Inspecting Informing Improving

Healthcare Commission

Complaints handling in the NHS – is anyone listening?

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About the Healthcare Commission

The Healthcare Commission is an independent body responsible for reviewing the quality of healthcare and public health in England and Wales. In England, we are responsible for assessing and reporting on the performance of the National Health Service (NHS) and independent healthcare organisations.

The annual health check is the most comprehensive assessment of the NHS to take place. It has several components that we use to assess different aspects of performance. A key part of the annual health check is the annual rating of performance of every NHS organisation.

We assess the performance of the NHS against standards set by the Department of Health. These core standards describe the level of quality that all organisations providing NHS care across England are expected to meet.

The annual health check assesses whether standards, in areas such as safety, patient focus and clinical effectiveness, are being met on behalf of patients.

Through the annual health check, we aim to assure that:

- basic, core standards are being met
- improvements are being sought
- healthcare services provide value for money

By bringing together relevant information on the performance of healthcare providers, we can support informed decision-making by patients, the public and NHS staff, including clinicians.

Our programme of service reviews and national studies also assesses the performance of the NHS on specific topics or services.

We are also responsible for independently reviewing second-stage complaints about NHS services that have not been resolved locally. Assessing trusts' performance against the core standard relevant to complaints handling is part of the annual health check, and forms the basis of this report.

Foreword

The Healthcare Commission's research tells us that the majority of patients are satisfied with the care they receive[1,2,3,4]. The NHS provides over 380 million treatments every year, yet only receives 100,000 formal complaints[5].

When people do complain, they take for granted that the NHS has a formal complaints system. However, we know that sometimes people still find it difficult to make a complaint and are often dissatisfied when they do. We know this because we have received over 23,000 requests for independent review in the past three years.

Consumers' complaints provide health services with a unique source of information. Open discussion of consumers' needs and their concerns about the quality of care helps healthcare professionals and services understand potential problems and how they can improve their service.

Since the Commission was given responsibility for independently reviewing complaints about the NHS in 2004, we have become increasingly concerned about the way complaints are being managed. Earlier this year we released our report on second-stage complaints handling[5] in which we highlighted some of these concerns.

The Government's 2006 White Paper *Our health, our care, our say*[6] gave a commitment to develop a comprehensive single complaints system across health and social care by 2009. The Department of Health has recently proposed a new system for handling complaints that will place greater responsibility on health and social care organisations for ensuring that complaints are resolved locally[7].

We welcome and fully support any initiative that ensures that patients and the public get quicker and local resolution to their complaints – that is what they tell us they want.

We have been highlighting this feedback for some time. It is therefore right to consider a system that requires health and social care organisations to handle complaints better and with one, not two, independent review processes.

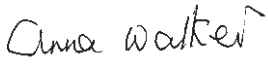
Our audit is the first-ever detailed analysis of complaints handling in the NHS. The findings are therefore timely, as they highlight gaps in local systems that we feel may be important to address when we are considering the future of complaints handling in the NHS.

As the emphasis within healthcare shifts to one where the patient and the consumers of services have greater say and choice, and the NHS commissions services on their behalf, it is only right that we consult more and listen when our customers give us feedback. The NHS needs to treasure complaints as a rich source of information and a vital component of a trust's performance improvement framework.

The purpose of this report is to highlight what needs to be done if complaints are to be handled better for patients. As a regulator, the Healthcare Commission stands ready to play our part in achieving that aim.

We strongly support a system that acts on and resolves complaints more efficiently. It is clear that to achieve this will require a substantial change in the way the NHS currently manages complaints. Everyone who works in the NHS has a responsibility for effective complaints handling. The key question for us remains: 'is anyone listening?'

Professor Sir Ian Kennedy
Chairman



Anna Walker CB
Chief Executive

Introduction

Research tells us repeatedly that people who raise concerns want:

- their complaint resolved as close as possible in place and time to the events complained about
- to receive an explanation and an apology where warranted
- any necessary action taken to prevent repetition[8,9]

Prior to July 2004, if a complaint could not be resolved at a local level, the NHS was responsible for reviewing the case. At that time, if a complainant remained dissatisfied after the NHS body dealt with their complaint, they could ask a convener for an independent review by a panel of lay people. Panel members were usually non-executive members of the organisation who had access to clinical advice.

However, a national evaluation of the NHS complaints procedure showed that the public thought the process was not sufficiently independent, was applied inconsistently and took too long[10].

As a result, the Department of Health launched a new three-stage system, which introduced a second stage to be carried out independently of the NHS by the Healthcare Commission.

In the first instance, if a patient believes that something has gone wrong during their treatment they can make a complaint to their local healthcare provider in the NHS. Depending on the type of healthcare involved, this could be an NHS trust, a general practitioner (GP), a dentist, a high street chemist or optician, or a private treatment centre providing care to the NHS. If the complaint is made to an NHS acute trust, primary care trust, strategic health authority or special health authority, the organisation then has 25 days in which to investigate and respond to the complainant. Arrangements differ slightly for independent contractor primary care providers such as GPs, dentists, pharmacies and opticians, who instead have 10 days to investigate and respond.

If people who complain find the experience unsatisfactory and are unable to get their issue resolved, they then have six months to decide whether they want to take the matter further and ask the Healthcare Commission to review their case. This stage in the complaints procedure, known as the second stage, is to find out why a complaint about the NHS has not been resolved locally and to identify what action needs to be taken to achieve resolution.

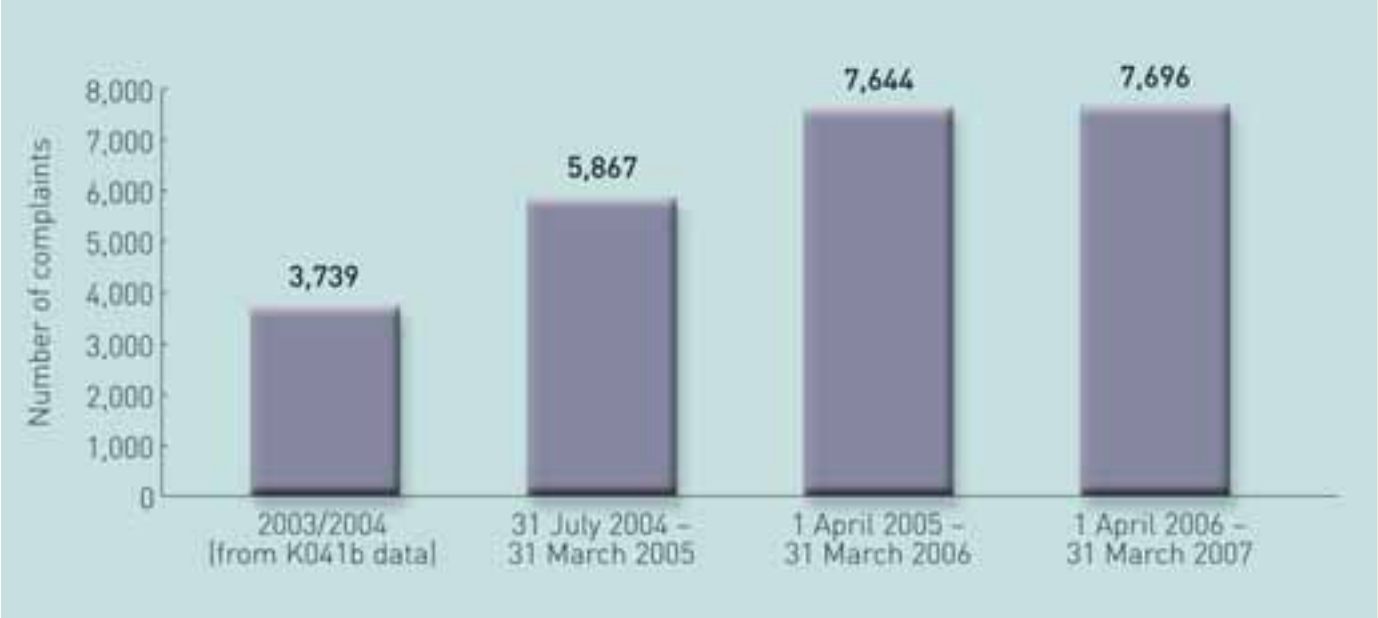
In some cases, we may also investigate the substance of the complaint and make recommendations for how a case might be resolved or make recommendations on how organisations can improve services or prevent similar complaints in the future.

If patients or their representatives remain dissatisfied with the outcome of the second-stage independent review, they may ask the Health Service Ombudsman (the Ombudsman) to carry out an independent investigation of their complaint. In 2006/2007 the Ombudsman reported on 1,139 health investigations[11].

Since we assumed responsibility for second-stage complaints in August 2004, we have experienced an unprecedented demand for independent review of NHS complaints that are not resolved locally.

