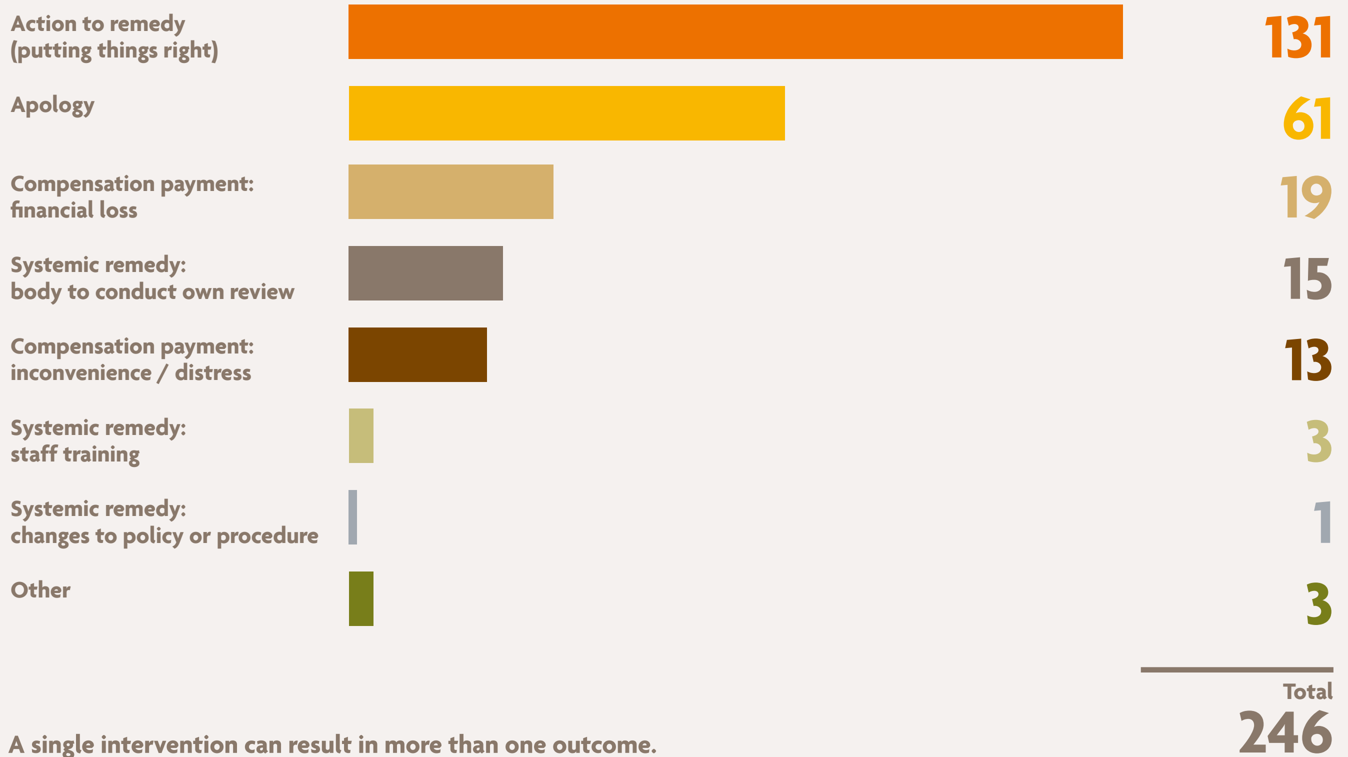


Total
15,579

The percentages do not add up to 100 per cent due to rounding.

* Not properly made: health complaints not made in writing as required by legislation.
** Premature: for example, the complainant has not attempted to resolve the complaint at a local level first or has not completed that process.
*** Discretionary: we may decide not to accept a complaint for investigation for a variety of reasons, for example we may feel that the body has acted correctly, reasonably or, where there have been errors, that the complainant has already been offered appropriate redress.

Figure 2: Intervention outcomes



A single intervention can result in more than one outcome.

Intervening to secure proportionate remedy

Mrs T was, unknowingly, placed on the wrong consultant's list. She did not realise this error until she arrived at the hospital for her appointment. As she had taken a day off work and had had a substantial journey for no purpose, she asked for reimbursement of her costs. The trust agreed to pay her travel costs, but refused to contribute to her loss of earnings. The total sum Mrs T requested was £85.25. We considered that this was reasonable and, following our intervention, the trust agreed to make the payment.

Intervening to ensure impartial treatment

Ms K complained about the way in which a care programme review had been carried out and wanted acknowledgement of her own version of events. Whilst the trust had accepted there were shortcomings, it had not apologised. Following a review of the correspondence and records and contact with Ms K and trust staff, we intervened to secure a written apology from the trust, together with an offer to include Ms K's account of that meeting within her records.

Providing better explanations through intervention

Mrs B complained to us, distressed that her late mother may not have received adequate care from her GP practice and frustrated that the practice had not dealt with all her concerns satisfactorily.

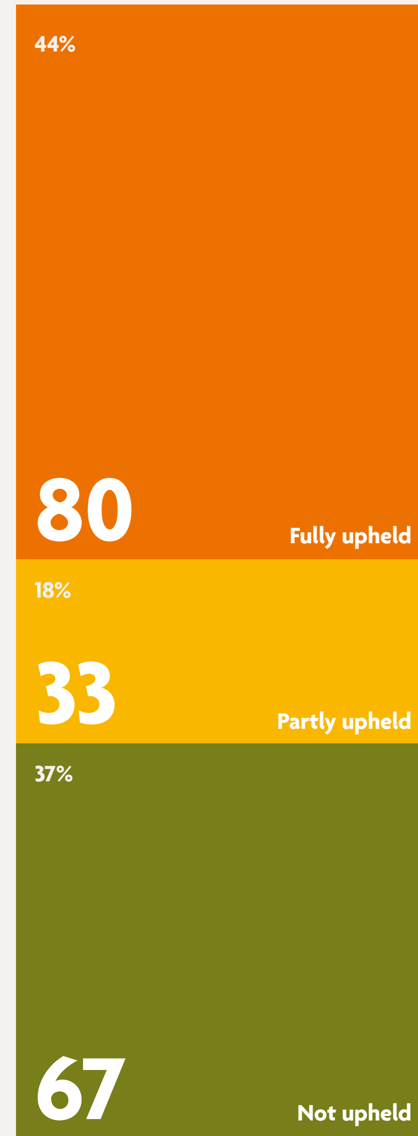
We reviewed all the relevant correspondence, notes of meetings and clinical records from the practice and spoke to Mrs B herself. We took clinical advice on the management of her late mother's health, which was assessed as appropriate. We considered the way in which Mrs B's complaint had been handled and discussed the identified shortcomings with the GP practice. The practice agreed that Mrs B should have had a more timely response, with fuller explanations, in the first place.

Within three months of receiving the complaint, we had written to Mrs B reassuring her about the management of her late mother's health and confirming that the handling of her complaint could certainly have been better. As a result, the practice agreed to write and apologise to her.

'I wrote a formal letter of complaint to the Chief Executive of the Trust, which was ignored.'

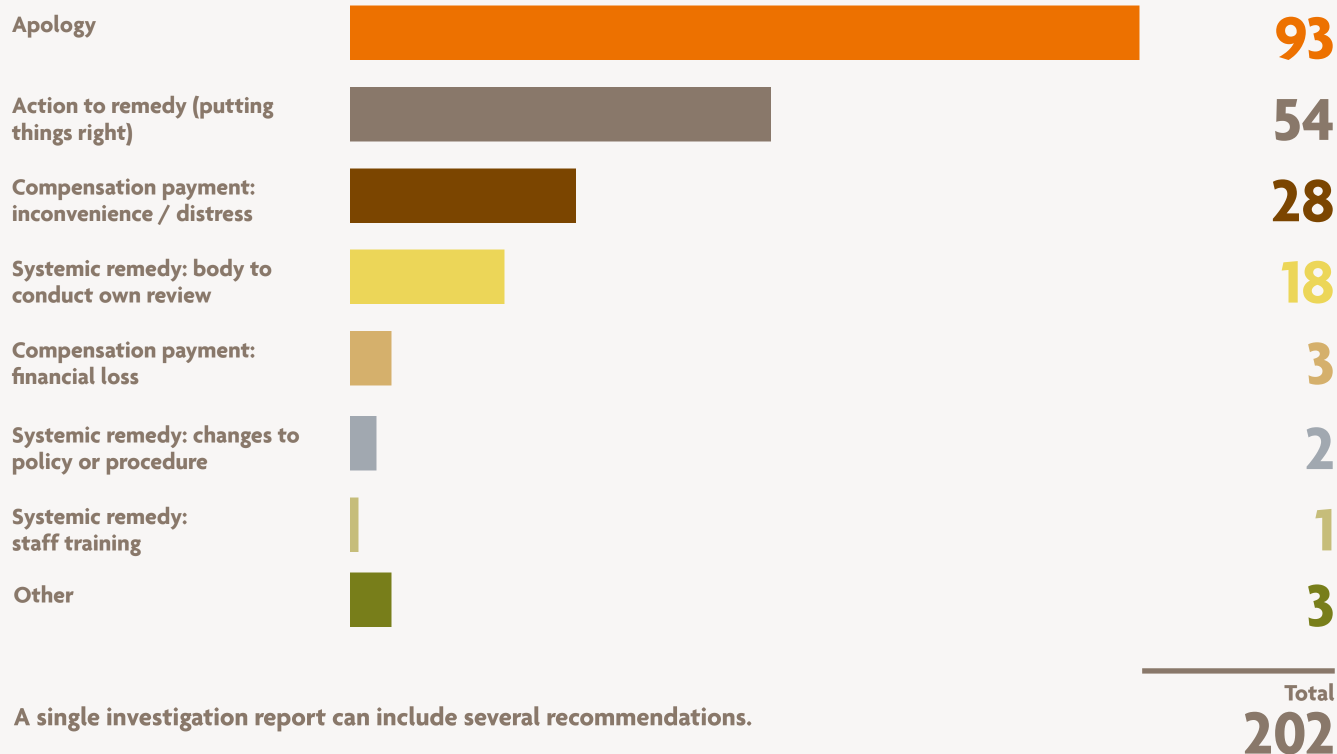
Letter to the Ombudsman from a complainant.

Figure 3: Health complaints reported on



The percentages do not add up to 100 per cent due to rounding.

Figure 4: Health investigation recommendations



A single investigation report can include several recommendations.

Investigating complaints

Where our detailed further assessment shows evidence of service failure and injustice, and the matter is too complex or difficult to be resolved through intervention, the complaint will be referred for an investigation. Investigation involves the gathering and in-depth consideration of detailed evidence.

During the year, we completed and reported on 180 complaints that had been accepted for investigation. Of those, a total of 113 were fully or partly upheld; the remainder were not upheld. Our fully or partly upheld investigations included 202 recommendations[6] for the NHS body or practitioner concerned.

There are a wide range of appropriate responses to a complaint that has been upheld. These are detailed in the Ombudsman's *Principles of Good Complaint Handling* and include:

- an apology, explanation and acknowledgement of responsibility;
- remedial action, which may include reviewing or changing a decision on the service given to an individual complainant; revising published material, procedures, policies or guidance to prevent the same thing happening again; training or supervising staff; or any combination of these; and

[6] A single investigation report can include several recommendations.

- financial compensation for direct or indirect financial loss, loss of opportunity, inconvenience, distress or any combination of these.

Nearly half of our recommendations included the need for an apology, in comparison with 15 per cent which involved some form of compensation payment.

Reasons for complaints

Health complaints brought to the Ombudsman often relate to the most difficult times in people's lives. An individual may complain about their own experience, or they may be complaining on behalf of a family member or friend. Sadly, those complaints are sometimes about the circumstances leading up to the death of the person concerned.

Complaints can be complex, covering extended periods of time and multiple issues of maladministration or service failure. Identifying the substance of a complaint ensures that we have understood it correctly. We assign a subject keyword to some complaints; the most frequently occurring subjects are listed in figure 5 on the next page. Some complaints cover a range of different issues and can have multiple subject keywords.

Clinical care and treatment forms the largest subject category, followed by the attitude of NHS staff. When these figures are broken down by type of body, clinical care and treatment still generates the largest category, apart from for strategic health authorities where funding is the biggest issue.

For GPs and acute trusts issues about diagnosis are slightly higher than those about attitude of staff, whilst for primary care trusts funding is the second highest category.

We measure complaints against the *Ombudsman's Principles* which sets out our overall standard for complaint handling in public bodies. Often patients and their families bring complaints to us that relate to the way in which the NHS body concerned handled their original complaint. In these cases, we may find that poor complaint handling constituted maladministration or injustice for the complainant, even if we do not uphold their original complaint about the NHS service.

Figure 6 (see page 21) shows the complaint handling subject keywords assigned, where relevant, in 2009-10. Poor explanation forms the biggest subject category, followed by incomplete response or unnecessary delay. When this data is broken down by type of NHS body, poor explanation is still the most common reason for dissatisfaction with complaint handling. For GPs and dentists the second biggest factor is no acknowledgement of mistakes, while for ambulance trusts and primary care trusts the second biggest factor is unnecessary delay.

Stories about the impact these failings can have on NHS service users and their families can be found on pages 22 to 28.

Figure 5: Subject keywords assigned to health complaints

2009-10

Clinical care and treatment
3,705

Attitude of staff
1,043

Diagnosis: delay, failure to diagnose, misdiagnosis
976

Communication and information (including confidentiality)
855

Access to services
625

Funding
571

Medication
365

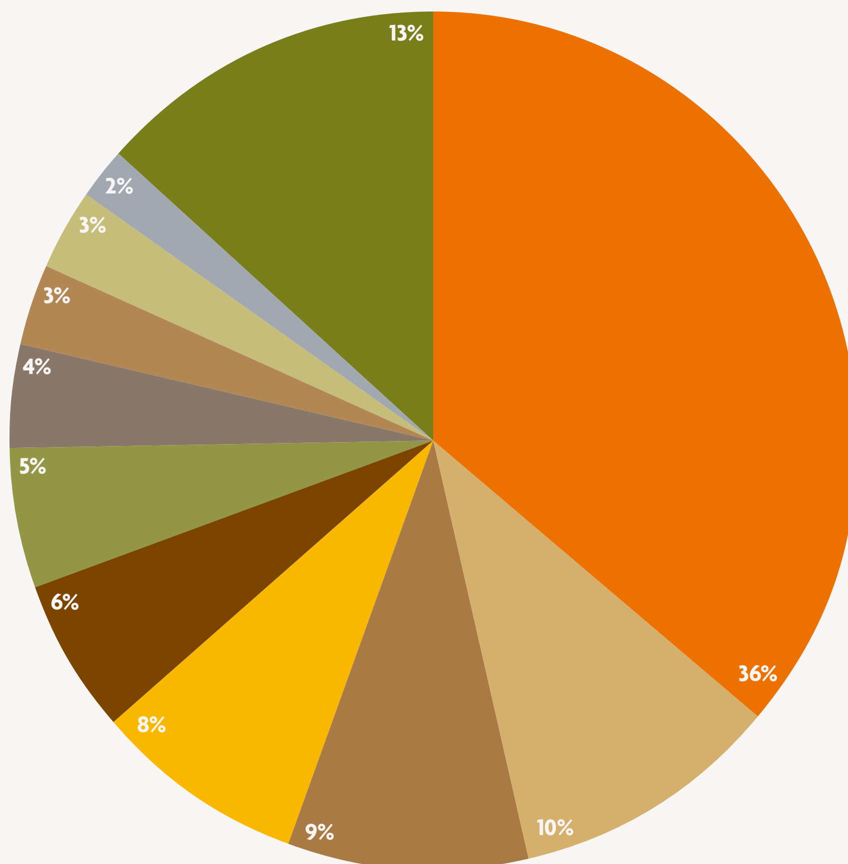
Records
322

Discharge from hospital and co-ordination of services
311

Waiting times
227

Other
1,384

Total
10,384



The percentages do not add up to 100 per cent due to rounding.

