



Parliamentary
and Health Service
Ombudsman

Making Complaints Count:

Supporting complaints handling
in the NHS and UK Government
Departments

HC 390

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Making Complaints Count: Supporting complaints handling in the NHS and UK Government Departments

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Foreword from the Ombudsman



People who use the NHS and other public services should be able to expect a good quality service. But even when services are excellent, things can go wrong. Complaints offer direct feedback about what it is like to use the NHS and other public services.

Complaints matter because feedback can help staff learn from when things go wrong and improve services as a result. But the complaints system needs reform if people who rely on public services are to have confidence that their voices are being heard and being used to make improvements.

Since becoming Ombudsman, I have visited a large number of public service organisations to learn first-hand about the work they do and how they view the current health of the complaints system. I have met many hard working, dedicated staff who carry out difficult and complex roles while facing increasing workloads.

What complaints staff tell me about their role and experience often provides a raw picture of a complaints system that is in urgent need of reform and investment. Some receive commendable help from their organisations to do their job, but many others feel poorly equipped to handle complaints. They often receive limited access to training and are asked to address serious and complex issues with little assistance.

This places significant pressure on the staff we expect to provide a high quality, responsive and empathetic service to people who may have suffered serious harm or injustice. The impact of the coronavirus pandemic on all aspects of public services – both now and in the future – will significantly amplify these pressures on an already fragile complaints system. It is almost inevitable that these burdens will result in poor experiences for those making complaints.

The feedback captured in our report from staff across the NHS and Government departments is stark, but remarkably consistent at all levels. It has led to agreement that more is needed to support and strengthen frontline complaints handling across public services. There is also an acceptance that the current system is not best equipped to resolve the difficulties it faces now – particularly in meeting the anticipated increase in demand in the aftermath of an unprecedented public health crisis.

This shared view has prompted action. I am encouraged by the willingness of a wide circle of organisations to come together under PHSO leadership to address the core areas of complaints handling that need reform and investment. The initial result of that joint enterprise, our draft Complaints Standards Framework, creates a single, consistent vision for best practice expected from all staff and senior leaders delivering essential public services. The Framework sets a clear path for how best to invest in and encourage staff to achieve this vision.

The Framework takes us in the right direction, but more is needed. To deliver this commitment, the Framework places emphasis on organisations reporting on how they are meeting these new expectations. PHSO will play a key role in reviewing progress and supporting organisations to develop further. Yet change will not happen unless there is effective and inclusive leadership across the public sector to make the cultural transformation needed to recognise complaints as a valuable source of learning. This includes senior leaders investing in their staff through access to better, more consistent, training and professional development in complaints handling.

Last year, the House of Commons Select Committee on Public Administration and Constitutional Affairs (PACAC) invited me to lay a report reviewing front-line complaints systems. I look forward to supporting the Committee's scrutiny of the issues identified, including where we have proposed that new legislative powers for the Ombuds are needed and long overdue.

Rob Behrens CBE

Ombudsman and Chair, Parliamentary and Health Service Ombudsman

Introduction

Our 2018-21 strategy sets out a clear ambition for PHSO to be exemplary in delivering Ombuds services. This includes playing a more significant and visible role in raising standards and improving public services, something we cannot do in isolation. It can only be achieved by working in partnership with others who share the same commitment to recognising the vital role learning from complaints has in driving service improvements.

This report follows an invitation from the House of Commons Select Committee on Public Administration and Constitutional Affairs¹ to explore the '*state of local complaints handling*' across the NHS and UK Government departments. It draws upon significant evidence taken from interviews carried out with a wide range of individuals and organisations who have first-hand experience of how the NHS and UK Government departments approach complaints. It also incorporates a review of a wide range of other research reports and over 300 of our own investigation reports documenting complainant experience.

The term 'complaint' can cover a wide range of circumstances. Within the NHS, sometimes serious issues are raised that trigger significant patient safety concerns. Such cases should be investigated by the organisation under the Serious Incident Framework, rather than through the NHS complaints process.