We are currently receiving nearly 8,000 requests a year compared to 3,739 under the previous system. We are sending just under a third of all the complaints we receive back to trusts for further work to achieve local resolution.

Figure 1: Number of second-stage complaints about the NHS received by year



Note: 2003/2004 number taken from the Department of Health website.

The number of complaints that we have been asked to review, and the fact that nearly a third have needed to be referred back to trusts for further action, reveals inadequacies in the way that some trusts deal with complaints.

With the full support of the Department of Health, we have taken action on two fronts to help ensure that the handling of complaints is as effective as possible.

In January this year, we published our first report on second-stage complaints about the NHS. *Spotlight on complaints: A report on second-stage complaints about the NHS in England*[5] covers the 16,000 requests for independent review that we received between July 2004 and July 2006, and highlights recurring themes raised by complainants, such as the safety of clinical practices and poor communication by providers.

As outlined in the published plans for the 2006/2007 annual health check[12], we have undertaken an in-depth audit of the local handling of complaints in the NHS.

The audit represents our first move towards in-year risk assessment of trusts' performance in relation to national standards. It is also an important part of our mission to drive trusts to improve.

This publication reports the findings of the audit and builds on our January 2007 report. Its focus is on trusts' systems for handling complaints and not on individual cases.

This is the first time that this type of audit has been undertaken. It therefore provides us with good evidence to consider the future of complaints handling, in light of the Department of Health's consultation (see Box 1).

Box 1: Proposed changes to complaints handling

Much attention has been given to how the NHS handles complaints in recent years[13]. The Department of Health has recently proposed changes that represent a further drive towards improving the system by integrating health and social care.

In June 2007, the Department of Health issued the consultation paper *Making experiences count: A new approach to responding to complaints*[7].

The proposed changes would place greater responsibility on each organisation providing NHS and local authority-commissioned health and social care services to resolve complaints locally. The regulator will no longer have a role in investigating individual complaints.

Instead, the Department of Health is proposing that the regulator will focus on the standard of complaints handling and the implementation of learning from complaints. The Health Service Ombudsman will still have a role in investigating complaints and requests for independent review.

Summary of findings

While the mechanisms and processes for handling complaints are evident throughout the organisations audited, the manner and degree in which they operate is influenced by many cultural and organisational factors. These include the availability of resources, leadership, level of skills and commitment of complaints handling staff, and the education and training of frontline staff.

Ultimately the effectiveness of the complaints handling system, and therefore the quality of the outcomes from complaints and patients' experiences, depends on these factors and how successfully each trust puts them into operation.

The results from the audit are therefore presented in this context.

During the audit, we visited a total of 42 trusts. The findings of our visits to all 42 trusts, highlighting both good and poor practice, are detailed in the section 'Measuring what matters' on page 16. Of the 32 trusts that were most at risk of not meeting core standard C14, two trusts had adequate arrangements in place across all parts of the standard. Looking at all three parts of core standard C14, there was the potential to issue a total of 96 notifications – following our assessment, we issued 25 notification letters to trusts. We found adequate arrangements in place in 27 of the potential 96 occasions across all parts of the standard. These results are presented in Table 1 on page 13.

The results of the inspection of 32 poor performing trusts are also available on our website: www.healthcarecommission.org.uk

The findings from the visits to all 42 trusts have been synthesised into conclusions that all NHS trusts can learn from.

Our key findings were that:

- complaints handling differs markedly across the country, and processes can be fragmented and applied inconsistently within trusts and across the NHS
- the basic elements of a complaints handling system were evident, however the emphasis appeared to be on procedures rather than on outcomes. This may be due to the focus of the current core standard C14, relating to complaints handling (see Box 3 on page 10), or due to inadequate interpretation of its intent by trusts
- despite the best efforts by trusts to meet the needs of their communities, the NHS needs to do more to open the system and make it more accessible, especially for groups with special needs, such as people with learning disabilities and people from culturally and linguistically diverse backgrounds
- patients often need support to make a complaint. The Patient Advice and Liaison Service (PALS) is often the first point of contact for complainants and it can play a helpful role for patients who wish to make a formal complaint
- no single trust addressed standard C14b, pertaining to discrimination, comprehensively. Trusts need to better communicate their commitment on discriminatory practice to staff and patients. There is also a serious absence of systems to monitor if care has changed or been altered as a result of a patient or carer making a complaint
- there is little evidence of trusts using complaints data to inform their decision-making when commissioning services, particularly the services of independent contractors

- there is no one-size-fits-all approach to investigation. A common understanding of methodologies, such as root cause analysis, would benefit the system, improve risk management of complaints and manage the expectations of complainants
- complaints handling was more effective where staff had access to support from complaints handling professionals, who are trained in related and complementary skills such as customer care, investigation, mediation and resolution
- there are no nationally-available standardised tools and resources, such as case studies, checklists, flow charts, process maps, templates and training aids. At trusts where these were available, staff felt supported and better able to manage complaints
- improving links between data on complaints with other safety and quality data, such as risk and incident monitoring data, can lead to complaints being taken more seriously as a source of information and feedback on the standard of service or care being provided
- using complaints data and real life case studies can promote positive attitudes to complaints among clinicians
- trusts use many tools to capture and report complaints data. Few trusts appeared to approach this in a systematic way, such as using trended data to highlight systemic or structural changes and linking this to long term planning as part of a trustwide strategy to help focus on patients
- there are many examples of complaints data leading to one-off changes to service delivery, but these are not necessarily shared across trusts or health economies. While some trusts use complaints data to undertake remedial action, this was not universal across the sites visited or within trusts
- the Healthcare Commission is the only mechanism currently providing routine national analysis and feedback on NHS complaints handling

These findings show clearly that the trusts' complaints handling systems need to be improved. Our conclusions and recommendations are outlined later in this report.

Approach

Complaints provide an invaluable source of learning for organisations, and the way an organisation responds to and acts on the complaints it receives shows its attitude to, and engagement with, patients and their families. How complaints are handled is therefore of vital importance.

We approached the audit with the principle of undertaking an assessment that made intelligent use of a wide range of existing sources of information and that contributed to national learning about complaints.

We considered a number of options for how we might do this and consulted with those who use the NHS, patients and providers, the Parliamentary and Health Service Ombudsman, the Department of Health, NHS management, strategic health authorities and special interest groups[8].

The overarching aim of the Healthcare Commission is to promote improvements in healthcare. The objective of the audit is therefore to improve the experience of people making complaints at a local level by:

- giving a richer picture to the screening information used in the assessment of the 2006/2007 annual health check
- reducing the number of requests for independent review received by the Healthcare Commission
- contributing to national learning on how complaints can be handled effectively, highlighting best practice and where there are gaps in practice
- making recommendations on the way complaints handling could be improved

Assessing the risk and the annual health check

In the first stage of this audit, we used a wide range of data on complaints handling to benchmark the performance of all trusts.

These measures include the proportion of second-stage complaints that were upheld or referred back for local resolution as well as other nationally available data (see Box 2 overleaf).

The Healthcare Commission assesses NHS organisations to determine the extent to which they are meeting national standards for service provision. The annual health check requires trusts to declare each year whether they are compliant with the core standards published by the Department of Health in July 2004[14].

Core standard C14 is used to assess trusts' performance on complaints handling (see Box 3 overleaf). We check trusts' declarations against a wide range of information, including comments from representatives of patients and other partners in the community. Where this information gives us cause for concern, we follow this up with particular trusts.

To determine the degree of risk of non-compliance with standard C14 for the 2006/2007 annual health check, we took into account whether a trust had been inspected in the 2005/2006 annual health check, and the outcome of that inspection. In 2005/2006, 22 out of 570 trusts declared themselves 'non-compliant' with one or more parts of core standard C14. In addition, after looking at trusts' declarations, we found five additional trusts who were not meeting one or more parts of standard C14.

Box 2: Data used for risk profiling trusts

Department of Health written complaints data
These relate to Department of Health data collected from 2002/2003, 2003/2004, 2004/2005 and 2005/2006, for all written complaints. Two indicators have been used: the mean of all data for these years and the latest figure. The denominators used for different types of trusts were: patient journeys for ambulance trusts, bed days for acute trusts, patient encounters for mental health trusts and registered general practice population for primary care trusts.

Third party comments
These data are third party comments coded to core standards C14a, C14b and C14c. They can come from a variety of organisations, such as patient and public involvement forums and strategic health authorities.

Core standards status
These data show the trusts' status for standards C14a, C14b and C14c in the 2005/2006 annual health check. To avoid double counting when data are aggregated, we have removed Department of Health data and third party comments.

We also used trusts' inspection status (that is, whether they have been subject to inspection by the Healthcare Commission and the outcome of that inspection).