Subject keywords reflect the issues raised by complainants. They are assigned to complaints that are not taken forward at the Ombudsman's discretion or because they are premature. Complaints which are taken forward for investigation are assigned further subject keywords according to the issues we identify when investigating the complaint; these may be different from the issues raised by complainants.

Figure 6: Complaint handling subject keywords assigned to health complaints

2009-10

Poor explanation
828

Response incomplete
403

Unnecessary delay
383

Factual errors in response to complaint
298

No acknowledgement of mistakes
296

Failure to understand the complaint and outcome sought by complainant
251

Communication with complainant unhelpful, ineffective, disrespectful
189

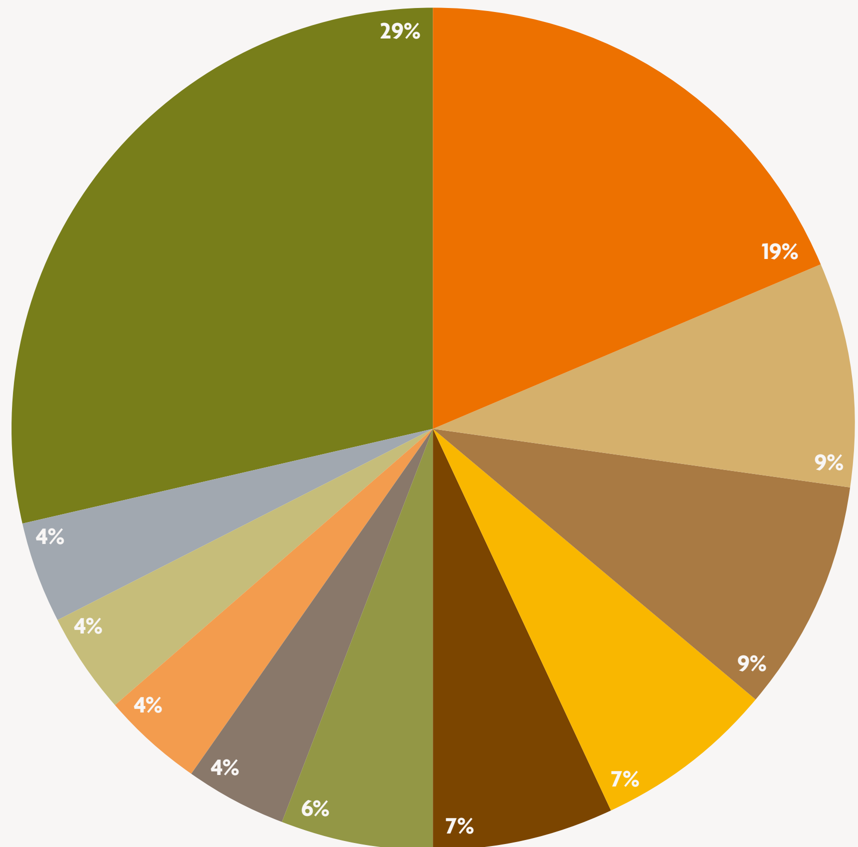
Inadequate financial remedy
188

Inadequate apology
169

Failure to ensure recommendations implemented
162

Other
1,290

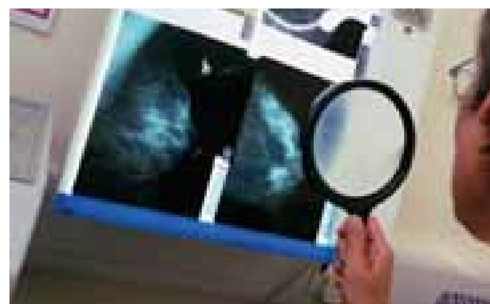
Total
4,457



The percentages do not add up to 100 per cent due to rounding.

Complaint handling subject keywords reflect the issues raised by complainants. They are assigned to complaints that are not taken forward at the Ombudsman's discretion or because they are premature. Complaints which are taken forward for investigation are assigned further complaint handling subject keywords according to the issues we identify when investigating the complaint; these may be different from the issues raised by complainants.

Putting things right: complainants' stories



The NHS Constitution places the needs of individual human beings at the centre of the work and purpose of the service. Respect, dignity and compassion are core values within the Constitution, as is the assertion that everyone counts. The Constitution exhorts NHS staff to work together for patients to improve lives, with a shared vision of quality care.

The stories featured here paint a vivid picture of what happens when something goes wrong and the NHS struggles to put it right. While there are many stories of excellent patient care throughout the NHS, recurring themes are highlighted here – poor communication characterised by incomplete responses to complaints or inadequate explanations, unnecessary delays, factual errors and no acknowledgement of mistakes.

NHS practitioners all work to provide high quality care for their service users. Complaints often come to us because their professionalism has been let down by poor complaint handling, reducing the opportunities to learn from complaints in order to prevent future mistakes, and making it harder to respond to the impact of the failing on patients and their families.

All the people featured here brought their complaint to the Ombudsman when local resolution failed. Some had been battling for years to get their complaints resolved, while others had suffered serious harm or injury as a result of careless or unthinking actions. Two were removed from a practice list or advised to seek treatment elsewhere following their complaint. Sometimes this happens following aggressive or abusive behaviour towards NHS staff. Such behaviour is never acceptable, but a patient must normally be given prior warning of deregistration, providing the opportunity for both sides to address problems and rebuild the relationship.

The Ombudsman's impartial perspective allows us to see those involved in complaints not just as patients, or practitioners, but as individuals.

By taking account of people's needs beyond their medical treatment or health care, we can help to reinstate the values of the NHS Constitution in situations where they have been forgotten or overlooked.

'It is disappointing that my complaint cannot be handled in a way which I would see fit as I have not received any answers to my questions, merely a small apology, which is not enough for the loss of an amazing lady.'

Complainant's description of a trust's complaint handling.

Being open and accountable

Mr K's doctor responded inappropriately when Mr K complained that his treatment for a heart attack had been delayed because his condition had not been assessed thoroughly.

Mr K's story

When Mr K experienced pain in his shoulder, neck and chest and intense pins and needles in his fingers, he rang his GP practice. He told the nurse that whilst he first thought the pain was posture-related, he was worried that he had a serious chest condition. Mr K saw a GP the same day, who thought the cause of his pain was muscular. A week later, the same GP gave Mr K an ECG and he was taken to hospital. On the way there, another ECG indicated he had suffered a heart attack.

Mr K complained to the practice that the GP had dismissed his symptoms, accepting the nurse's initial assessment of a posture problem. At a meeting with Mr K, his GP and the senior partner apologised for the delay in diagnosing Mr K's heart attack, but said that an earlier diagnosis would have made no difference to his condition. The practice outlined the changes made following his complaint, including plans to *'over-investigate'* patients with chest pain, which they described as *'defensive medicine'*.

What our investigation found

Our investigation found that the GP failed to assess appropriately the possibility that Mr K was having, or was at risk of, a heart attack. A more thorough assessment might have led to earlier hospital admission, which might have helped prevent his heart attack.

When Mr K complained, the practice's attempt to resolve his complaint showed a lack of understanding of effective complaint handling. The complaint process took too long, and comments made by practice staff at the meeting were inaccurate, inappropriate and misleading. The decision to *'over-investigate'* patients with chest pain in future was not an appropriate or proportionate response and their reference to *'defensive medicine'* suggested that the practice had not learnt from the complaint.

What happened next

The Ombudsman upheld Mr K's complaint about the practice. As a result of the recommendations contained in our report, the practice acknowledged the service failure experienced by Mr K, and apologised to him for it. The partners at the practice prepared an action plan, which they shared with Mr K, and which detailed the lessons they had learnt from his complaint and the actions they were taking as a result. These included better guidance and training for clinical staff in treating patients with chest pain, adoption of NHS complaints procedures and better record keeping, to help prevent inaccuracy or the misinterpretation of complaints in future. Mr K wrote to us: *'I am so grateful that my complaint has been upheld'*.

Bearing in mind individual circumstances

When Mrs L complained about a dentist's refusal to treat her teenage son, who has special needs, the dental practice responded by suggesting she seek treatment for him elsewhere.

R's story

R, a 15 year old boy with Asperger's syndrome, attended an appointment at the dental practice where he had been registered for 13 years. The dental surgeon, Dr M, abandoned the examination without treating him.

R's mother, Mrs L, complained that Dr M failed to take R's special needs into account and that her attitude, lack of compassion and unprofessional behaviour meant that R did not receive the dental treatment that he needed on that day.

In response, the practice said that Dr M had acted properly, that R had used abusive language and that it would be in his best interests to seek treatment with another dentist.

Mrs L brought her complaint to the Ombudsman, saying she had concerns about Dr M's suitability to treat children. She said that the response to her complaint, and the allegation that her son had been abusive, added to her distress about the abandoned appointment.

What our investigation found

There were differing accounts of what took place during R's dental appointment. We were unable to reconcile them and reach a finding about Dr M's conduct on that day.

However, we found that in responding to Mrs L's complaint, the practice and Dr M failed to act in line with professional guidelines and their own complaints policy. They were defensive, did not offer an apology or practical solution and failed to show that lessons had been learnt from the complaint, or services improved as a result.

The decision that R should seek treatment elsewhere was hasty, showed a lack of understanding and was disproportionate given the isolated nature of the incident. (R had been examined successfully by Dr M twice in the previous 14 months.) We partly upheld the complaint as both the practice and Dr M's responses fell significantly below the applicable standard and caused distress to Mrs L and her son.

What happened next

At our recommendation, the dental practice and Dr M apologised in writing to Mrs L and forwarded action plans outlining the steps they would take to ensure the same mistakes were not repeated. Mrs L told us: *'I look forward to receiving a copy of the action plans ... which will provide some reassurance that people in R's situation will receive a better service in future'.* In addition, Dr M made a payment of £500 in recognition of the distress and inconvenience caused to Mrs L and the unfair decision that R should seek treatment elsewhere.

The practice acknowledged that they had not adhered to professional guidelines in responding to the complaint and that they had been remiss in not offering to meet Mrs L to discuss the problem. They said that they should have apologised and researched the needs of patients with Asperger's syndrome. The practice said that in future they would invite patients with anxiety about dental treatment to visit the practice beforehand and meet informally with staff to help allay their fears.

Being customer focused

When Miss M had a disagreement with her GP surgery about receiving appointment reminders by text message, the surgery sent her a text informing her she was being removed from their list.

Miss M's story

Miss M attended her local doctors' surgery to register as a patient. While she was completing the registration forms, Miss M had a disagreement with the surgery's receptionist about the availability of text message appointment reminders. Miss M wanted to receive reminders in this way, but the receptionist told her this service was not yet available, although there was a question about it on the registration forms.

Miss M's registration forms were forwarded to the primary care trust and she was registered on the surgery's list. However, the following day she received a text message from the surgery telling her that she was not being accepted onto their list because she had been *'rude'* and *'uncivil'*.

Miss M complained to us that her registration on the surgery's patient list was declined. She said that although she had received a response to her complaint from the surgery, she remained dissatisfied and upset that she had not been given a satisfactory explanation about what she said or any behaviour that she displayed that caused such offence that her registration was declined.

What our investigation found

NHS regulations[7] say that a contractor, such as a GP surgery, which has reasonable grounds for wishing a patient to be removed from its list of patients should notify the patient of those reasons. Normally a contractor may only request a removal if, within the period of 12 months prior to the date of its request, it has warned the patient that he or she is at risk of removal and explained the reasons for this.

We found that the decision to remove Miss M from the list without prior warning was a clear breach of these regulations and the Ombudsman upheld her complaint. The surgery's actions had not been customer focused – they did not accept Miss M onto their list because of a seemingly minor incident and then informed her of this decision by text message, which was the reason for the original disagreement.

What happened next

At our recommendation the surgery apologised to Miss M for the distress and inconvenience caused by her removal from their list in breach of the relevant regulations. They also undertook to provide Miss M with details of action taken to ensure that their staff were trained in the regulations on the removal of patients from practice lists, and to improve their staff's customer focus.

[7] *NHS General Medical Service Regulations 2004.*

Having clear and simple procedures

When Mrs V complained about her medical treatment during labour, it took nine months for hospital staff to arrange a meeting to discuss the matter.

Mrs V's story

Mrs V suffered discomfort and distress during her labour when a midwife at North West London Hospitals NHS Trust administered intravenous antibiotics in her arm incorrectly. This made her arm red, swollen and painful. Although the midwife took remedial action, the symptoms lasted for six weeks, causing pain and inconvenience in trying to look after her new baby. Mrs V complained that she had suffered unnecessary stress during a crucial part of her labour.

The Trust replied that the administration of the drug had been checked in accordance with their policy and that the correct dosage had been prepared. However, the drug had been insufficiently diluted by the midwife, causing the swollen painful arm. The Trust apologised for the incident, concluding that training would be undertaken to learn from the complaint and the drug policy would be reviewed. When Mrs V asked for a meeting to discuss the matter, it took 39 weeks to arrange.

In her complaint to the Ombudsman, Mrs V told us that the Trust's handling of her complaint added to her frustration and unhappiness. In her view, the Trust had taken an unacceptable length of time to produce an unconvincing conclusion, with no evidence of the lessons learnt.

What our investigation found

There was no doubt that an error occurred in the way the drug was administered to Mrs V. Yet our investigation into the way Mrs V's complaint was handled revealed that the Trust's response was inaccurate and staff had not complied with the drug administration policy. Moreover, the Trust were wrong to focus solely on the error by the midwife: the doctor prescribing the drug had failed to follow procedures and the delivery suite co-ordinator had not fulfilled her responsibilities properly either. The investigation into Mrs V's complaint was inadequate and took too long; it failed to establish the facts and to identify wider, possibly systemic, problems.