Second-stage complaints
This indicator is derived from the number of second-stage complaints received and closed at the Healthcare Commission (in the 12 months from April 2005 to April 2006). Two items have been used: the proportion of complaints upheld and the proportion of complaints referred back

This risk assessment flagged the 10% of trusts (32) that were most at risk of not meeting core standard C14 and therefore requiring a visit by our inspectors (see section on the impact on the annual health check on page 12).

Of these 32 trusts, we found that the overall risk was evenly distributed by trust type and region (see Figures 2 and 3). This provided us with a good cross section of trusts to be visited and can be viewed positively in the context of the findings of the audit.

Box 3: Department of Health's core standard C14 relating to complaints handling

Healthcare organisations have systems in place to ensure that patients, their relatives and carers:

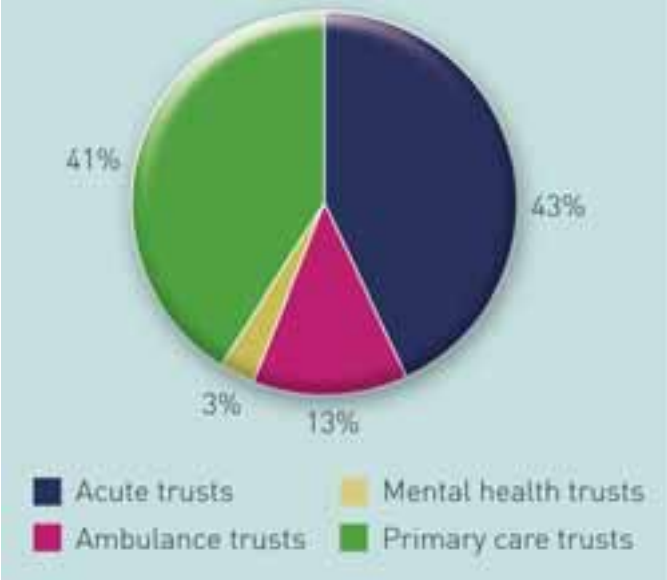
a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;

b) are not discriminated against when complaints are made; and

c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

Figure 2: Distribution of risk-selected trusts by region

Figure 3: Distribution of risk-selected trusts by sector



The focus of the visits to the 32 poor performing trusts was on the operation of their arrangements for the handling of complaints on the day of the visit. The assessment team examined these arrangements with reference to *The NHS (Complaints) Regulations 2004*[15] and the associated *Guidance to support implementation of the NHS (Complaints) Regulations 2004*[16] and the three parts of core standard C14 (see Box 3).

We also used the findings of the risk assessment to identify the trusts that appeared to be least at risk. We randomly selected and visited 10 of these better performing trusts (see Box 4) in order to gain a better understanding of the factors that make them work well and to help us understand why this is.

Box 4: Better performing trusts

The following trusts were among those identified as appearing to be least at risk, and were randomly selected for a visit as part of the audit:

1 Central Manchester Primary Care Trust
2 East Kent NHS and Social Care Partnership Trust
3 East Lancashire Hospitals NHS Trust
4 Gloucestershire Partnership NHS Foundation Trust
5 Guys and St Thomas NHS Foundation Trust
6 Haringey Teaching Primary Care Trust
7 Heart Of Birmingham Teaching Primary Care Trust
8 North East Ambulance Service NHS Trust
9 Plymouth Hospitals NHS Trust
10 Scarborough and North East Yorkshire Health Care NHS Trust

Impact on the annual health check

For the audit of the 32 poor performing trusts, we used a five-point scale, as shown in Box 5, to assess them.

The results of each inspection were subject to a rigorous quality assurance process in order to ensure that judgments were consistent and determined equitably across those trusts visited. A copy of the inspection report from each trust is available on our website at www.healthcarecommission.org.uk.

Where appropriate, we issued notification letters to inform trusts where any of our findings may have a direct consequence on their compliance with the three parts of core standard C14.

Where we identified a significant lapse in compliance, we informed trusts of this finding. We also informed them that if they failed to declare 'not met' in their core standards declaration for the 2006/2007 annual health check, we would qualify the declaration for the relevant parts of standard C14.

We also issued a notification letter where we identified a potential risk to a trust's compliance and we asked the trust's board to consider this risk when making its annual health check declaration.

After trusts submit their self declaration of compliance with core standards for the annual health check, we cross-check their declarations with our own findings. In cases where these differ, our inspectors carry out follow-up visits.

The results of the audit inspection are set out in table 1.

Box 5: Five-point scale for assessing trusts' compliance with core standard C14	
1 Findings demonstrate appropriate information is available and arrangements are in place for access to complaints procedures	No further action required
2 Insufficient evidence reviewed by the Healthcare Commission to determine a conclusion for this element	No further action required
3 Some areas for improvement identified	Follow up through engagement meeting within six months
4 Some risks to the trust's compliance identified	Issue notification letter
5 Significant lapse identified	Issue notification letter

Table 1: Results of audit inspection using five-point assessment scale			
Name of trust	Core standard C14a	Core standard C14b	Core standard C14c
Basildon and Thurrock University Hospitals NHS Foundation Trust	3	1	3
Basingstoke and North Hampshire Hospitals	3	3	1
Bristol Primary Care Trust	3	3	3
Derbyshire County Primary Care Trust	3	**4**	1
Devon Primary Care Trust	3	3	**5**
Eastern & Coastal Kent Primary Care Trust	**5**	**5**	**5**
East of England Ambulance Service NHS Trust	**4**	**5**	1
Kingston Hospital NHS Trust	1	**4**	1
Lambeth Primary Care Trust	3	**5**	3
Lincolnshire Primary Care Trust	1	3	1
Liverpool Primary Care Trust	3	1	3
Merseycare NHS Trust	3	1	3
Mid Cheshire Hospitals NHS Trust	3	**4**	3
North Cumbria Acute NHS Trust	3	**5**	1
North Devon NHS Trust	**5**	3	**5**
North West Ambulance Service NHS Trust	**4**	**5**	3
North West London Hospitals NHS Trust	3	**4**	3
Pennine Acute Hospitals Trust	**4**	**5**	**4**
Plymouth Primary Care Trust	3	**5**	3
Portsmouth Hospitals Trust	1	**4**	3
Queen Mary's Sidcup NHS Trust	3	**5**	3
Royal Brompton and Harefield NHS Trust	**4**	3	3
Southampton City Primary Care Trust	1	3	1
Southampton University Hospitals NHS Trust	3	3	1
South Central Ambulance Service	3	3	1
South West Essex Primary Care Trust	3	1	3
Suffolk Primary Care Trust	3	**5**	3
Surrey Primary Care Trust	1	1	1
Telford and Wrekin Primary Care Trust	**5**	1	1
The Whittington Hospital NHS Trust	1	1	1
West Hertfordshire Hospitals NHS Trust	1	3	1
Yorkshire Ambulance Service NHS Trust	3	3	3

Note: The audit results correspond to the five-point scale in box 5. The shaded cells indicate that a notification letter was issued.

What the audit found

Figure 4: Distribution of audit outcome (out of 96 possible notifications)

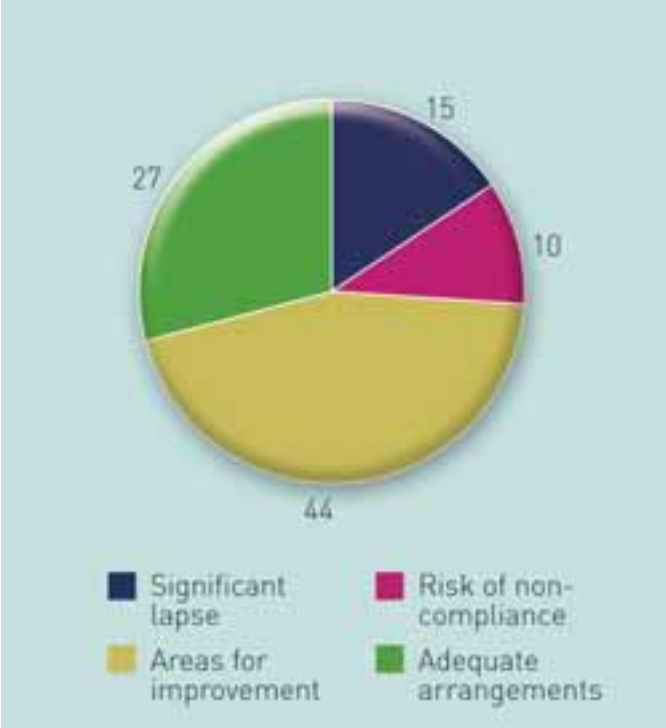
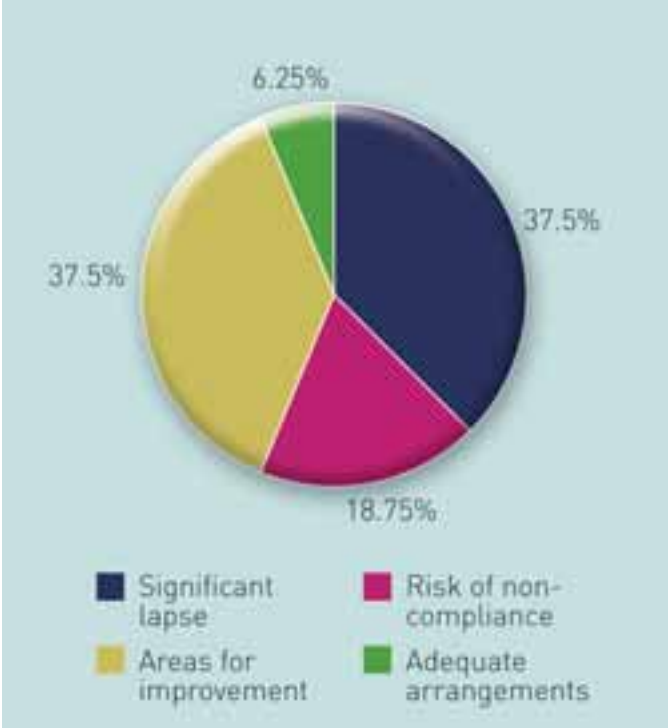