What happened next

We upheld Mrs V's complaint and, as a result of our recommendations, the Trust apologised and gave Mrs V a thorough account of what had happened to her and the failings in her treatment. They also made her a payment of £200 in recognition of the delays and inconvenience caused to her.

At our recommendation, the Trust also reinvestigated the incident, and formulated an action plan to demonstrate the learning and the changes required to prevent a similar thing happening again. That action plan was shared with Mrs V, who wrote to us: *'I am writing to thank you for all your efforts and understanding of my complaints against the North West London Hospitals NHS Trust'*. Mrs V hopes that others will benefit from changes to the Trust's policy for administering medication as a result of her complaint.

Acting fairly and proportionately

After Mr F broke both legs whilst being transferred home from hospital, the North West Ambulance Service NHS Trust failed to provide an unbiased account of what had gone wrong.

Mr F's story

Mr F, who was 88 and had a history of bone cancer and osteoporosis, was discharged from hospital to his home. His daughter, Mrs P, later complained that while helping Mr F from a wheelchair to his own chair, the crew from North West Ambulance Service NHS Trust had not given him adequate support and he had fallen heavily to the floor. She said that when Mr F spoke of pain in his leg, the crew did not check for injury, but advised him to call 999 if the pain worsened. Later that evening, Mr F was admitted to hospital and fractures were found in both legs. Mrs P complained to the Ombudsman about the conduct of the Trust's investigation and that they had not given her a proper explanation of what had happened.

What our investigation found

Although the Trust made a reasonable attempt to establish the facts of the case, we found shortcomings in the way the investigation was carried out.

The Trust's investigator took statements from the ambulance crew and Mrs P's family, but because of differing accounts, could not conclude with certainty what had actually happened.

Despite this, the letter sent by the Trust's chief executive in response to Mrs P's complaint appeared to accept the crew's version of events over the family's without any reasonable justification. The Trust had not addressed all of the points that Mrs P had complained about, including her complaint that the crew had not acted appropriately after Mr F complained of pain. The Trust also speculated that Mr F's bone cancer left him prone to fractures, although they did not have a full understanding of his clinical condition.

We upheld Mrs P's complaint. We concluded that the Trust's failure to provide a thorough, unbiased response to Mrs P's complaint added to her distress at what was already a difficult time.

What happened next

At our recommendation, the chief executive of the Trust wrote to Mrs P to apologise for mishandling her complaint and for not providing her with a thorough and unbiased response. He acknowledged that when Mr F complained of pains in his legs, further medical care should have been arranged and proposed to remind staff in future to seek A&E back-up when injury cannot be ruled out.

The Trust also prepared an action plan aimed at preventing a recurrence of what had gone wrong. That has led, among other things, to a review of the Trust's complaints policy and changes to the investigation training programme. This includes ensuring that all aspects of a complaint received are investigated and answered, and that any conclusions reached as a result of an investigation into a complaint are proportionate, appropriate, fair, open and accountable.

Seeking continuous improvement

When Mr C complained about the length of time his young son, J, had to wait for a suitable wheelchair, the service did not improve, despite Plymouth Teaching Primary Care Trust's attempts to reduce the delays.

Mr C and his son J's story

J, aged 7, has cerebral palsy and requires the constant use of a wheelchair. He is a growing child, and regularly outgrows his wheelchairs, which are provided by Plymouth Teaching Primary Care Trust (the PCT) Wheelchair Services.

J and his parents experienced substantial delays, having to wait several months before the PCT acted on requests for first, an initial wheelchair assessment and, later, adjustments to the chair or replacements. Between March 2005, when J was first referred for a wheelchair, and January 2009, he had to wait around eight months on three separate occasions for an appropriate wheelchair or for adjustments to be made so that his wheelchair was suitable for him to use. These delays meant that J was forced to use a wheelchair that was too small for him, or that his family had to carry him or push him in a pushchair.

Mr C complained about the delays, but, although he received replies from the PCT, the service the family received did not improve.

What our investigation found

The delays J had experienced were excessive and had caused him and his family significant distress and inconvenience. Having either no wheelchair at all, or using one that was unsuitable affected J's schooling and he had to cope with further attention being drawn to his disability amongst his peers.

It was clear that the service the PCT were providing did not address the fact that children using wheelchairs will regularly require assistance to either adjust the chairs, or obtain new ones without delay. In total, J had spent more than two of his seven years waiting for wheelchairs, or for adjustments to his wheelchairs. We accepted that the PCT had attempted to improve their service but it was clear that this had not specifically helped J or his family. Instead, the failure to address the issues in Mr C's complaint had compounded their frustration and distress.

What happened next

The PCT apologised to Mr and Mrs C for the injustice their family had suffered as a result of both the original delays and the failure to respond appropriately to their complaint. They told us that they had reduced the average waiting times for paediatric wheelchair service users to eight weeks, and were working to reduce this even further.

We recommended that the PCT make a payment of £5,000 in compensation to Mr and Mrs C, which could be used to fund a new wheelchair for their son. Mr C told us: *'I am delighted that you made such recommendations and when told of them last week I felt quite emotional. This has already felt like a pretty long journey and I know there's much more to come, but for now this feels like very positive news, when so often we're faced with disappointment.'*

NHS complaint handling performance 2009-10

NHS providers must produce an annual report on their complaint handling performance specifying the number of complaints received and the subject matter; the number which were considered well-founded; the number referred to the Health Service Ombudsman; and any action which has been taken to improve services as a result of those complaints.

The national data on complaints, interventions and investigations we publish here, broken down by strategic health authority as well as by type of NHS body, complements this local reporting. This is important information: details of complaints can provide early warning of failures in service delivery, or can show areas of improvement, reflecting a body's commitment to learning from feedback. Our snapshot of complaints received and investigated can help support improvement not just on a local level, but across the NHS in England.

Complaints received

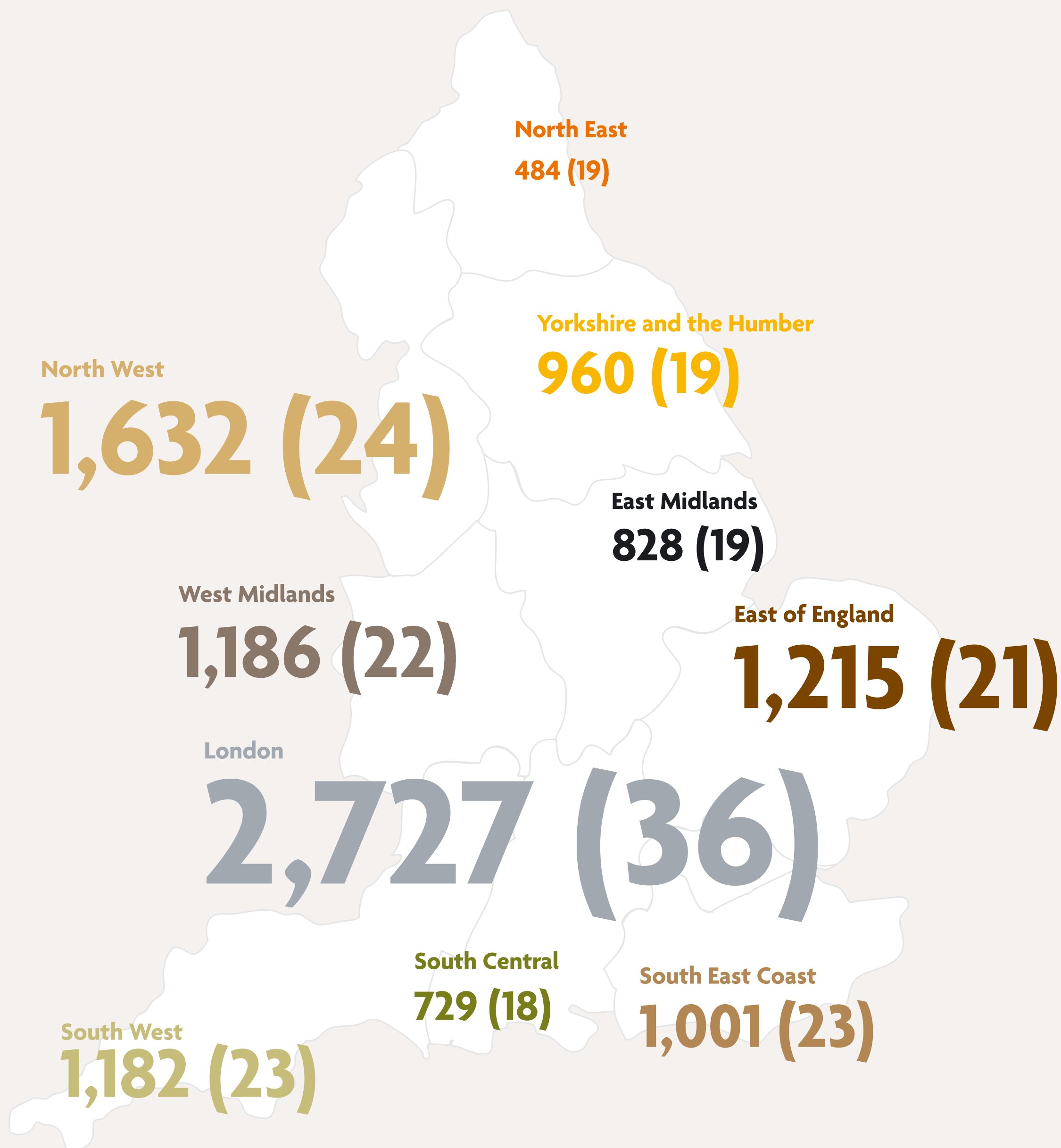
Figure 7 shows the health complaints received by the Ombudsman in 2009-10, grouped by the strategic health authority region in which they originated. To account for the difference in population in each region, the figure in brackets shows the number of complaints received per 100,000 inhabitants.[8]

There were more complaints to the Ombudsman about NHS trusts and primary care practitioners in the London strategic health authority region than any other, reflecting the inclusion of six London acute trusts in the most complained about trusts (see page 41). The rate for London is twice that of the South Central region and it is unclear why there is such a disparity. Large numbers of complaints received do not necessarily result in an equivalent number of investigations and could be a result of good signposting to the Ombudsman, or an open and accountable approach to handling complaints.

[8] Office of National Statistics 2008 mid-year population estimates.

Figure 7: Health complaints received, by strategic health authority region

2009-10



Complaints received per 100,000 population are shown in brackets.

Figures do not include complaints relating to the Healthcare Commission, special health authorities or where the strategic health authority is unknown.

The pie chart below shows the number of complaints received by type of body.
At 44 per cent, complaints about acute trusts make up the biggest proportion of the health complaints that the Ombudsman receives. General practitioners (GPs) and primary care trusts both account for 17 per cent of the complaints that the Ombudsman receives.

Figure 8: Health complaints received, by type of body

2009-10

NHS hospital, specialist and teaching trusts (acute)
6,304

Foundation trusts	2,672
Non-foundation trusts	3,632

General practitioners
2,419

Primary care trusts
2,411

Mental health, social care and learning disability trusts
1,393

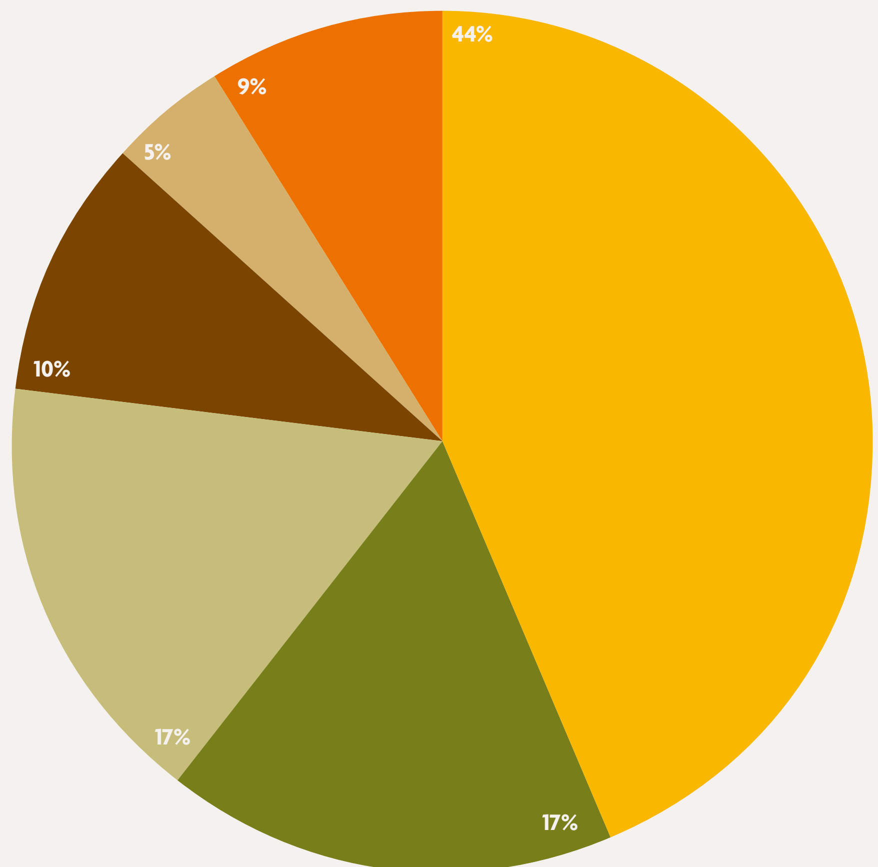
Foundation trusts	798
Non-foundation trusts	595

General dental practitioners
659

Other
1,243

Healthcare Commission	531
Strategic health authorities	300
Ambulance trusts	216
Special health authorities	85
Pharmacies	62
Care trusts	31
Opticians	18

Total
14,429



The percentages do not add up to 100 per cent due to rounding.

Interventions

Our intervention with an NHS body as a result of a complaint offers the chance for timely and effective resolution, without the need for a lengthier formal investigation. More information about the different types of intervention we conduct is available on pages 16 and 17.

In 2009-10 we resolved 219 complaints by intervention. Figure 9 shows the breakdown of those interventions by strategic health authority region. As might be expected from the high number of complaints received, we intervened with trusts in the London region more than with any other.

In the coming months we will start to provide tailored feedback about our assessment of a trust's complaint handling performance where our interventions have indicated that further work could be done locally to improve the response to complainants.

Complaints accepted for investigation

Figures 10 and 11 on pages 34 and 35 show the health complaints we accepted for investigation broken down by strategic health authority and type of body.

The South East Coast strategic health authority region had the highest rate of complaints accepted, at 0.96 per 100,000 inhabitants, double that of both the South Central and North East regions (both 0.47 per 100,000 inhabitants), and nearly three times the rate for Yorkshire and the Humber (0.35 per 100,000 inhabitants). This higher rate reflects a particular issue around continuing healthcare funding and this is described in more detail in the adjacent box.