Figure 5: Distribution of audit outcome (by trust)



Across the three parts of core standard C14, there was the potential to issue a total of 96 notifications to the 32 poor performing trusts. Overall, we issued 25 notifications. Fourteen of these were issued on core standard C14b which relates to discrimination against complainants.

We found adequate arrangements in place in 27 of the potential 96 occasions across all parts of core standard C14.

Of the 32 trusts:

- two trusts (6.25%) had adequate arrangements in place across all standards
- 12 trusts (37.5%) had areas for improvement
- six trusts (18.75%) were at risk of non-compliance
- 12 trusts (37.5%) had a significant lapse

What trusts declared in the annual health check

The annual health check emphasises the responsibility of each NHS trust to ensure that they are meeting the Department of Health's core standards. Trusts undertake a self-assessment process, then make a public declaration on whether they were meeting core standards during the year of assessment. They can choose to declare one of three positions:

1 met

2 not met

3 insufficient assurance

The audit inspections were carried out during February and March 2007. Following this, trusts declared publicly their compliance with core standards as part of the annual health check in May 2007.

In the 2006/2007 annual health check:

- 100% of trusts declared 'not met' in their declaration where the audit found there had been a significant lapse
- at the two trusts where we found adequate arrangements across all parts of core standard C14, one trust declared 'insufficient assurance'
- at the six trusts where we identified a risk of non compliance, four trusts declared 'compliant', one trust declared 'insufficient assurance' and one trust declared 'not met'

Follow-up

As part of our ongoing engagement with trusts, we undertake follow-up visits to trusts where we identify areas for improvement.

If a trust's declaration of compliance with standard C14 was different to our own decision, based on the results of the audit, they were visited during our annual health check inspections.

The outcomes of these visits will be reflected in the annual health check results due to be published in October 2007.

Measuring what matters

We have worked closely with patients, members of the public, interest groups, clinicians and other key stakeholders to identify what matters most to them in measuring improvement in complaints handling.

We were told that the important areas were:

- the accessibility of the complaints service
- the quality of investigations
- the quality of responses
- how well trusts learn from complaints and use this information to bring about improvements to services

Access

People take for granted that the NHS has a formal complaints system. However, we know that sometimes they still find it difficult to make a complaint.

The degree to which the system is open and accessible is therefore important.

Our inspectors found that of the 32 poor performing trusts, 78% of trusts need to take some action to make their complaints handling system more accessible. We found that appropriate information was available and arrangements were in place at only 22% trusts visited (seven out of 32).

Case study 1: Poor complaints handling

Mr A received treatment from his local hospital, part of a large teaching trust in the East of England. Mr A had concerns about the treatment he received and was advised by a member of staff that he could write to complain. His letter of complaint was headed 'complaint' and was addressed to the complaints manager (the name he had been given by the staff member).

After a period of time, Mr A received a response from the chief executive. He also had a meeting with the manager responsible for the service he had complained about. Mr A was not informed about the Independent Complaints Advocacy Service (ICAS) or any local support for his case.

However, this response did not resolve his concerns and, having done his own research, he sought to escalate his concerns to the next level. Mr A was then surprised to be informed that the trust was dealing with his concerns informally and not as a formal complaint, and he could not therefore escalate his case.

Mr A was also told that, as it had been a long time since the matter occurred, the trust would not accept the case as a complaint on the grounds of time. The trust indicated that it would not supply any information to assist an independent review as it felt that no complaint had been made. The Healthcare Commission subsequently challenged this and was able to review and uphold Mr A's complaint.

The Healthcare Commission is also addressing the issue of how concerns are dealt with at the trust.

We found that in general, policies and procedures were in place; however these may not be consistent within trusts that have multiple sites. Many policies need updating to reflect current services such as in newly-merged trusts. At one rural primary care trust (PCT) that had recently been formed from the merger of five trusts, there was no standardised trustwide approach to complaints handling and current practice was based on the policies of the superseded organisations.

Levels of awareness of the procedures for complaints handling among staff varied. Training of staff was ad hoc and mostly confined to inductions of new staff. As a consequence, newly-appointed staff appeared to be more conversant with up-to-date practices and what to do if they receive a complaint than staff who had been in post for some time.

Information for patients on making a complaint tended to consist of posters, leaflets and websites. We found that these were not always readily available or had the most up-to-date information, such as correct telephone numbers or contact details.

"Oh yes there are plenty of leaflets. The managers ran around and put them there yesterday." (interview with staff)

Despite the best efforts by trusts to meet the needs of their communities, more should be done to make the complaints system more accessible for groups such as people from culturally and linguistically diverse backgrounds or those with disabilities.

A good example was a metropolitan PCT which used census data to profile the racial and ethnic characteristics of its catchment area and used this information to ensure that its promotional information was available in the languages spoken within the community.

However, the trust's data on complaints indicated that 80% of complainants were white males. This could indicate that the complaints handling system was still not accessible to people from ethnic minorities.

In order to make the system more open and accessible, the better-performing trusts promoted feedback from consumers, including positive and negative comments and complaints. These trusts had strong links with the Patient Advice and Liaison Service (PALS), which is often the first point of contact for complainants.

For example, one top performing acute trust used all the standard methods to publicise its complaints handling system but wanted to do more to encourage people to come forward.

To achieve this, they worked with PALS on an active community out-reach programme. The programme linked in with existing patient support groups, disability groups and hard-to-reach special interest groups, as well as social services. The staff worked closely with these groups by attending meetings, distributing leaflets, sharing information and talking about what they do.

The trust also had a good link with its patient and public involvement forum (PPIF) and has now established a community involvement forum. Service users and patients sit on this group and work with the trust to advise on the design of its patient information leaflets.

The trust keeps this programme active by continually searching through local newspapers to learn about new groups or meetings that may also be worth targeting.

"A big part in our complaints handling is through our PALS team. Quite a lot of people within the community and within the trust know about PALS. They act as a gateway for complaints and it is through PALS that we have a high profile around the trust and within the community. PALS try and nip things in the bud on the spot and offer advice and support to patients, relatives and carers, and to staff. If they can't get any further with that then we do go down the formal complaints process, which is supported by a PALS worker. If any problem is identified at the time of contact with the PALS team we offer them as much support as we possibly can in formulating a complaint and accessing the complaints team." (interview with senior complaints manager)

An example of good proactive practice involved a couple with learning disabilities who had not always had a very positive experience on their visits to the accident and emergency (A&E) department, for a number of reasons. It was quite clear that whenever they presented, things just didn't run smoothly, as they frequently complained to the trust.

The trust was keen to work with the couple to improve their experience and a meeting was organised with them. The trust asked them who they would like to be there and the meeting was attended by an advocate from their support group as well as an Independent Complaints Advocacy Services (ICAS) advocate. Their GP and on-call GP services manager also attended. A senior consultant from A&E, the complaints manager and the matron attended on behalf of the trust.

As a result of the meeting, the couple now have a plan that enables them to determine when their condition warrants emergency treatment or if it can wait until they can see their GP.

They have since visited A&E twice, once on a very busy day, and have had much more successful visits.

The result of this proactive measure is that the couple now have a process if they need to attend the trust at short notice and an immediate point of contact if they have a general concern about the trust.

We found an example of good practice when visiting a teaching trust servicing a large urban area surrounded by smaller towns and rural communities.