Early warning – complaints about South East Coast Strategic Health Authority

When we received a high number of complaints about continuing healthcare funding we took action to resolve the problem directly with the relevant health authority.

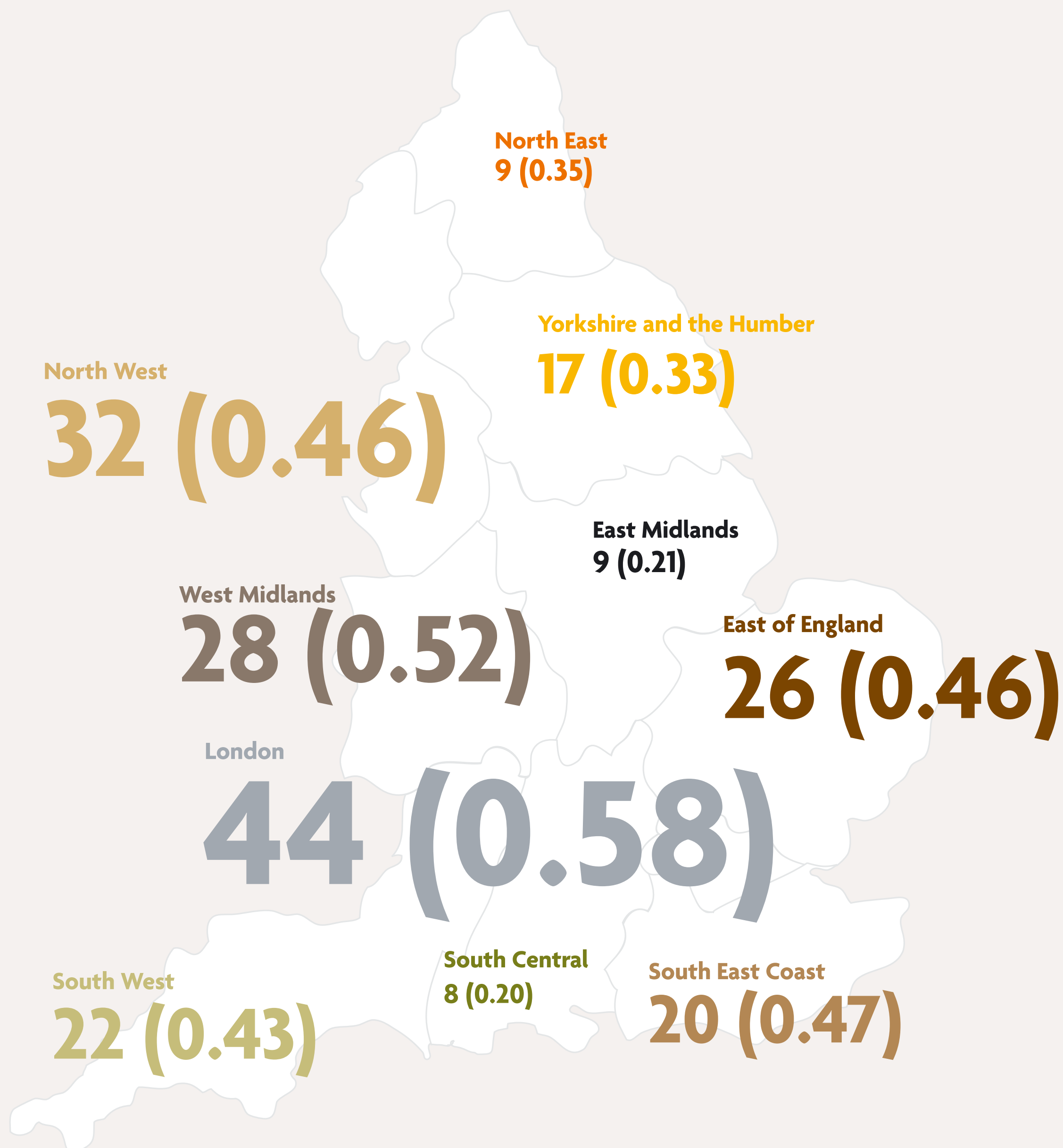
The NHS provides funding for the long term continuing care of people who need it because of accident, illness or disability. In 2003, the Ombudsman reported that some people were paying for their care, when the NHS should have been doing so. The recommendations in that report, and those of two subsequent reports, were taken forward and led to the establishment of a national framework for eligibility criteria.

The number of complaints we receive about this issue annually has fallen from thousands to hundreds over the past seven years. In 2009-10 we received 539 complaints from people who were dissatisfied that their claims for continuing healthcare funding had been turned down. Most of these complaints were premature, or could be resolved without the need for an investigation but of the 16 complaints we accepted for investigation, 12 were about the South East Coast Strategic Health Authority (the Authority).

We brought this geographical cluster to the attention of the Authority's chief executive and met with her staff to provide more information and agree a way forward. Following a further meeting the Authority told us that they now had a much clearer understanding of our perspective on the complaints and the way we work. Since then, substantial progress has been made in resolving the complaints.

Figure 9: Health interventions, by strategic health authority region

2009-10

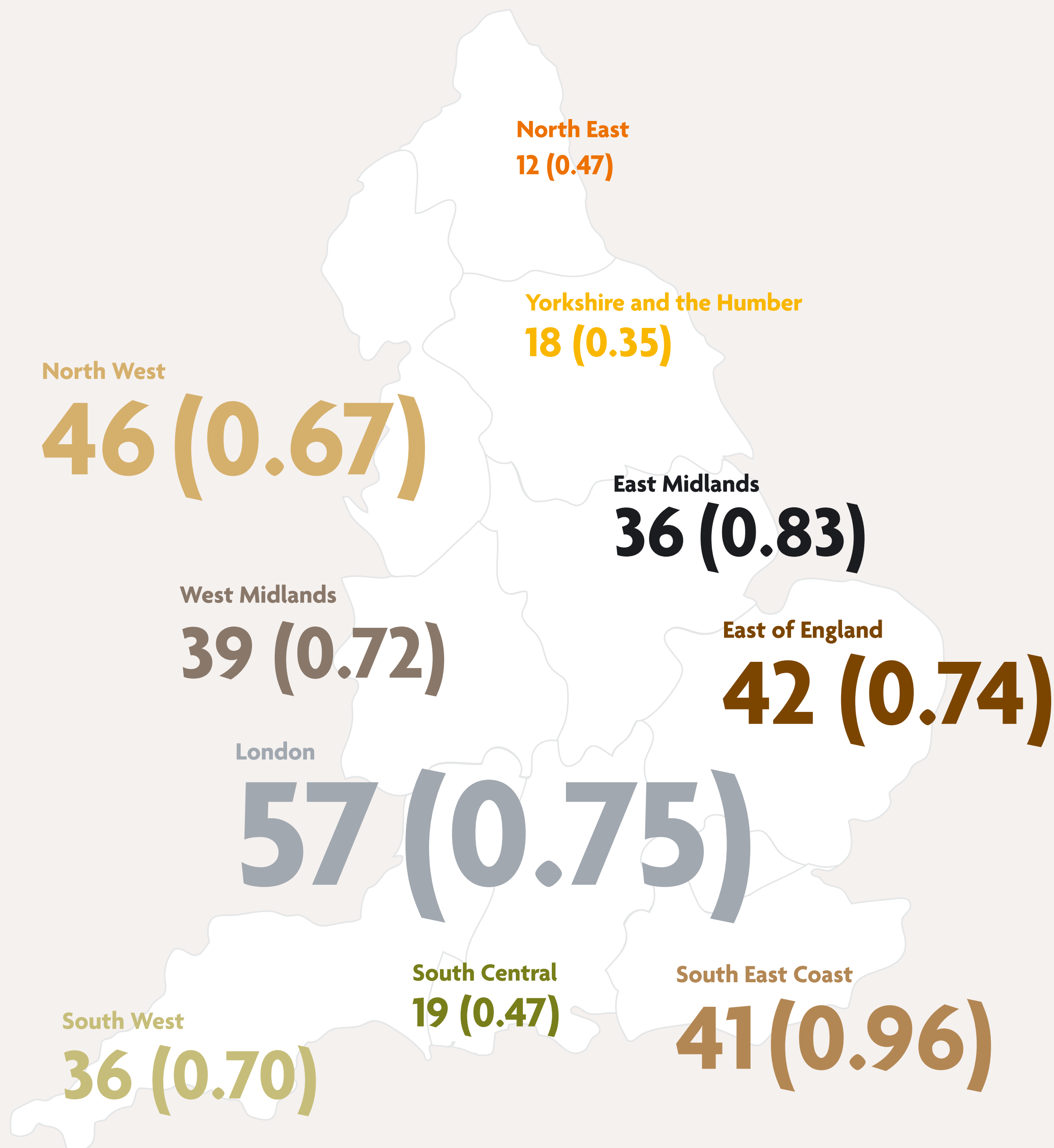


Complaints resolved through intervention per 100,000 population are shown in brackets.

Figures do not include complaints relating to the Healthcare Commission or special health authorities.

Figure 10: Health complaints accepted for investigation, by strategic health authority region

2009-10



Complaints accepted per 100,000 population are shown in brackets.

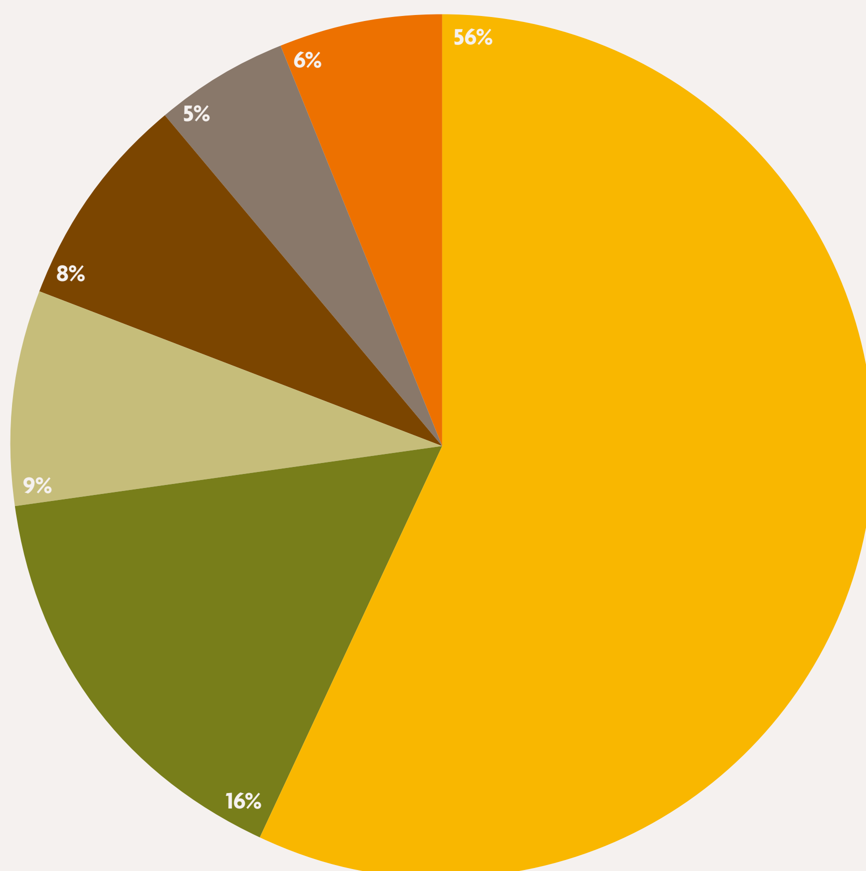
Figures do not include complaints relating to the Healthcare Commission, or special health authorities.

As the pie chart below illustrates, 56 per cent of health complaints accepted for investigation were about acute trusts, with GPs making up the second largest group at 16 per cent.

Figure 11: Health complaints accepted, by type of body

2009-10

NHS hospital, specialist and teaching trusts (acute)	**195**
Foundation trusts	69
Non-foundation trusts	126
General practitioners	**57**
Primary care trusts	**30**
Mental health, social care and learning disability trusts	**26**
Foundation trusts	14
Non-foundation trusts	12
Strategic health authorities	**16**
Other	**22**
Ambulance trusts	12
General dental practitioners	9
Pharmacies	1
Healthcare Commission	0
Special health authorities	0
Opticians	0
Care trusts	0
Total	**346**



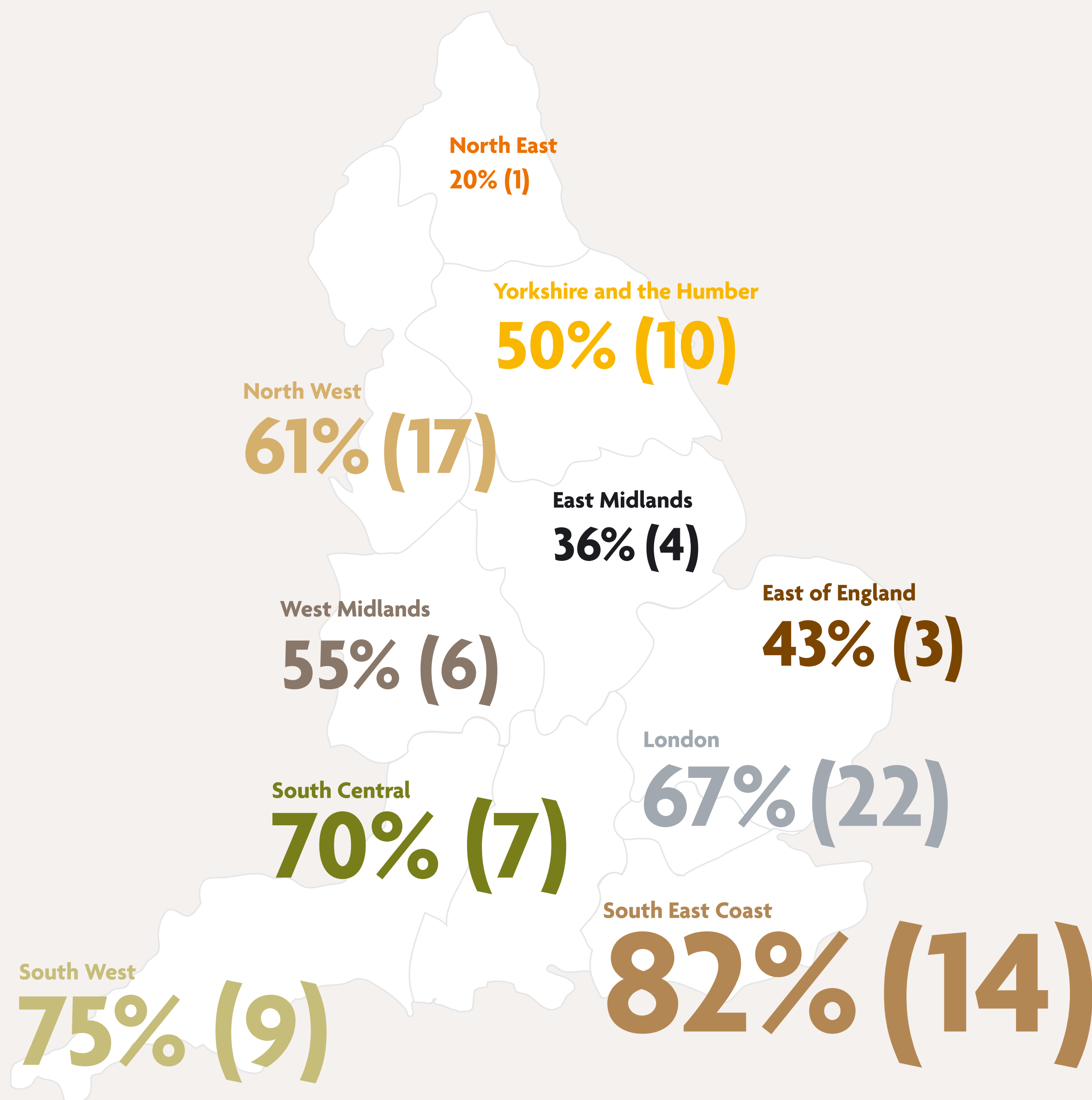
Investigated complaints

In 2009-10 we reported on 180 health complaints. Figure 12 depicts the numbers and percentage of complaints investigated that were upheld or partly upheld, broken down by strategic health authority region. The figures include complaints about primary care practitioners and trusts located within that region and about the strategic health authority itself.