The population of the area has become more diverse in recent years, with the arrival of a significant number of Eastern Europeans coming to work in the region. There is also a sizeable Asian community within the city.

The trust has recently appointed an equality and diversity (E&D) officer who is available to advise the complaints team on cultural issues. This partnership has been working well and the E&D officer recently attended a resolution meeting with two complainants, their Independent Complaints Advocacy Services (ICAS) advocate and the complaints manager, at which examples of poor accessibility to the trust were highlighted. The E&D officer listened to the complainants' concerns regarding the inadequacy of facilities and examples of a lack of staff training, and shared with them details of the trust's action plan to resolve the matter.

Though it was recognised that some of the problems involving the design of the hospital facilities could not be quickly resolved, the complainants were reassured to learn that the trust was listening and acting on the issues arising from their complaint. A copy of the action plan was sent to the complainants following the meeting, along with the notes of the meeting.

Case study 3: Good complaints handling

The London Primary Care Complaints Consortium identified that individual GP practices required some support in helping people who do not speak English to use the complaints procedure. The cost of translating complaints literature had previously been borne by each GP practice. The consortium was able to address this by arranging for a standard text, that described the complaints procedure and explained how to use it, to be translated into 10 of the most commonly spoken languages in the London area.

This new standard text has been shared across primary care providers to form the basis of readily-available leaflets and posters in health facilities and community centres, and among local groups.

By working collaboratively, it is now easier for people to access the complaints system locally.

Investigation

The objective of a good investigation is to obtain a sufficient amount of clinical and other information in order to decide what has occurred and to identify appropriate action.

Trusts were assessed on the extent to which they apply *The National Health Service (Complaints) Regulations 2004*[15] and associated guidance[16]. These set out ways in which the trust may conduct an investigation and include:

- early face-to-face meetings with the complainant using, if appropriate, mediation or conciliation
- not being adversarial, and the investigating officer considering the complaint with an open mind, being fair to all parties
- seeking to understand the scope and nature of the complaint and identifying any issues not immediately obvious
- being supportive to those involved and taking a blame-free approach. This includes providing anyone identified as the subject of a complaint with a full account of the reasons for the investigation, giving them a proper opportunity to talk to the investigating officer and ensuring that they are kept informed of progress

The manner in which trusts approach a complaints investigation varied across the audit. There is no one-size-fits-all method and each investigation is dependent on the circumstances of the individual complaint.

Complaints policies were evident, but these did not always adequately reflect the latest regulations and guidance. In the case of PCTs, this may be due to recent mergers of trusts.

At some trusts, the focus appeared to be on the procedure rather than the quality of the investigation. At trusts where responsibility for investigation had been devolved to directorate-level, with no centralised support, the quality of the investigation diminished. For example, investigation reports contained subjective comments by staff about the complainant and information was not appropriately supported by evidence. At one organisation visited, a review of a complaint case file showed that there was a lack of information provided to complainants during the course of the investigation.

At another trust, we saw that a backlog of 67 complaints was shown to be due to problems with inaccuracies in clinical information and poor filing and tracking of complaints, such as cases not being logged into the database. Another trust had examples of letters from complainants referring to long delays in investigation.

The trusts where we felt adequate arrangements were in place had clear unambiguous systems and processes for investigating complaints.

> *"It is about thoroughness... a very clear system; it's about having some authority, which is enhanced, I suppose, by having those sort of systems in place and training so people understand what you're doing and why you're doing it and feel that it's fair and thorough, so that they can participate in it."* (interview with complaints manager)

These systems and processes included:

- risk-stratifying the seriousness of a complaint
- recognised investigative methodologies, such as root cause analysis
- customer care, role play and conflict resolution training for staff conducting investigations
- access for staff to complaints handling professionals trained in related and complementary skills such customer care, investigation, mediation and resolution
- access to independent clinical advice
- keeping the complainant informed
- leadership
- complaints management staff having access to frontline clinical staff for advice
- resources such as templates, checklists and flow charts
- clearly-defined levels of accountability and monitoring

We saw a small complaints team at a large acute general hospital who found that the hospital could improve its complaints handling by providing simple and cost effective support to staff undertaking complaints investigations.

Case study 4: Poor complaints handling

This case concerns a one-year-old child who was admitted to a large London hospital after a febrile convulsion associated with an upper respiratory tract infection. His condition deteriorated and two days later he died. His parents complained to the trust about his care and treatment. They were not satisfied with the response, so they approached the Healthcare Commission.

The trust's investigation was found to be lacking. No members of staff were interviewed and statements were not obtained from key members of staff. The investigation was not thorough and left a high degree of ambiguity about the events that had occurred. It did not appear that a meeting was offered, and there was no clear audit trail of the investigation process. As a result, the trust did not identify any significant improvements.

The complainants had also raised concerns that nurses had reset the parameters of a heart monitor to prevent it from sounding. The trust acknowledged that this should not have happened, but did not identify any actions as a result. It stated that observations every two hours were an acceptable alternative to electronic monitoring. The Commission's clinical adviser emphasised that this was not the case. The Commission wrote to the trust's chief executive to seek its immediate assurance that it did not regard two-hourly observations as an acceptable alternative.

The Commission also decided to carry out an investigation of this complaint.

The team produced a toolkit and circulated this to all the directorates in the hospital. The toolkit included:

- a template setting out general issues to be covered in an investigation, such as who is responsible for ensuring that the investigation is carried out and the timeframes involved
- information on how to write a coherent response and how staff should avoid the use of clinical terminology or, if it is necessary, to do so in a way that the complainant will understand
- a set of slides about how to set up and conduct interviews, resolution and conciliation meetings
- guidance on how to make good written notes of the investigation so that the notes are detailed and cover all the issues raised in the complaint. The guidance also states that these should always be shared with the complainant

This particular complaints team is also available to assist staff with carrying out stakeholder analysis, scoping and process mapping the complaint, interviewing staff and writing up the report.

Case study 5: Good complaints handling

Mr C's GP diagnosed him as having shingles. However, over the next few days his symptoms continued to get worse. He was admitted to hospital but died of septicaemia.

Mr C's wife complained to the GP practice about his care and treatment. The GP provided a detailed letter to the complainant explaining the basis on which the doctor made his diagnosis of shingles.

The complainant was not fully satisfied with this explanation. Rather than giving up and inviting the complainant to approach the Healthcare Commission, the practice took additional steps to help resolve the complaint. It offered a local resolution meeting to the complainant, which she attended.

At this meeting, the doctor who made the diagnosis and the practice manager offered explanations to the complainant.

The outcome of the meeting was that the practice agreed that a doctor from a neighbouring practice would provide an independent clinical view on the circumstances surrounding Mr C's death. The independent GP interviewed both parties and concluded that the original diagnosis made by Mr C's doctor was reasonable.

Mrs C remained dissatisfied and approached the Healthcare Commission. We reviewed the way that the complaint had been handled, and having taken clinical advice from another GP, concluded that no further action was necessary.

Response

A good response is an effective customer-centred resolution process where everyone involved can focus on arriving at a satisfactory outcome.

The NHS (Complaints) Regulations 2004[15] require the complaints manager to prepare a written response that summarises the nature and substance of the complaint, describes any investigation and summarises its conclusions. Responses should address all the points raised by the complainant and an outcome, or explanation, of any action planned.

Case study 6: Poor response to a complaint

Ms P sent a letter of complaint to a large trust in the South East of England regarding the care and treatment provided to her late mother. The letter was not acknowledged. A month later, she wrote again and received an acknowledgement seven days later, informing her that an investigation would take place.

Ms P did not hear from the trust for three months. As she was concerned, she contacted the trust again. A meeting was arranged, and was attended by the complainant and clinical staff from the trust. This did not resolve the complaint, and Ms P made a request for the Healthcare Commission to independently review the complaint.

Having conducted its review of the complaint, the Commission's decision was to refer Ms P's complaint back to the trust recommending further work at the local level to resolve the complaint. The decision letter advised the trust of the timescale for informing Ms P of the actions taken in connection with the Commission's recommendation: 25 working days from the date of the letter or within an extended time period that must be agreed with the complainant.

Three months passed, during which time Ms P repeatedly tried to contact the trust without success. Ms P contacted the Commission for help. Our case manager also attempted unsuccessfully to contact the trust.

When the trust did eventually respond, it informed the case manager that it was not possible to give an estimated timeframe for completion of the investigation – there was no evidence that the trust had agreed an extended timescale with the complainant. As a result of this, a more senior member of staff at the Healthcare Commission wrote to the trust's chief executive asking that Ms P be given a realistic timescale for the conclusion of the investigation as a matter of urgency.