Although the numbers involved are relatively small, there is considerable variation between the regions. While in the North East region only 20 per cent of complaints investigated were upheld about a trust or primary care practitioner (there were none about the strategic health authority itself), in the South West region 75 per cent of complaints investigated were upheld about a trust or primary care practitioner (again there were none about the strategic health authority itself). The highest uphold rate is in the South East Coast region where 82 per cent of complaints investigated were upheld about a trust, primary care practitioner or the strategic health authority itself. We are unsure why these disparities exist and will be exploring the reasons for them through our targeted meetings with trusts and at our regional conferences for NHS complaint managers.

Figure 12: Upheld or partly upheld health complaints, by strategic health authority region

2009-10



Total number upheld is shown in brackets.

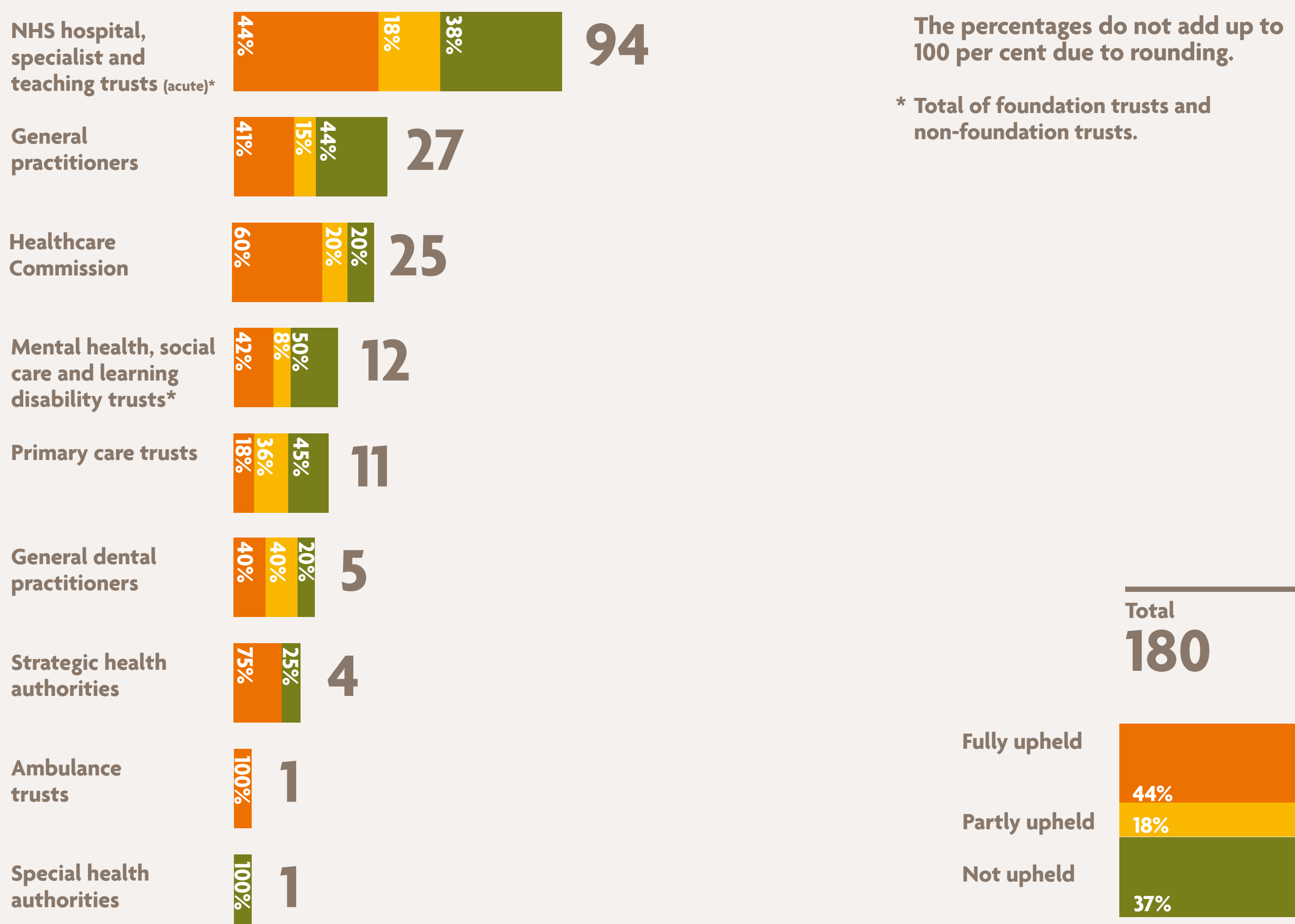
The percentages shown relate to 154 of the 180 health complaints reported on. The remaining 26 complaints consist of 25 about the Healthcare Commission and 1 about a special health authority, which cannot be attributed geographically.

The chart below shows the total number of complaints reported on, broken down by type of body.

The changes to the health complaints system meant that the number of complaints reported on about acute trusts was over three times higher than the year before, consisting of 52 per cent of the total. However, the percentage of upheld or partly upheld complaints about acute trusts in 2009-10 showed only a small change from 2008-09 (down 2 per cent to 62 per cent).

Of the 27 GP complaints reported on in 2009-10, 56 per cent resulted in the complaint being upheld or partly upheld; a significant increase from the 10 per cent uphold rate (from 10 complaints investigated) in 2008-09.

Figure 13: Health complaints reported on, by type of body



‘I am not happy with the response I received from [the Trust]*. I do not believe the questions and concerns I raised were fully answered at either the meeting or the final response letter I received a long time after the meeting. Out of the 34 questions I sent them well before the meeting took place, many questions were either not fully answered or completely ignored.’*

Letter from complainant.

‘If that [complaint] *came in now the first thing we’d be saying to the complainant is ‘What would you like us to do? How would you like us to investigate?’ And we would’ve gone down the right road from the beginning. That’s a major cultural shift.’*

Health organisation respondent,
Ombudsman’s Stakeholder Impact Study.

Most frequently complained about NHS bodies

In the appendix we publish the full list of complaints about NHS bodies received, resolved through our intervention and investigated in 2009-10. This includes:

- the number of complaints received;
- the number of complaints resolved through intervention;
- the number of complaints accepted for investigation; and
- the number of investigated complaints reported on, showing what percentage of those complaints were fully upheld, partly upheld or not upheld.

Here, we extract the data for those bodies that have generated most work for us during the year.

Complaints about the Healthcare Commission, which was disbanded on 31 March 2009, made up the highest number of complaints we received (531 complaints). As time goes on, the number of complaints we receive about the Healthcare Commission is falling, and in order to provide a consistent approach to reporting in future years, those complaints are reported separately here (Figure 15). They include complaints that the Healthcare Commission did not resolve before its closure and which have been taken forward by the Ombudsman.

While the number of complaints received and investigated, and the number of interventions, can provide an indication of a trust's approach to complaint handling, drawing firm conclusions from the data is more complex. A high number of complaints about a particular body need not imply poor service while a single investigation may identify serious consequences arising from a failing in clinical care. We received no complaints about two trusts – Gateshead PCT and Oxfordshire Learning Disability NHS Trust – which could be indicative of either good complaint handling, or poor signposting of patients' right to bring their complaint to the Ombudsman.

The trust generating the most complaints in 2009-10 was Barts and The London NHS Trust, yet with three complaints accepted, it does not rank as one of the trusts with the most complaints accepted for investigation. The same trust features at the top of the interventions list, revealing that on five occasions a formal investigation was not necessary and we were able to work with staff at Barts and The London NHS Trust to resolve complaints in a more straightforward and timely way.

Figure 18 on pages 44 and 45 lists the top ten health bodies by complaints reported on during the year. The total number of complaints reported on differs from the number of complaints accepted for investigation because some complaints received the year before may have been reported on in 2009-10, and others will not be reported on until 2010-11.

Figure 14: Top ten health bodies by complaints received

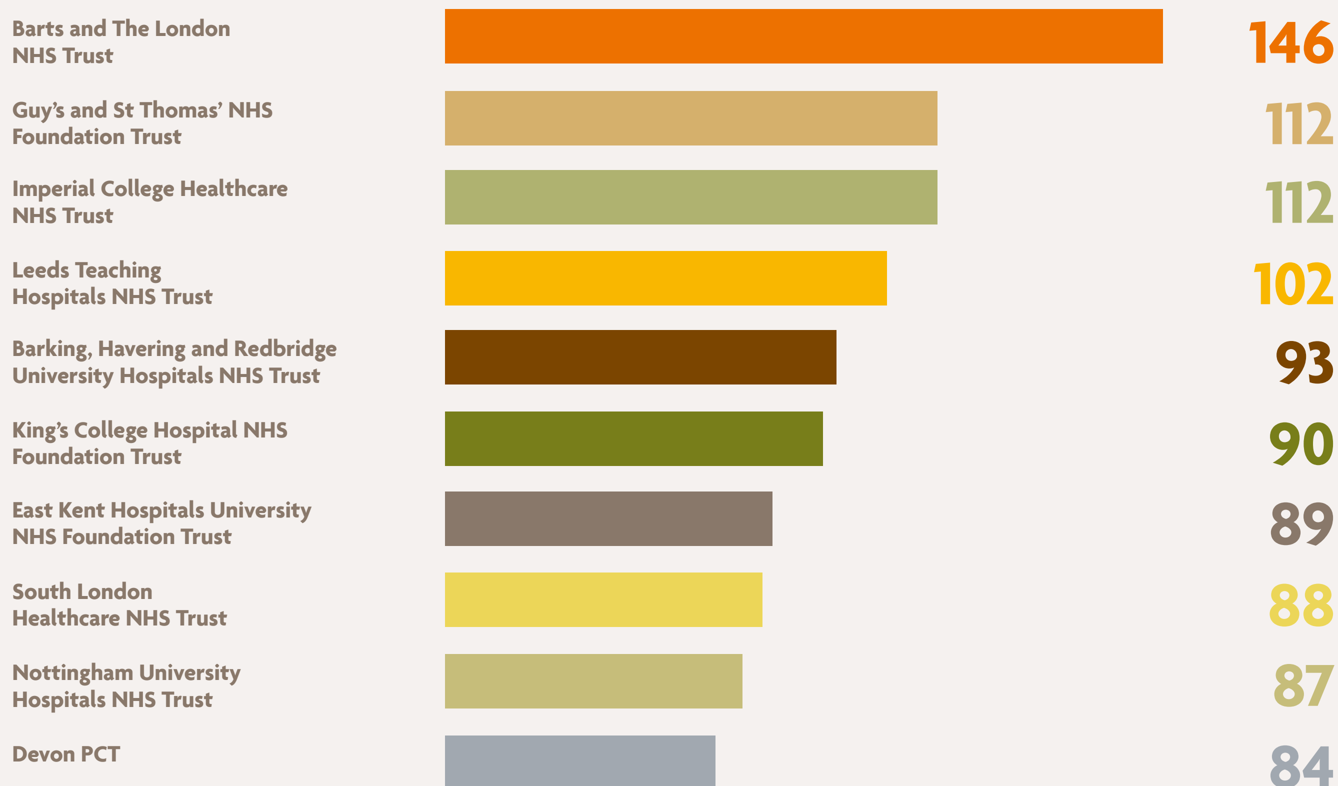


Figure 15: Complaints about the Healthcare Commission received and reported on 2009-10

531
Complaints received

25
Complaints reported on

80%
upheld or partly upheld

Figure 16: Top ten health bodies by interventions

2009-10

5 Interventions	4 Interventions	3 Interventions
Barts and The London NHS Trust	East of England Strategic Health Authority	Central Lancashire PCT
	East Sussex Hospitals NHS Trust	Central Manchester University Hospitals NHS Foundation Trust
		Imperial College Healthcare NHS Trust
		Sandwell and West Birmingham Hospitals NHS Trust
		South West Strategic Health Authority
		Stockport NHS Foundation Trust
		Surrey PCT
		Western Cheshire PCT
		Wrightington, Wigan and Leigh NHS Foundation Trust

Nine bodies received three interventions, generating a list of 12 bodies overall

Figure 17: Top ten health bodies by complaints accepted for investigation

2009-10

12 Accepted

South East Coast Strategic Health Authority

7 Accepted

The Royal Wolverhampton Hospitals NHS Trust

University Hospitals Birmingham NHS Foundation Trust

6 Accepted

East Midlands Ambulance Service NHS Trust

East Sussex Downs and Weald PCT

Nottingham University Hospitals NHS Trust

Pennine Acute Hospitals NHS Trust

5 Accepted

Plymouth Hospitals NHS Trust

University Hospitals of Morecambe Bay NHS Trust

4 Accepted

Barking, Havering and Redbridge University Hospitals NHS Trust

Devon PCT

East and North Hertfordshire NHS Trust

East Sussex Hospitals NHS Trust

Mayday Healthcare NHS Trust

North East Essex PCT

Northampton General Hospital NHS Trust

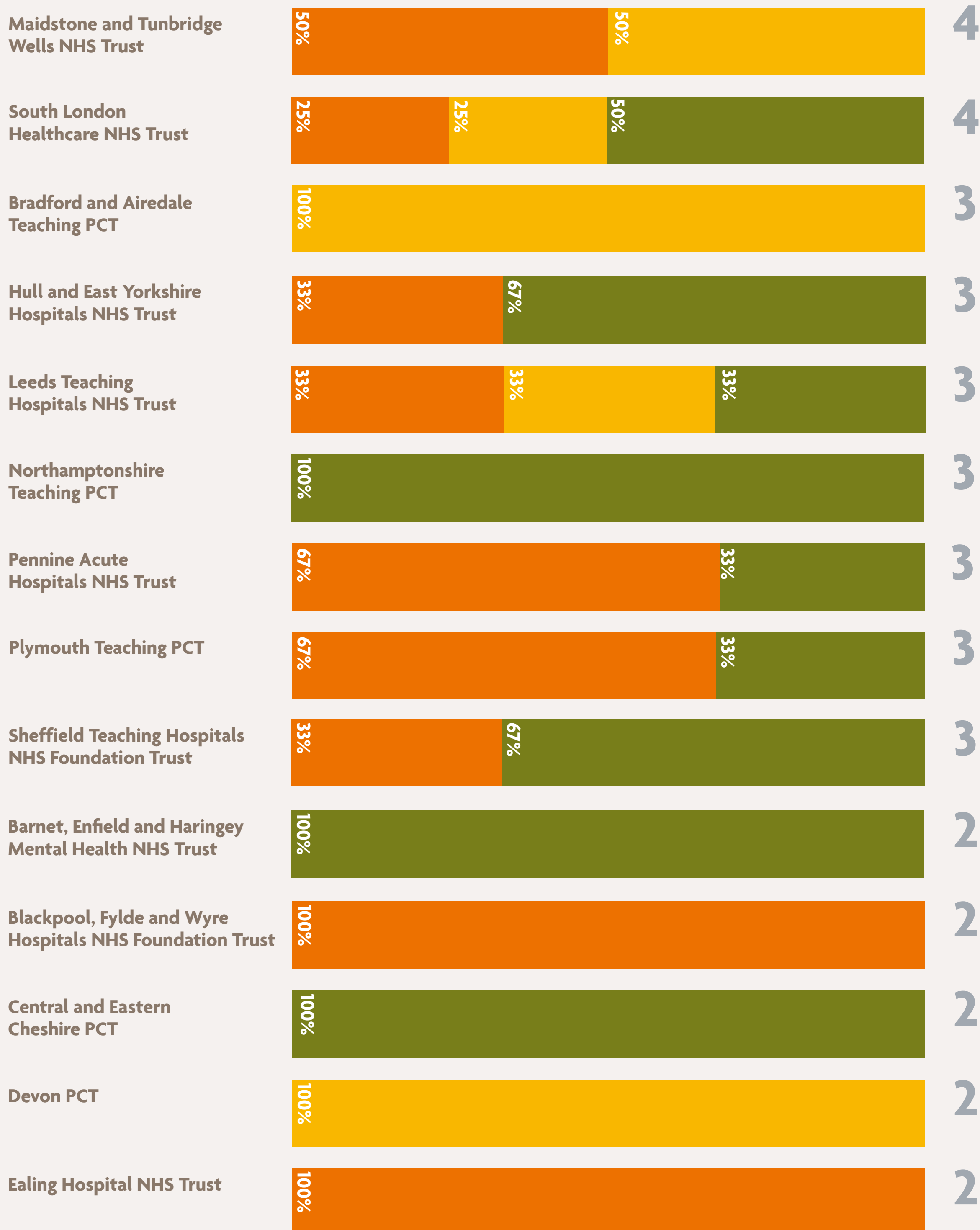
Peterborough and Stamford Hospitals NHS Foundation Trust

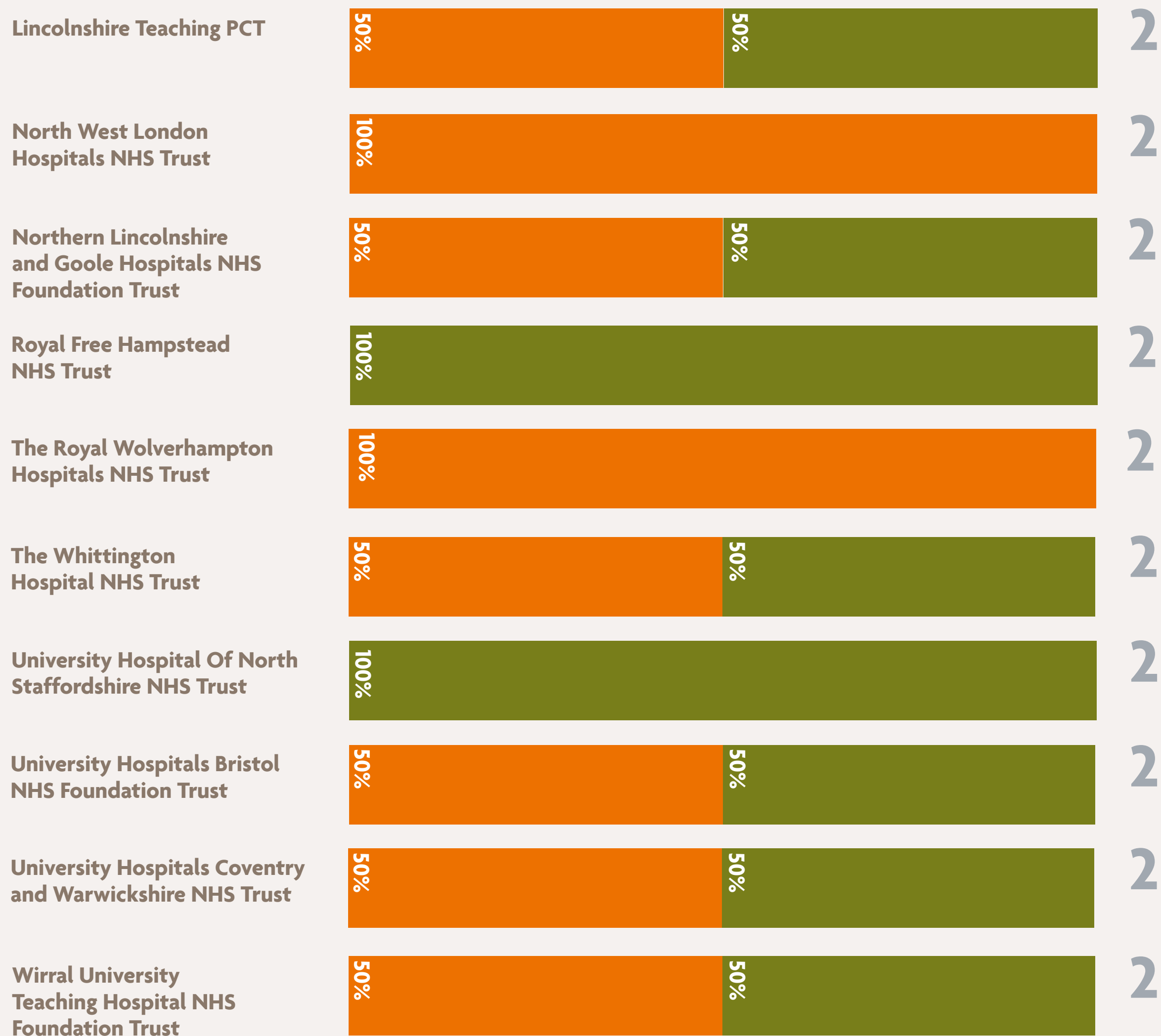
South London Healthcare NHS Trust

United Lincolnshire Hospitals NHS Trust

Ten bodies each had four complaints accepted for investigation, generating a list of 19 bodies overall.

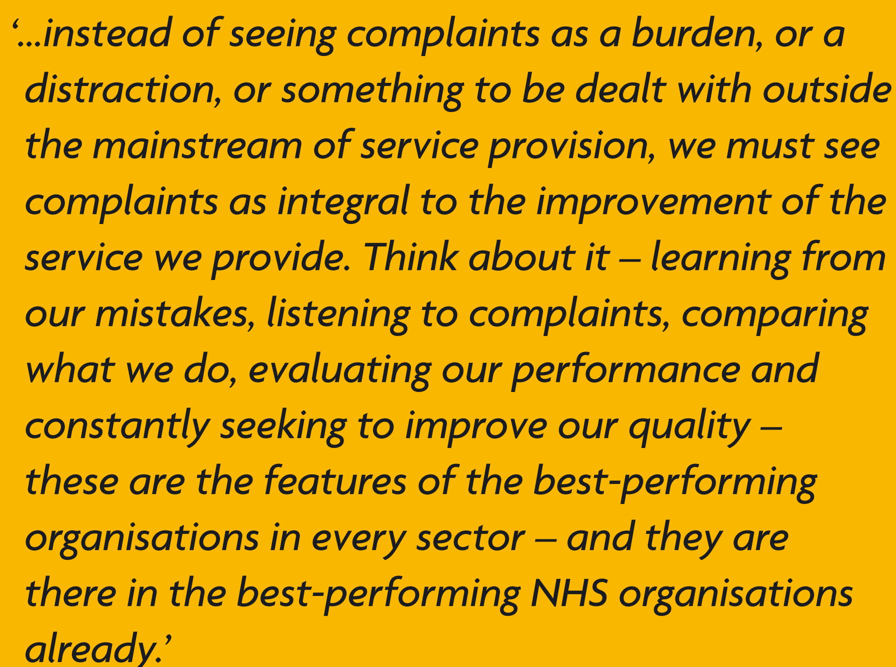
Figure 18: Top ten health bodies by complaints reported on





Key

15 bodies each had two complaints reported on, generating a list of 24 bodies overall.



'...instead of seeing complaints as a burden, or a distraction, or something to be dealt with outside the mainstream of service provision, we must see complaints as integral to the improvement of the service we provide. Think about it – learning from our mistakes, listening to complaints, comparing what we do, evaluating our performance and constantly seeking to improve our quality – these are the features of the best-performing organisations in every sector – and they are there in the best-performing NHS organisations already.'

Andrew Lansley MP, Secretary of State for Health, *'My ambition for patient-centred care'* speech, 8 June 2010.

Looking to the future

These are challenging times for the NHS. The current economic climate and the proposed reorganisation detailed in this summer's White Paper, *Equity and excellence: Liberating the NHS*, will mean considerable structural change and uncertain times for practitioners and staff. As the changes take place, complaints information will offer a ready and invaluable insight into the patient experience and can act as a key driver for improving the quality of NHS services.

The additional commissioning responsibilities for GPs, outlined in the White Paper, are expected to result in greater accountability, but will also require changes to administration at local level. Improved complaint handling will need to be embedded within these new systems, with clear communication for patients and training for both clinical and administrative staff. This will be a particular focus for us as we record an increasing number of enquiries to the Ombudsman from patients removed from GP lists. While our investigations into these complaints are still at an early stage, we are concerned that some complainants may have been removed from lists without appropriate warning or explanation, or that removal has occurred following a complaint.

In the past year we have been expressing our concern to the organisations and individuals whose record keeping falls short of what is required.

It is for this reason that we have welcomed the national standards for medical record-keeping approved by the Academy of Medical Royal Colleges and will be referencing these standards in our own casework from now on as a benchmark of best practice.

We will continue to develop our relationship with the NHS to help harness the insight that complaints bring. In their response to the Ombudsman's consultation on sharing and publishing information on complaints, the Nursing and Midwifery Council referred to the importance of collaboration and communication: *'Only through a multi-organisation approach to complaints, regulation and investigation, can we as a sector hope to truly safeguard patient safety and public wellbeing'.* We are committed to working with others to drive improvement across the NHS and look forward to developing further our alliances with the Care Quality Commission, Monitor and the professional regulators.

Our forthcoming regional conferences will provide the opportunity for us to speak directly with complaint managers and executives in strategic health authority regions and, in the months ahead, we will seek to extend our dialogue with individual trusts and NHS bodies, using the knowledge from complaints that come to us to support their efforts for improvement.

Throughout all this, our commitment to the fair and independent resolution of complaints will continue. The work outlined above should, in time, lead to a reduction in the number of complaints that reach us before local resolution has been exhausted. We expect to see clearer signposting and improved information about complaint procedures for patients and their families. We hope the NHS will make greater use of simple yet effective remedies in handling complaints – apologies and better explanations of how mistakes have occurred. Our report next year will chart the progress that has been achieved.

Appendix: complaints received, resolved and investigated in 2009-10

In this appendix we publish the full list of complaints about NHS bodies received, resolved through our intervention and investigated in 2009-10.

This includes:

- The number of complaints received;
- The number of complaints resolved through intervention;
- The number of complaints accepted for investigation; and
- The number of investigated complaints reported on, showing how many of those complaints were fully upheld, partly upheld or not upheld

NHS bodies are listed in alphabetical order by their official name, but please note that some are known publicly by another name. For example, we have listed Westminster PCT by its official name but it is also known as NHS Westminster.

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
[2]gether NHS Foundation Trust	9	0	1	0	-	-	-
5 Boroughs Partnership NHS Foundation Trust	15	0	1	0	-	-	-
Aintree University Hospitals NHS Foundation Trust	23	0	2	0	-	-	-
Airedale NHS Trust	12	1	1	1	0%	0%	100%
Alder Hey Children's NHS Foundation Trust	7	1	0	0	-	-	-
Ashford and St Peter's Hospitals NHS Trust	14	0	1	0	-	-	-
Ashton, Leigh and Wigan PCT	20	0	1	1	0%	0%	100%
Avon and Wiltshire Mental Health Partnership NHS Trust	53	1	3	0	-	-	-
Barking and Dagenham PCT	16	1	0	0	-	-	-
Barking, Havering and Redbridge University Hospitals NHS Trust	93	1	4	1	0%	100%	0%
Barnet and Chase Farm Hospitals NHS Trust	46	2	2	1	0%	0%	100%
Barnet PCT	34	0	0	0	-	-	-
Barnet, Enfield and Haringey Mental Health NHS Trust	36	1	0	2	0%	0%	100%
Barnsley Hospital NHS Foundation Trust	8	0	0	0	-	-	-
Barnsley PCT	21	0	0	0	-	-	-
Barts and The London NHS Trust	146	5	3	1	100%	0%	0%
Basildon and Thurrock University Hospitals NHS Foundation Trust	47	0	2	1	0%	0%	100%
Basingstoke and North Hampshire NHS Foundation Trust	10	0	0	1	100%	0%	0%
Bassetlaw PCT	5	0	0	0	-	-	-
Bath and North East Somerset PCT	12	1	1	0	-	-	-
Bedford Hospital NHS Trust	21	0	1	0	-	-	-
Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust	9	0	0	0	-	-	-
Bedfordshire PCT	32	1	1	0	-	-	-
Berkshire East PCT	27	0	0	0	-	-	-
Berkshire Healthcare NHS Foundation Trust	20	0	0	0	-	-	-
Berkshire West PCT	28	2	3	1	0%	100%	0%
Bexley Care Trust	22	0	0	0	-	-	-
Birmingham and Solihull Mental Health NHS Foundation Trust	40	1	1	0	-	-	-
Birmingham Children's Hospital NHS Foundation Trust	7	0	0	0	-	-	-
Birmingham East and North PCT	24	0	0	0	-	-	-
Birmingham Women's NHS Foundation Trust	13	0	0	0	-	-	-
Blackburn with Darwen PCT	13	0	0	1	100%	0%	0%
Blackpool PCT	15	0	0	0	-	-	-
Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust	53	2	2	2	100%	0%	0%
Bolton PCT	20	0	0	0	-	-	-