A month later, the trust's chief executive wrote to Ms P apologising for the standard of care offered to her mother and giving assurances that improvements had been made. He also offered profuse apologies for the way in which the complaint was handled and gave an assurance that more thorough systems would be introduced in the complaints department to ensure compliance with the relevant regulations.

Healthcare organisations should therefore ensure that arrangements are in place for any outcomes to be monitored to ensure that action is taken. The associated guidance to support implementation of the regulations[16] states that it is good practice to keep the complainant, and those involved in the complaint, informed of progress and the final outcome when all actions have been taken.

The guidance also states that a response must refer to the complainant's right to take the complaint to the Healthcare Commission and advise what they can do if they disagree with the response or would like further explanation.

At trusts where our inspectors found inadequate arrangements or a significant lapse, the systems for monitoring responses to complaints were not always evident. This included the absence of a documentary log of complaints. In addition, not all written responses clearly summarised the nature and substance of the complaint, nor adequately described the investigation and conclusions.

At poor performing trusts, systems for monitoring outcomes from complaints were ad hoc. This meant that neither staff nor the complainant are routinely informed of actions or outcomes. For example, at a large metropolitan PCT, the final outcomes following recommended actions from a complaint were not always shared with the complainant, and at another, only 59% of complaints had been responded to within the statutory 25 days.

At one recently merged PCT, there was insufficient evidence to demonstrate that complaints handling had been embedded in the new organisation, and outstanding complaints cases had not reached resolution for some months. Although the recently updated policy stated that acknowledgment letters should follow the trust's standards, the policy did not provide staff with a description of what these standards are.

At one better performing trust, the complaints manager thought the tone of the trust's response was as important as the outcome.

"I feel the tone of our response is very understanding. I think it's very open and honest, and apologetic, because the people who complain genuinely feel upset, distressed, angry. It is important that we recognise that, and it is important that we get it right through our letters. We don't spread it on thickly. We just categorically say, "I am very sorry" without repeating it so it doesn't appear disingenuous. We are very careful with that, we are very honest, but we do apologise for the way they felt.

Whatever the factual outcome of an investigation might be, the perception or the experience of the client might be something different or might be a little bit more subjective, and so it's always that we've taken it seriously, we're not minimising it in any way, even if it's not totally upheld, so it's all about understanding and thanking them for giving us the feedback and trying to give something positive and constructive in the response, it's: 'thank you for taking the trouble to do this, it must have been difficult, and we take your experience very seriously'."
(interview with complaints manager)

Case study 7: Good response to a complaint

Three years ago, a large teaching trust recognised that there were some significant issues around the continuity and quality of responses to complainants. Up until that time, the trust felt that the focus had been solely about improving response times. However, it found this resulted in more cases bouncing back or being referred for independent review.

The trust appointed a medical advisor to the complaints team, who has been key to providing insight into the more complex clinical complaints and wider organisational issues. This also improved the trust's ability to provide a more detailed and contextual response to complaints. In two recent cases, the medical advisor has sought expert opinions from clinical specialists outside the directorate named in the complaint.

Although this process takes time and a meeting with the complainant is often necessary following an initial response, they believe it is possible to better resolve complex complaints by adopting this approach.

The trust also felt that it is very important to acknowledge the limitations of the complaints handling procedure and that it is not always possible to reach resolution. It is therefore important to acknowledge this point and ensure that complainants understand the boundaries and what can realistically be achieved through the complaints process. In cases where the patient wants to pursue another course of action, such as compensation, the complaints manager and medical advisor ensure that complainants are directed appropriately.

Discrimination

People who complain should feel confident that their care will not be changed or altered in any way as a result of having made a complaint.

Our visits to trusts therefore looked at what systems are in place to ensure that patients, carers and relatives are not discriminated against.

This included how the trusts:

- communicate their commitment that people will not be adversely affected if they make a complaint
- encourage people to speak openly and reassure them that whatever they say will be treated with appropriate confidence and sensitivity
- communicate their commitment to policies and expectations of staff
- identify any areas where discrimination may have occurred and what action had been taken

From the available data, it is clear that no single trust approached this comprehensively. Our inspectors found that 78% of trusts needed to undertake some action to improve, and only 22% of trusts had adequate systems in place.

At nine trusts, we found there had been a significant lapse against the standard. For example, some trusts had explicit statements pertaining to discrimination in their policies but had not adequately communicated their commitment to staff and patients.

Case study 8: Removal from GP practice list

A London GP practice removed Mr O from its patient list, having referred him to the local PCT's violent patient scheme. The reason given by the practice was that Mr O had been abusive to a member of staff when he was told that he would have to re-book an appointment after arriving late; this was apparently the third time that this had happened.

Mr O complained to the practice and the PCT about his removal from the list and the referral to the violent patient scheme. He felt that he had been discriminated against on the grounds of his race. Dissatisfied with the response to his complaint, Mr O requested an independent review by the Healthcare Commission.

When the Commission's case manager reviewed the case, she could find no evidence of an investigation into these events or a record of the two previous incidents referred to. The only reference to the incident was a brief note in Mr O's medical records saying that he had been 10 minutes late for his appointment and was abusive when asked to make another appointment. Although the British Medical Association, the Royal College of General Practitioners and the General Medical Services contract (2004) all have guidelines for removing patients, there was nothing to indicate that the practice had used any of these.

The Commission's decision was to recommend that the PCT appoint an independent expert to investigate the circumstances of Mr O's removal. This investigation found that there was no evidence to support the decisions of the GP practice, and that Mr O's removal and referral to the violent patient scheme was unjustified.

Consequently, the PCT removed Mr O's name from the violent patient scheme, agreed to append a note to his medical records to confirm this, and asked the GP practice to reinstate him to its list. Mr O decided that he did not wish to return to the practice.

To improve patient services, the PCT also asked the practice to draw up a discrimination and harassment policy and to arrange a training session for staff on handling difficult situations. The PCT itself sent a newsletter to practices in its area emphasising the need to properly record incidents occurring on practice premises.

At other trusts, the focus appeared to be more procedural. For instance, they had clear statements of their commitment to policies, training and patient information but no clear system in place to measure whether discrimination occurred.

Guidance to support implementation of the NHS (Complaints) Regulations 2004[16] recommends that trusts collect local data, such as patient surveys, to monitor changes in practice and procedures as a consequence of complaints handling.

We found that the majority of trusts do not have systems in place to monitor if care has changed or been altered as a result of a patient or carer making a complaint.

At a few trusts, we found isolated examples of mechanisms to identify areas where discrimination against complainants had

occurred but these needed to be used more systematically and rolled out across the trust.

NHS senior staff told us that they felt that this was a particularly difficult area in which to demonstrate compliance. There appears to be a general lack of understanding about core standard C14b and its meaning, and that it is about discrimination due to a person making a complaint and is **not** related to race or equality – although this type of discrimination could be the root cause of the complaint.

We were concerned that some trusts relied on anecdotal evidence to demonstrate that patients were not being discriminated against. Senior staff at a London trust had made a conscious decision to explicitly not include a statement about discrimination in its literature because to do so "would prompt concerns from people".

Case study 9: Good complaints handling

A complainant had presented a very detailed complaint to the trust regarding the care he received from the ear, nose and throat and cardiology departments at a major hospital in London. His complaint concerned the trust's PALS; delays in appointments; being removed from the trust's premises under the management of violent incidents policy; and the length of time that he had waited for a hearing aid.

The complainant's letters were often difficult to follow, but the trust worked extremely hard to address all of his concerns.

There was good evidence that the departments at the trust worked together effectively to produce a coordinated response. Statements were taken from the appropriate staff and incorporated into this. The trust's investigation letter was very clear, with all medical terms explained in lay language.

The complainant was unhappy with the trust's first response letter, but the trust did not immediately refer him to the Healthcare Commission. Instead they drafted a very detailed second letter to address his outstanding concerns.

The trust showed great patience and empathy in dealing with a sometimes difficult complainant. They provided clear explanations of the complainant's treatment and were prepared to provide detailed accounts of his care and treatment over a long period of time.

The complainant approached the Healthcare Commission about his complaint. Having taken clinical advice, we concluded that no further action was required.

Learning

Research tells us that people who make a complaint want to ensure that their concerns have been listened to and that the same thing won't happen again.

Core standard C14c states that healthcare organisations should have systems in place to ensure that patients, their relatives and carers are assured that the organisation acts appropriately on any concerns and, where appropriate, makes changes to ensure improvements in service delivery.

Under this part of the standard we looked at how healthcare organisations use concerns and complaints to improve their services.