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
Bournemouth and Poole Teaching PCT	29	0	0	0	-	-	-
Bradford and Airedale Teaching PCT	22	0	1	3	0%	100%	0%
Bradford District Care Trust	11	0	0	1	0%	0%	100%
Bradford Teaching Hospitals NHS Foundation Trust	35	1	0	0	-	-	-
Brent Teaching PCT	31	2	0	0	-	-	-
Brighton and Hove City PCT	22	0	0	1	0%	100%	0%
Brighton and Sussex University Hospitals NHS Trust	78	1	2	1	0%	0%	100%
Bristol PCT	36	0	0	0	-	-	-
Bromley PCT	16	0	0	0	-	-	-
Buckinghamshire Hospitals NHS Trust	28	0	1	1	100%	0%	0%
Buckinghamshire PCT	39	0	0	0	-	-	-
Burton Hospitals NHS Foundation Trust	20	1	1	0	-	-	-
Bury PCT	16	0	0	0	-	-	-
Calderdale and Huddersfield NHS Foundation Trust	57	1	0	0	-	-	-
Calderdale PCT	14	1	0	0	-	-	-
Calderstones Partnership NHS Foundation Trust	1	0	0	0	-	-	-
Cambridge University Hospitals NHS Foundation Trust	32	1	0	0	-	-	-
Cambridgeshire and Peterborough NHS Foundation Trust	16	0	0	0	-	-	-
Cambridgeshire PCT	43	1	0	0	-	-	-
Camden and Islington NHS Foundation Trust	29	1	0	0	-	-	-
Camden PCT	29	1	1	0	-	-	-
Central and Eastern Cheshire PCT	35	0	1	2	0%	0%	100%
Central and North West London NHS Foundation Trust	44	1	0	0	-	-	-
Central Lancashire PCT	65	3	1	0	-	-	-
Central Manchester University Hospitals NHS Foundation Trust	83	3	0	0	-	-	-
Chelsea and Westminster Hospital NHS Foundation Trust	43	0	1	1	0%	100%	0%
Cheshire and Wirral Partnership NHS Foundation Trust	17	0	1	0	-	-	-
Chesterfield Royal Hospital NHS Foundation Trust	16	1	0	0	-	-	-
City and Hackney Teaching PCT	19	0	0	0	-	-	-
City Hospitals Sunderland NHS Foundation Trust	35	1	1	1	0%	0%	100%
Clatterbridge Centre For Oncology NHS Foundation Trust	5	0	1	1	0%	0%	100%
Colchester Hospital University NHS Foundation Trust	41	1	3	0	-	-	-
Cornwall and Isles of Scilly PCT	45	1	1	1	100%	0%	0%
Cornwall Partnership NHS Foundation Trust	13	0	0	0	-	-	-
Countess of Chester Hospital NHS Foundation Trust	9	0	1	1	0%	100%	0%
County Durham and Darlington NHS Foundation Trust	44	1	2	0	-	-	-
County Durham PCT	23	0	0	1	0%	0%	100%
Coventry and Warwickshire Partnership NHS Trust	25	0	0	0	-	-	-
Coventry Teaching PCT	18	2	0	0	-	-	-

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
Croydon PCT	24	1	1	0	-	-	-
Cumbria Partnership NHS Foundation Trust	9	0	0	0	-	-	-
Cumbria Teaching PCT	31	1	0	0	-	-	-
Darlington PCT	20	0	1	0	-	-	-
Dartford and Gravesham NHS Trust	21	0	0	1	0%	100%	0%
Derby City PCT	24	0	0	0	-	-	-
Derby Hospitals NHS Foundation Trust	18	0	0	0	-	-	-
Derbyshire County PCT	48	1	0	0	-	-	-
Derbyshire Mental Health Services NHS Trust	31	0	0	0	-	-	-
Devon Partnership NHS Trust	19	2	3	1	100%	0%	0%
Devon PCT	84	0	4	2	0%	100%	0%
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	44	1	0	0	-	-	-
Doncaster PCT	13	0	2	0	-	-	-
Dorset County Hospital NHS Foundation Trust	15	0	0	0	-	-	-
Dorset Healthcare NHS Foundation Trust	6	0	0	1	0%	0%	100%
Dorset PCT	43	1	0	0	-	-	-
Dudley and Walsall Mental Health Partnership NHS Trust	9	0	1	0	-	-	-
Dudley PCT	25	1	1	1	0%	100%	0%
Ealing Hospital NHS Trust	23	0	0	2	100%	0%	0%
Ealing PCT	39	0	2	0	-	-	-
East and North Hertfordshire NHS Trust	43	2	4	1	0%	0%	100%
East and North Hertfordshire PCT	53	1	2	1	100%	0%	0%
East Cheshire NHS Trust	18	0	1	1	100%	0%	0%
East Kent Hospitals University NHS Foundation Trust	89	2	0	1	100%	0%	0%
East Lancashire Hospitals NHS Trust	64	1	0	0	-	-	-
East Lancashire Teaching PCT	20	0	1	0	-	-	-
East London NHS Foundation Trust	42	0	1	0	-	-	-
East Midlands Ambulance Service NHS Trust	23	0	6	0	-	-	-
East Midlands Strategic Health Authority	18	0	1	0	-	-	-
East of England Ambulance Service NHS trust	26	1	1	0	-	-	-
East of England Strategic Health Authority	48	4	2	1	100%	0%	0%
East Riding of Yorkshire PCT	25	0	0	0	-	-	-
East Sussex Downs and Weald PCT	47	2	6	0	-	-	-
East Sussex Hospitals NHS Trust	54	4	4	1	100%	0%	0%
Eastern and Coastal Kent PCT	60	1	0	0	-	-	-
Enfield PCT	17	0	1	1	0%	100%	0%
Epsom and St Helier University Hospitals NHS Trust	40	0	1	1	100%	0%	0%
Frimley Park Hospital NHS Foundation Trust	18	0	0	0	-	-	-
Gateshead Health NHS Foundation Trust	16	1	0	1	0%	100%	0%
Gateshead PCT	0	0	0	0	-	-	-

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
George Eliot Hospital NHS Trust	30	0	2	1	0%	0%	100%
Gloucestershire Hospitals NHS Foundation Trust	51	2	1	0	-	-	-
Gloucestershire PCT	32	0	3	0	-	-	-
Great Ormond Street Hospital for Children NHS Trust	29	0	0	0	-	-	-
Great Western Ambulance Service NHS Trust	13	0	0	0	-	-	-
Great Western Hospitals NHS Foundation Trust	21	0	0	0	-	-	-
Great Yarmouth and Waveney PCT	20	0	0	0	-	-	-
Greater Manchester West Mental Health NHS Foundation Trust	27	1	0	0	-	-	-
Greenwich Teaching PCT	26	1	1	0	-	-	-
Guy's and St Thomas' NHS Foundation Trust	112	1	1	1	0%	100%	0%
Halton and St Helens PCT	18	0	2	0	-	-	-
Hammersmith and Fulham PCT	27	0	0	0	-	-	-
Hampshire Partnership NHS Foundation Trust	24	0	2	0	-	-	-
Hampshire PCT	79	1	1	0	-	-	-
Haringey Teaching PCT	38	1	0	0	-	-	-
Harrogate and District NHS Foundation Trust	19	0	0	1	100%	0%	0%
Harrow PCT	27	1	0	0	-	-	-
Hartlepool PCT	3	0	0	0	-	-	-
Hastings and Rother PCT	14	0	1	0	-	-	-
Havering PCT	23	1	0	1	0%	0%	100%
Health and Social Care Information Centre	1	0	0	0	-	-	-
Healthcare Commission	531	2	0	25	60%	20%	20%
Heart of Birmingham Teaching PCT	21	0	0	0	-	-	-
Heart of England NHS Foundation Trust	82	2	3	0	-	-	-
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	39	1	1	1	100%	0%	0%
Hereford Hospitals NHS Trust	14	0	0	0	-	-	-
Herefordshire PCT	9	0	0	0	-	-	-
Hertfordshire Partnership NHS Foundation Trust	29	0	0	0	-	-	-
Heywood, Middleton and Rochdale PCT	17	2	0	0	-	-	-
Hillingdon PCT	45	1	0	0	-	-	-
Hinchingbrooke Health Care NHS Trust	11	0	0	1	100%	0%	0%
Homerton University Hospital NHS Foundation Trust	39	2	0	0	-	-	-
Hounslow PCT	20	0	0	0	-	-	-
Hull and East Yorkshire Hospitals NHS Trust	31	1	2	3	33%	0%	67%
Hull Teaching PCT	34	1	0	0	-	-	-
Humber NHS Foundation Trust	12	1	0	0	-	-	-
Imperial College Healthcare NHS Trust	112	3	2	0	-	-	-
Ipswich Hospital NHS Trust	18	0	1	0	-	-	-

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
Isle of Wight NHS PCT	47	0	1	1	0%	100%	0%
Islington PCT	21	0	0	0	-	-	-
James Paget University Hospitals NHS Foundation Trust	15	0	1	0	-	-	-
Kensington and Chelsea PCT	22	0	1	1	100%	0%	0%
Kent and Medway NHS and Social Care Partnership Trust	34	1	0	0	-	-	-
Kettering General Hospital NHS Foundation Trust	28	0	0	0	-	-	-
King's College Hospital NHS Foundation Trust	90	0	1	1	0%	0%	100%
Kingston Hospital NHS Trust	27	0	0	0	-	-	-
Kingston PCT	14	2	0	0	-	-	-
Kirklees PCT	19	0	0	0	-	-	-
Knowsley PCT	11	1	0	0	-	-	-
Lambeth PCT	38	1	0	0	-	-	-
Lancashire Care NHS Foundation Trust	34	0	0	0	-	-	-
Lancashire Teaching Hospitals NHS Foundation Trust	46	0	1	1	0%	0%	100%
Leeds Partnerships NHS Foundation Trust	11	0	0	0	-	-	-
Leeds PCT	71	1	1	1	0%	0%	100%
Leeds Teaching Hospitals NHS Trust	102	1	1	3	33%	33%	33%
Leicester City PCT	33	1	0	0	-	-	-
Leicestershire County and Rutland PCT	49	1	1	0	-	-	-
Leicestershire Partnership NHS Trust	28	0	1	1	100%	0%	0%
Lewisham PCT	27	0	0	0	-	-	-
Lincolnshire Partnership NHS Foundation Trust	9	0	2	0	-	-	-
Lincolnshire Teaching PCT	39	0	1	2	50%	0%	50%
Liverpool Heart and Chest Hospital NHS Foundation Trust	3	0	0	1	100%	0%	0%
Liverpool PCT	36	0	0	0	-	-	-
Liverpool Women's NHS Foundation Trust	9	0	0	0	-	-	-
London Ambulance Service NHS Trust	49	0	0	0	-	-	-
London Strategic Health Authority	29	1	0	0	-	-	-
Luton and Dunstable Hospital NHS Foundation Trust	39	0	3	0	-	-	-
Luton PCT	15	1	0	0	-	-	-
Maidstone and Tunbridge Wells NHS Trust	45	2	2	4	50%	50%	0%
Manchester Mental Health and Social Care Trust	23	0	0	0	-	-	-
Manchester PCT	65	0	1	0	-	-	-
Mayday Healthcare NHS Trust	37	1	4	1	0%	100%	0%
Medway NHS Foundation Trust	46	0	3	1	0%	0%	100%
Medway PCT	38	0	1	1	0%	0%	100%
Mersey Care NHS Trust	25	0	1	0	-	-	-
Mid Cheshire Hospitals NHS Foundation Trust	28	0	0	0	-	-	-
Mid Essex Hospital Services NHS Trust	52	1	0	0	-	-	-

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
Mid Essex PCT	20	0	0	0	-	-	-
Mid Staffordshire NHS Foundation Trust	33	0	0	1	100%	0%	0%
Mid Yorkshire Hospitals NHS Trust	43	1	1	0	-	-	-
Middlesbrough PCT	13	0	0	0	-	-	-
Milton Keynes Hospital NHS Foundation Trust	43	0	2	1	0%	0%	100%
Milton Keynes PCT	28	1	0	0	-	-	-
Moorfields Eye Hospital NHS Foundation Trust	29	1	0	0	-	-	-
National Institute for Health and Clinical Excellence	3	0	0	0	-	-	-
National Patient Safety Agency	3	0	0	0	-	-	-
Newcastle PCT	12	0	0	0	-	-	-
Newham PCT	25	1	1	0	-	-	-
Newham University Hospital NHS Trust	36	1	1	0	-	-	-
NHS Blood and Transplant	6	0	0	1	0%	0%	100%
NHS Business Services Authority	34	0	0	0	-	-	-
NHS Direct	34	0	0	0	-	-	-
NHS Litigation Authority	4	0	0	0	-	-	-
Norfolk and Norwich University Hospitals NHS Foundation Trust	42	1	0	0	-	-	-
Norfolk and Waveney Mental Health NHS Foundation Trust	15	1	0	0	-	-	-
Norfolk PCT	56	2	0	0	-	-	-
North Bristol NHS Trust	51	1	1	1	100%	0%	0%
North Cumbria University Hospitals NHS Trust	20	0	0	1	0%	100%	0%
North East Ambulance Service NHS Trust	11	0	0	0	-	-	-
North East Essex PCT	60	0	4	0	-	-	-
North East Lincolnshire Care Trust Plus	9	0	0	0	-	-	-
North East Lincolnshire PCT	5	0	0	0	-	-	-
North East London NHS Foundation Trust	34	0	0	1	0%	100%	0%
North East Strategic Health Authority	6	0	0	0	-	-	-
North Essex Partnership NHS Foundation Trust	12	0	0	0	-	-	-
North Lancashire Teaching PCT	33	0	0	0	-	-	-
North Lincolnshire PCT	4	1	0	0	-	-	-
North Middlesex University Hospital NHS Trust	31	0	2	0	-	-	-
North Somerset PCT	24	1	0	0	-	-	-
North Staffordshire Combined Healthcare NHS Trust	9	0	0	0	-	-	-
North Staffordshire PCT	16	1	1	0	-	-	-
North Tees and Hartlepool NHS Foundation Trust	37	1	2	0	-	-	-
North Tyneside PCT	15	0	0	0	-	-	-
North West Ambulance Service NHS Trust	22	0	2	1	100%	0%	0%
North West London Hospitals NHS Trust	66	2	2	2	100%	0%	0%