We specifically assessed the extent to which trusts:

- review and analyse concerns and complaints received about their services
- take action to improve service delivery as a result of individual complaints or concerns, or analysis of trends from complaints data
- act on any recommendations from independent reviews by the Healthcare Commission
- report the number, type and outcome of complaints received, particularly the timing, format and method of reporting to the trust board

Across the audit we found that the 13 trusts could provide assurance that they were compliant with this standard. Our inspectors found that trusts had adequate systems in place to monitor and report complaints and, if necessary, seek to improve service delivery. Trusts use many tools to capture and report complaints data. These include performance reports to the board and clinical governance committees, outcome logs and action plans, annual and quarterly reports, and service level agreements with independent contractors and commissioned services.

It is evident that some trusts use this information to undertake remedial action. However this was not universal across the sites visited, and also varied within trusts. This could mean that although trusts collect and report complaints data there needs to be greater effort on using this data to make improvements.

Within the data there are many examples of one-off changes to service delivery. There were excellent examples of complaints data being discussed at ward or unit level meetings, leading to improvement at a local level. Sometimes these lessons are shared across departments or throughout the trust.

> *"We change little things every day. We introduced hotplates so that people get their meal in one go, so we've introduced little hot dishes that sit under and above them to keep the main course and a hot pudding warm while they have their starter. Something very small, but it makes such a difference to our patients."* (interview with a complaints manager)

Few trusts appeared to approach this in a systematic way, such as using trended data to highlight systemic or structural changes, and linking this to long term planning as part of a trustwide patient focus strategy.

"As part of our reporting, after about six or eight weeks we go back to cases that haven't been re-opened and ask them whether or not they were satisfied with the service, the accessibility, the outcome of the complaint, and the tone of our response. We've had some very mixed feedback... some has been good, very positive, but frankly we've had some not so good. We feed it all into our quarterly reports to the trust board so that they can see how the trust is performing."
(interview with complaints manager)

One PCT we visited has a population of 300,000, with 75 GP practices. The average GP's list size is approximately 2,900 patients and the majority of the practices are run single-handedly.

The PCT is very committed to improving the services of GPs in the area. To achieve this it has set up a filter and advice service. GPs can ask the PCT to review their complaints or draft a response on their behalf. The PCT's chief executive will also sign the letter if the GP wishes him to.

By working closely with its GPs, the PCT now has routine access to data about complaints handling which it uses to identify problems and, if necessary, feed this into its performance review processes.

In one such case, a GP had drafted an initial response to a complaint stating that treatment was within acceptable standards. The GP forwarded this to the PCT to draft a reply. The PCT arranged for another doctor to review the case who found that the treatment did not meet the nationally agreed guidelines. The trust raised this through its performance review processes and the GP must undertake refresher training.

Case study 10: Good learning

A PCT had recently completed a review of breast screening services. Following the review and a consultation process, the trust de-commissioned one breast screening van and re-located another to a location 90 minutes away.

The PCT subsequently noticed an increase in the number of complaints about the breast screening service. On investigation, it became clear that the issue was not about the quality of the service but that the breast screening van had moved from one side of the city to the other.

The complaints staff worked very closely with the team responsible for the screening service to look for a solution.

The PCT contacted the city transport services to let them know about the new location of the breast screening van. The trust provided bus drivers with information about the van's location and informed them that they could expect passengers who may need help in finding the van.

In addition, the trust now has an arrangement with the local 'ring and ride' scheme, for people on low incomes, where patients can book a door-to-door service when they make an appointment.

After the trust implemented these improvements the number of appointments for the breast screening service increased.

One better performing PCT told us that using information from complaints to inform its decision-making about commissioning was ad hoc and was something to aspire to.

However there were two examples where it had acted on its data. One involved complaints about adverse outcomes following minor private surgical procedures. The trust ended up paying for these patients to receive acute care, as the procedure is not covered by the NHS. It therefore decided to commission a vasectomy service.

The trust also received a complaint about its religious circumcision service. The GP involved also carries out private circumcisions and the complaint concerned a patient who had been treated privately.

Although it felt that it had no jurisdiction, the PCT chose to assist the patient and investigate the complaint. The trust also forwarded the case to its commissioning team, as part of an overview of how well the circumcision service was being managed.

Case study 11: Good complaints handling

One of the largest and busiest acute hospital trusts in the North West treated a patient for a particular condition. The man died and the autopsy revealed he had an MRSA infection.

The family of the deceased was upset about this and approached the trust to find out what had happened.

The trust arranged a meeting between the chief executive, the director of clinical governance and the family, which went very well and had two positive outcomes.

The trust was able to educate the family about MRSA and its infection control procedures. The family expressed concerns about seeing staff outside the hospital wearing their uniforms.

This led the trust to implement significant cultural and organisational change. It devised a new dress code and uniform policy, and invested in facilities for staff to change clothes.

The family agreed to help the trust in an MRSA public awareness campaign and is still working with the trust.

Case study 12: Good complaints handling

Mrs B, a 91-year-old patient, was admitted to hospital with pneumonia. She was the primary carer for her husband, who has arthritis and is blind. After a week, she was discharged at short notice. Her family was concerned that she was made to leave her bed and sit around for hours waiting to be discharged, and that her mobility was still limited. Mrs B also had difficulties with the drugs she needed when she left hospital. Her family cared for her but after four days she had to be re-admitted to hospital following an emergency call from her GP.

The family made a complaint to the trust, who suggested a meeting. At the meeting, the trust admitted that it had failed to follow correct procedures when discharging Mrs B. The consultant still maintained that the patient was fit to be discharged, but admitted that there was no consideration of recuperative care or Mrs B's social circumstances.

When the Healthcare Commission reviewed the complaint, we found that the assessment of Mrs B was inadequate. Her discharge from hospital had not been discussed in advance with her family, even though the trust's procedures stated that 24 hours' notice should be given, and there was no consideration of her circumstances as a carer.

We upheld the complaint and asked the trust to improve its procedures for discharging patients and to inform Mrs B's family of the outcome. The trust introduced a more robust discharge policy and provided training to staff in these new procedures. It introduced a new single access point, which now holds information about the availability of all beds in the hospital so that patients can be allocated a bed appropriately. The trust also set up a working group to review and agree a new information booklet for patients about leaving hospital.

The trust met Mrs B's family again, with a representative from the Independent Complaints Advocacy Service (ICAS). The chief executive also wrote to Mrs B to apologise for the distress caused, acknowledging that the arrangements for her discharge from hospital did not take account of her social needs.

Case study 13: Poor complaints handling

A trust received a complaint that a consultant had been over-prescribing a drug (zopiclone) when he was aware that the patient was becoming dangerously dependent upon the drug. The patient felt that this directly led to her being admitted as an inpatient to a mental health unit.

The trust's response to the complaint was inadequate and its letter to the complainant did not reflect the seriousness of the complaint. Essentially, the trust said that because the consultant concerned had now left its employment, it was unable to answer the complaint. The trust explained that it had been unable to contact the consultant, but would inform the complainant if it managed to do so in future.

From the Healthcare Commission's review of the complaint, it was apparent that the trust did manage to contact the consultant after the response letter had gone to the complainant. The trust did not inform the complainant of this, contrary to its previous letter. The consultant advised the trust that it would be relatively straightforward to investigate the complaint: an appropriate clinician could review the prescription records to determine whether there was any evidence of over-prescribing. The trust failed to act on this advice, and instead let the complainant go to the Healthcare Commission.

The Commission referred the matter back to the trust so that its clinical director could review the patient's records to determine whether zopiclone had been over-prescribed. He found that this medication had indeed been prescribed outside of its licensed dosage, and that there was a lack of detailed information in the patient's notes. However, the trust did not appear to identify any learning points from this.

The Healthcare Commission wrote to the trust to ask for assurance that action had been taken as a result of these findings, which was provided.

We found a good example of a trust that wanted to promote awareness of good complaints handling as a good source of learning for doctors.

Medical 'grand rounds' are formal meetings where physicians discuss the clinical case of one or more patients. They present clinical problems by focusing on current or interesting cases and are integral to education and learning.

Although it is difficult to get a subject onto the grand rounds roster, the complaints manager approached consultants who she felt would be supportive as they had worked with her on cases and had positive experiences.

They agreed that it was a good idea for her to give a talk on learning through complaints. The grand round was widely advertised and well attended by consultants, registrars and associate specialists.

They discussed case studies, figures and trends on complaints, such as poor communication.

The grand round had provided an opportunity to engage very positively with an important clinical group and the complaints manager felt that this has changed doctors' perceptions of complaints handling. She has since been invited back to present another grand round in the future.

Conclusion and recommendations

When a customer takes the time to give feedback about a product or service, it is a fundamental principle of good practice to listen and, if necessary, act on and learn from the feedback. Complaints are an excellent source of information about customers' experiences and should therefore be an integral component of an organisation's performance management system.

People take for granted that NHS trusts have a formal complaints system. When they make a complaint we know that they want it to be resolved as close in time and place as possible to the event, and that some action is taken to ensure that the same problem will not happen again to someone else.