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
North West Strategic Health Authority	40	1	0	1	100%	0%	0%
North Yorkshire and York PCT	65	1	1	0	-	-	-
Northampton General Hospital NHS Trust	42	0	4	1	0%	0%	100%
Northamptonshire Healthcare NHS Foundation Trust	16	0	0	0	-	-	-
Northamptonshire Teaching PCT	42	0	2	3	0%	0%	100%
Northern Devon Healthcare NHS Trust	34	0	2	0	-	-	-
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	25	1	0	2	50%	0%	50%
Northumberland Care Trust	12	1	0	0	-	-	-
Northumberland, Tyne and Wear NHS Foundation Trust	31	0	2	1	0%	0%	100%
Northumbria Healthcare NHS Foundation Trust	33	1	0	0	-	-	-
Nottingham City PCT	35	1	2	0	-	-	-
Nottingham University Hospitals NHS Trust	87	1	6	1	0%	0%	100%
Nottinghamshire County Teaching PCT	37	0	1	1	0%	0%	100%
Nottinghamshire Healthcare NHS Trust	55	1	1	0	-	-	-
Nuffield Orthopaedic Centre NHS Trust	10	0	0	0	-	-	-
Oldham PCT	7	0	0	1	100%	0%	0%
Oxford Radcliffe Hospitals NHS Trust	49	0	1	1	0%	0%	100%
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	19	0	0	0	-	-	-
Oxfordshire Learning Disability NHS Trust	0	0	0	0	-	-	-
Oxfordshire PCT	16	0	0	1	100%	0%	0%
Oxleas NHS Foundation Trust	16	0	0	0	-	-	-
Papworth Hospital NHS Foundation Trust	4	0	0	1	0%	0%	100%
Pennine Acute Hospitals NHS Trust	60	0	6	3	67%	0%	33%
Pennine Care NHS Foundation Trust	17	0	1	0	-	-	-
Peterborough and Stamford Hospitals NHS Foundation Trust	20	1	4	0	-	-	-
Peterborough PCT	14	0	0	0	-	-	-
Plymouth Hospitals NHS Trust	64	1	5	1	100%	0%	0%
Plymouth Teaching PCT	35	0	1	3	67%	0%	33%
Poole Hospital NHS Foundation Trust	15	0	1	0	-	-	-
Portsmouth City Teaching PCT	34	1	0	0	-	-	-
Portsmouth Hospitals NHS Trust	49	0	2	1	0%	0%	100%
Queen Victoria Hospital NHS Foundation Trust	10	0	0	0	-	-	-
Redbridge PCT	29	0	2	1	100%	0%	0%
Redcar and Cleveland PCT	9	0	1	0	-	-	-
Richmond and Twickenham PCT	7	0	0	0	-	-	-
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	3	0	0	0	-	-	-

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
Rotherham PCT	10	1	0	0	-	-	-
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	8	0	0	0	-	-	-
Royal Berkshire NHS Foundation Trust	28	0	0	0	-	-	-
Royal Bolton Hospital NHS Foundation Trust	18	0	0	1	100%	0%	0%
Royal Brompton and Harefield NHS Foundation Trust	16	0	1	1	0%	0%	100%
Royal Cornwall Hospitals NHS Trust	36	0	2	0	-	-	-
Royal Devon and Exeter NHS Foundation Trust	30	0	1	0	-	-	-
Royal Free Hampstead NHS Trust	73	1	1	2	0%	0%	100%
Royal Liverpool and Broadgreen University Hospitals NHS Trust	31	0	1	0	-	-	-
Royal National Hospital For Rheumatic Diseases NHS Foundation Trust	1	0	0	0	-	-	-
Royal National Orthopaedic Hospital NHS Trust	16	1	0	0	-	-	-
Royal Surrey County Hospital NHS Foundation Trust	18	0	1	0	-	-	-
Royal United Hospital Bath NHS Trust	47	0	0	0	-	-	-
Salford PCT	20	0	0	0	-	-	-
Salford Royal NHS Foundation Trust	44	0	0	0	-	-	-
Salisbury NHS Foundation Trust	17	0	1	0	-	-	-
Sandwell and West Birmingham Hospitals NHS Trust	69	3	3	0	-	-	-
Sandwell Mental Health and Social Care NHS Foundation Trust	3	0	0	0	-	-	-
Sandwell PCT	29	0	1	0	-	-	-
Scarborough and North East Yorkshire Health Care NHS Trust	26	0	0	0	-	-	-
Sefton PCT	18	0	0	1	0%	0%	100%
Sheffield Care Trust	3	0	0	0	-	-	-
Sheffield Children's NHS Foundation Trust	5	0	1	0	-	-	-
Sheffield Health and Social Care NHS Foundation Trust	7	0	0	0	-	-	-
Sheffield PCT	29	1	1	0	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	42	1	1	3	33%	0%	67%
Sherwood Forest Hospitals NHS Foundation Trust	23	0	1	1	0%	100%	0%
Shrewsbury and Telford Hospital NHS Trust	31	2	0	1	0%	100%	0%
Shropshire County PCT	12	0	2	0	-	-	-
Solihull Care Trust	13	0	0	0	-	-	-
Somerset Partnership NHS Foundation Trust	13	0	0	0	-	-	-
Somerset PCT	45	2	2	0	-	-	-
South Birmingham PCT	56	1	0	0	-	-	-
South Central Ambulance Service NHS Trust	4	0	0	0	-	-	-
South Central Strategic Health Authority	35	1	0	0	-	-	-

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
South Devon Healthcare NHS Foundation Trust	26	0	0	0	-	-	-
South Downs Health NHS Trust	4	0	0	1	0%	100%	0%
South East Coast Ambulance Service NHS Trust	14	0	0	0	-	-	-
South East Coast Strategic Health Authority	31	2	12	1	100%	0%	0%
South East Essex PCT	34	0	3	0	-	-	-
South Essex Partnership University NHS Foundation Trust	23	0	1	0	-	-	-
South Gloucestershire PCT	13	1	0	0	-	-	-
South London and Maudsley NHS Foundation Trust	54	0	1	0	-	-	-
South London Healthcare NHS Trust	88	0	4	4	25%	25%	50%
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	15	1	0	0	-	-	-
South Staffordshire PCT	40	1	1	0	-	-	-
South Tees Hospitals NHS Foundation Trust	35	0	0	0	-	-	-
South Tyneside NHS Foundation Trust	16	0	3	0	-	-	-
South Tyneside PCT	20	1	0	1	0%	0%	100%
South Warwickshire NHS Foundation Trust	16	0	0	0	-	-	-
South West Essex PCT	32	2	1	0	-	-	-
South West London and St George's Mental Health NHS Trust	58	1	0	0	-	-	-
South West Strategic Health Authority	31	3	0	0	-	-	-
South West Yorkshire Partnership NHS Foundation Trust	13	0	0	0	-	-	-
South Western Ambulance Service NHS Trust	11	0	0	0	-	-	-
Southampton City PCT	21	0	0	0	-	-	-
Southampton University Hospitals NHS Trust	46	0	3	0	-	-	-
Southend University Hospital NHS Foundation Trust	27	0	1	0	-	-	-
Southport and Ormskirk Hospital NHS Trust	40	0	0	0	-	-	-
Southwark PCT	22	0	0	0	-	-	-
St George's Healthcare NHS Trust	56	0	2	0	-	-	-
St Helens and Knowsley Hospitals NHS Trust	22	1	1	0	-	-	-
Stockport NHS Foundation Trust	30	3	0	0	-	-	-
Stockport PCT	29	0	3	1	100%	0%	0%
Stockton-on-Tees Teaching PCT	13	0	0	0	-	-	-
Stoke On Trent PCT	23	0	0	1	0%	0%	100%
Suffolk Mental Health Partnership NHS Trust	20	0	0	1	0%	0%	100%
Suffolk PCT	39	0	0	0	-	-	-
Sunderland Teaching PCT	8	0	0	0	-	-	-
Surrey and Borders Partnership NHS Foundation Trust	27	1	0	1	100%	0%	0%
Surrey and Sussex Healthcare NHS Trust	20	0	1	0	-	-	-
Surrey PCT	75	3	3	0	-	-	-
Sussex Partnership NHS Foundation Trust	43	1	0	1	100%	0%	0%

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
Sutton and Merton PCT	26	2	3	1	100%	0%	0%
Swindon PCT	20	0	0	0	-	-	-
Tameside and Glossop PCT	10	0	0	1	0%	0%	100%
Tameside Hospital NHS Foundation Trust	13	0	3	0	-	-	-
Taunton and Somerset NHS Foundation Trust	30	1	1	0	-	-	-
Tavistock and Portman NHS Foundation Trust	1	0	0	0	-	-	-
Tees, Esk and Wear Valleys NHS Foundation Trust	25	0	0	0	-	-	-
Telford and Wrekin PCT	13	0	0	0	-	-	-
The Christie NHS Foundation Trust	7	0	0	0	-	-	-
The Dudley Group of Hospitals NHS Foundation Trust	45	1	0	0	-	-	-
The Hillingdon Hospital NHS Trust	41	1	1	0	-	-	-
The Lewisham Hospital NHS Trust	22	0	2	0	-	-	-
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	47	2	0	0	-	-	-
The Princess Alexandra Hospital NHS Trust	45	2	3	0	-	-	-
The Queen Elizabeth Hospital King's Lynn NHS Trust	10	0	0	0	-	-	-
The Rotherham NHS Foundation Trust	9	0	0	0	-	-	-
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	16	1	0	0	-	-	-
The Royal Marsden NHS Foundation Trust	14	0	2	0	-	-	-
The Royal Orthopaedic Hospital NHS Foundation Trust	15	0	0	0	-	-	-
The Royal Wolverhampton Hospitals NHS Trust	52	0	7	2	100%	0%	0%
The Walton Centre NHS Foundation Trust	5	0	0	0	-	-	-
The Whittington Hospital NHS Trust	39	0	0	2	0%	50%	50%
Torbay Care Trust	14	0	0	0	-	-	-
Tower Hamlets PCT	38	0	2	0	-	-	-
Trafford Healthcare NHS Trust	15	0	0	1	100%	0%	0%
Trafford PCT	5	0	0	0	-	-	-
United Lincolnshire Hospitals NHS Trust	64	1	4	0	-	-	-
University College London Hospitals NHS Foundation Trust	58	0	0	0	-	-	-
University Hospital of North Staffordshire NHS Trust	45	0	1	2	0%	0%	100%
University Hospital of South Manchester NHS Foundation Trust	30	0	0	1	0%	0%	100%
University Hospitals Birmingham NHS Foundation Trust	66	2	7	0	-	-	-
University Hospitals Bristol NHS Foundation Trust	41	1	0	2	50%	0%	50%
University Hospitals Coventry and Warwickshire NHS Trust	39	2	2	2	50%	0%	50%
University Hospitals of Leicester NHS Trust	58	1	3	1	0%	100%	0%
University Hospitals of Morecambe Bay NHS Trust	49	2	5	1	100%	0%	0%

	Complaints received in 2009-10	Complaints resolved through intervention in 2009-10	Complaints accepted for investigation in 2009-10	Investigated complaints reported on in 2009-10	Investigated complaints reported on: Fully upheld%	Investigated complaints reported on: Partly upheld%	Investigated complaints reported on: Not upheld%
Wakefield District PCT	19	0	0	0	-	-	-
Walsall Hospitals NHS Trust	22	0	1	0	-	-	-
Walsall Teaching PCT	15	0	0	0	-	-	-
Waltham Forest PCT	39	0	0	0	-	-	-
Wandsworth PCT	21	0	0	0	-	-	-
Warrington and Halton Hospitals NHS Foundation Trust	36	0	0	0	-	-	-
Warrington PCT	16	2	0	0	-	-	-
Warwickshire PCT	27	2	0	0	-	-	-
West Essex PCT	16	1	1	0	-	-	-
West Hertfordshire Hospitals NHS Trust	79	2	1	0	-	-	-
West Hertfordshire PCT	30	0	2	0	-	-	-
West Kent PCT	41	0	1	1	100%	0%	0%
West London Mental Health NHS Trust	32	0	1	1	100%	0%	0%
West Middlesex University Hospital NHS Trust	26	0	0	1	100%	0%	0%
West Midlands Ambulance Service NHS Trust	11	0	0	0	-	-	-
West Midlands Strategic Health Authority	17	2	0	0	-	-	-
West Suffolk Hospitals NHS Trust	7	0	0	0	-	-	-
West Sussex PCT	81	0	1	1	100%	0%	0%
Western Cheshire PCT	15	3	1	1	0%	0%	100%
Western Sussex Hospitals NHS Trust	41	0	2	0	-	-	-
Westminster PCT	36	0	1	1	100%	0%	0%
Weston Area Health NHS Trust	35	1	0	0	-	-	-
Whipps Cross University Hospital NHS Trust	53	1	1	1	100%	0%	0%
Wiltshire PCT	47	1	2	0	-	-	-
Winchester and Eastleigh Healthcare NHS Trust	6	1	2	1	100%	0%	0%
Wirral PCT	25	1	1	0	-	-	-
Wirral University Teaching Hospital NHS Foundation Trust	28	1	3	2	50%	0%	50%
Wolverhampton City PCT	35	2	0	0	-	-	-
Worcestershire Acute Hospitals NHS Trust	41	0	1	0	-	-	-
Worcestershire Mental Health Partnership NHS Trust	13	0	1	0	-	-	-
Worcestershire PCT	25	1	2	0	-	-	-
Wrightington, Wigan and Leigh NHS Foundation Trust	46	3	1	0	-	-	-
Yeovil District Hospital NHS Foundation Trust	5	0	0	0	-	-	-
York Hospitals NHS Foundation Trust	26	0	1	1	100%	0%	0%
Yorkshire Ambulance Service NHS Trust	21	0	3	0	-	-	-
Yorkshire and the Humber Strategic Health Authority	30	0	1	1	0%	0%	100%
Unknown body	1869	-	-	-	-	-	-
GRAND TOTAL	**14429**	**219**	**346**	**180**	**44%**	**18%**	**37%**

Parliamentary and Health Service Ombudsman

Millbank Tower
Millbank
London SW1P 4QP

Tel: 0345 015 4033
Fax: 0300 061 4000
Email: phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

Published by TSO (The Stationery Office) and available from:

Online

www.tsoshop.co.uk

Mail, telephone, fax and email
TSO
PO Box 29, Norwich NR3 1GN
Telephone orders/general enquiries: 0870 600 5522
Order through the Parliamentary Hotline Lo-Call 0845 7 023474
Fax orders: 0870 600 5533
Email: customer.services@tso.co.uk
Textphone: 0870 240 3701

The Parliamentary Bookshop
12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders/general enquiries: 020 7219 3890
Fax orders: 020 7219 3866
Email: bookshop@parliament.uk
Internet: http://www.bookshop.parliament.uk

TSO@Blackwell and other accredited agents

Customers can also order publications from:
TSO Ireland
16 Arthur Street, Belfast BT1 4GD
Telephone orders/general enquiries: 028 9023 8451
Fax orders: 028 9023 5401