To achieve this, there needs to be an effective and efficient complaints handling system where the emphasis is on resolving complaints locally.

The Healthcare Commission, the Health Service Ombudsman, the Department of Health, and organisations representing patients have been advocating this for some time.

However, from what we have seen in the audit, substantial work remains to be done for this to be achieved. It is interesting to note that the Ombudsman's recent annual report laments that there is a long way to go before complaints are taken as seriously as they should be across the NHS[11].

Although the scope of this audit was on systems for handling complaints in NHS trusts and not on individual cases, data from independent reviews of complaints against the NHS tells us that when people do complain, many still find the experience unsatisfactory and are unable to get their issue resolved[5,11]. Indeed, we refer just under one-third of cases we receive back to the trust for further work to be done to resolve the complaint locally. This reveals inadequacies in the way that NHS trusts manage complaints.

Key areas needing improvement

Within the audit, we found that complaints handling differs markedly across the country, and processes can be fragmented and applied inconsistently within trusts and across the NHS. While the basic elements of a complaints handling system were evident, the emphasis remains on the process rather than focusing on the outcome. It is the outcome that counts for patients.

Our audit shows that NHS trusts need to improve the following key areas relating to core standard C14:

Accessibility (standard C14a)

Trusts need to do more to open the complaints system and make it more accessible, especially for groups such as people with learning disabilities and people from culturally and linguistically diverse backgrounds.

This means going beyond the traditional methods of communication and making a real effort to reach out to their communities. This may be, for example, by building links with existing special interest groups and attending their meetings to share information and talk about their work.

Discrimination (standard C14b)

People who complain should feel confident that their care would not be changed or altered in any way if they make a complaint. There appears to be a lack of understanding about core standard C14b and its meaning, as no single trust approached the standard comprehensively.

The intent of the standard is not about discrimination taking place because of a person's race or ethnicity or other issues relating to equality – although these could be the root cause of the complaint.

Rather, its purpose is to ensure that patients, their relatives and carers are not discriminated against when they make a complaint, for example, a patient who is removed from a GP list because they have complained about the care provided.

Learning (standard C14c)

Trusts collect and report complaints data using many different types of tools and formats. However, few trusts appeared to approach this in a systematic way. Learning from complaints will be vital as the emphasis within healthcare shifts to one where the patient and the consumers of services have greater say and choice, and NHS primary care trusts commission services on their behalf.

Trusts should collect and use aggregated data about complaints as part of their trustwide patient focus strategy, to highlight trends that can lead to systemic or structural changes in services for the benefit for all patients as part of their medium to long term planning.

Recommendations

Recommendations for trusts

Based on the audit findings we recommend trusts take immediate action to:

- do more to open the system and make it more accessible, especially for groups such as people with learning disabilities and people from culturally and linguistically diverse backgrounds
- better communicate their commitment to staff and patients that people who make a complaint will not be discriminated against
- provide education and training for frontline staff specifically covering discrimination
- develop a workforce of skilled complaints handling professionals, trained in related and complementary skills such as customer care, investigation, mediation and resolution
- use audits, patient surveys and focus groups to systematically monitor if care has changed or been altered as a result of a patient or carer making a complaint
- develop systems where complaints data informs their decision-making when commissioning services, particularly the services of independent contractors
- ensure that monitoring complaints is an integral component of performance and risk management and clinical governance systems and that trust boards receive a regular flow of information about complaints handling as part of their governance system

Recommendations for strategic health authorities

We recommend strategic health authorities take immediate action to:

- ensure that they have a flow of information about complaints handling from each of their trusts and use this information as part of their regular monitoring and performance management arrangements with trusts

We also recommend that:

- standardised tools and resources, such as case studies, checklists, flow charts and process maps, templates and training aids are made available nationally; and that the Department of Health work with strategic health authorities or the NHS Confederation to determine which organisation is best placed to do this
- the healthcare regulator should ensure that good complaints handling and listening to patients feature strongly in the inspection and performance regime
- the Department of Health should consider the findings of our audit in devising the new registration requirements/standards, in particular, that health providers should ensure that their complaints handling arrangements are less procedural and emphasise outcomes and resolution for the people making a complaint
- trusts and strategic health authorities establish local systems and mechanisms to collect, analyse and report on complaints handling data and trends, so that lessons can be shared and, where appropriate, improvements undertaken within and across health economies
- the Department of Health and the regulator establish systems and mechanisms to analyse and report on national complaints handling data and trends, so that lessons can be shared and, where appropriate, improvements made

What will the Healthcare Commission do?

As the existing regulator, the Healthcare Commission has an important role to play. We intend to continue to advocate for change in the way the NHS handles complaints and to drive improvement.

We therefore intend to immediately change the way we publish data about requests we receive for independent review. We have been providing this information to strategic health authorities for some time. We intend to explore whether this can be further expanded to include information such as the number of second-stage complaints returned to a trust as a proportion of the number received and, if feasible, publish this on our website.

If a trust's declaration of compliance was different to our own decision, based on the audit findings, they were visited during the annual health check inspections. The outcomes of these visits will be reflected in the annual health check results to be published in October 2007. We will also be making follow-up visits to the individual trusts where we identified areas for improvement as part of our ongoing programme of engagement. Complaints handling and the extent to which trusts are meeting the core standard will continue to be a focus of our assessments in 2007/2008 and 2008/2009.

As a result of the findings of this audit, we have strengthened the criteria by which we assess organisations' performance in handling complaints, in particular how they look for resolution for complainants and demonstrate improvements in service delivery as a result of concerns raised.

We also intend to take an active part in the discussions on the future of complaints handling in the NHS and the new registration process.

Implications for the future

This is the first time that such an audit has been undertaken. It therefore provides us with good evidence to use when considering the future of complaints handling.

We fully appreciate that trusts have many competing priorities and that it is all too easy to just 'tick the boxes'. However there is a cost in managing complaints and therefore an incentive to ensure they are handled more effectively.

Not doing so ignores the obvious. Complaints won't stop coming, and in some cases will only escalate. People will rightly continue to complain.

The Department of Health's proposal for new complaints handling arrangements

Complaints handling in the NHS has been given a great deal of attention in recent years[13]. The recent changes proposed by the Department of Health are a further attempt to drive improvements through an integrated system of health and social care.

The proposed changes would place greater responsibility on each NHS organisation to resolve complaints locally. Complainants who are not satisfied with local resolution will be able to refer their case to the Health Service Ombudsman for review. It is proposed that the regulator will no longer have a role in investigating individual complaints. Instead, the Department of Health is proposing that the regulator will focus on the standard of complaints handling and how trusts implement learning from complaints.

We recognise that the current proposal is only the framework for how complaints might be managed – how this framework will be implemented is yet to be determined.

It is important that the Department of Health, the Health Service Ombudsman, the Healthcare Commission and local NHS bodies work together to ensure that systems are in place to respond appropriately to complaints, to learn from them and to improve standards of complaints handling.

New regulation requirements

Additionally, the Department of Health is devising requirements that will be the basis for the new registration process for all providers of NHS and social care. At the request of the Department of Health, the Health Ombudsman and the Healthcare Commision have been working together to propose a refinement to the existing core standard C14, to focus more on resolving complaints in a way that is more flexible and responsive to the complainant. This could form the basis for informing the new registration process (see Appendix). There is now a unique opportunity for the Department of Health to consider the findings of our audit and shift the emphasis in the new registration requirements or standards from a procedural to a more outcomes-focused approach.

Complaints handling must be a compulsory component of the proposed registration process. When trusts are not performing positively, the new regulator must have the power to intervene. Without these conditions, the new complaints handling system will not function effectively.

In conclusion, there needs to be substantial work, both at a local and national level, before we achieve a complaints handling system that meets the needs of the complainants and, crucially, which serves as a rich and valued component of feedback on our customers' experiences.

Some of the changes can be implemented immediately. Others need work and will take time but are nonetheless important.

Appendix

New core standard on complaints proposed by the Healthcare Commission and the Health Service Ombudsman

Existing core standard relating to complaints handling (Standard C14)

Healthcare organisations have systems in place to ensure that patients, their relatives and carers:

a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;

b) are not discriminated against when complaints are made; and

c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery

Proposed new core standard

Healthcare organisations have an approach to handling complaints which:

a) is prepared for and successfully meets the diverse needs of actual and potential complainants

b) is simple and clear to the complainant, and consistent and integrated with that used by any other bodies involved with the same complaint

c) properly equips and supports those involved to achieve appropriate outcomes

d) demonstrates that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's management and development

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Age Concern England

Disability Rights Commission

Independent Complaints Advocacy Service

Mencap

National Association for Mental Health (MIND)

NHS staff

Refugee Council

The Department of Health

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