Our report focuses specifically on the NHS complaints system. We do, however, recognise that some of the expectations we raise about the complaint process may also be relevant to how NHS organisations approach patient safety investigations. This is particularly so for the issues we highlight about training and capacity of complaints staff to carry out investigations in their remit effectively, and the need for a more open and reflective culture towards learning and accountability. Our report makes no recommendations in this space, but we

hope our research is of use to those bodies responsible for the Serious Incident Framework and any future considerations for how that could be improved.

The focus has been to hear from a wide range of people about what is and is not working, and what can be done to strengthen frontline complaints handling. We also draw on learning taken from our casework, and research others have taken forward, to set out a 'three-dimensional' view of the current state of the complaints system in England.

The research we undertook shows a broad consensus that the complaints system needs reform and strengthening, and that there are three core weaknesses.

- There is no single vision for how staff are expected to handle and resolve complaints. Too many organisations provide their own view on 'good practice' and staff are left confused as to which one to follow, often leading to variable experiences for those who complain
- Staff do not get consistent access to complaints handling training to support them in what is a complex role, which should be recognised as a professional skill. When staff do get training, the quality and consistency of what is covered is variable
- Public bodies too often see complaints negatively, not as a learning tool that can be used to improve their service. This often leaves complaints staff feeling that they are not valued or supported by senior leaders in their organisation and lacking the resources to carry out their role effectively

All three of these weaknesses result in poor experiences for those who raise concerns about public services – and whose insight into how they can be improved is invaluable. This can lead to vital learning on patient safety and system improvements being missed.

1 See: https://publications.parliament.uk/pa/cm201719/cmselect/cmpubadm/1855/185508.htm#_idTextAnchor028

Inconsistency is a common feature of these weaknesses. There is inconsistency in what is expected of staff when handling complaints, and inconsistency in how senior leaders embed and promote a learning culture in their organisations. Unless more effective action is taken by leaders to embed a culture that sees complaints as a tool to promote change, the status quo will do nothing to resolve current problems. In light of the coronavirus pandemic, it is more important than ever that public services respond to feedback and learn from the experiences of their users.

Our research strongly suggests that the current complaints system is not meeting the needs of the public. Our discussions with key stakeholders across the NHS, Government, independent advice and advocacy sectors – as well as patients and complainants – suggest widespread support for tackling this. Our proposal to create a 'Complaint Standards Framework' modelled on the approach taken in devolved nations and Ireland has been widely welcomed.

We have called for the statutory powers to deliver this, and will continue to do so, to put us in line with public sector Ombuds in the UK's devolved nations. In the absence of these powers, and for now, we have worked in partnership to design a draft non-statutory Complaint Standards Framework for NHS staff. We have begun a related project to develop the Framework further to encompass Government departments. The engagement we have had during this process to date has been hugely positive.

This new Framework will provide a consistent approach and support to frontline staff, as well as assisting senior leaders to promote a positive culture embracing learning from complaints. It provides the basis for a central training platform for staff to give them the support and development they need, and to recognise that handling and resolving complaints is a professional skill.

This report is structured in line with the four areas that the draft Complaint Standards Framework covers. It seeks to make sure that:

- Senior leaders of public services **promote a learning and improvement culture** in their organisation, investing in their staff so that they can learn from complaints and make improvements
- Organisations train staff to **seek feedback** from service users, and ensure individuals can provide feedback easily, with any issues resolved in an open and responsive way
- Staff are trained to **carry out a detailed look** into complaints that is thorough, empathetic, objective, evidenced-based, and supportive of those who make a complaint and staff who are subject to a complaint
- Staff provide **clear and accountable decisions** based on the facts, and are empowered to put things right when mistakes are identified

Much of the evidence we have gathered is from staff and service users within the NHS, the sector we have focussed on at this stage. It also highlights evidence from our UK Parliamentary jurisdiction where relevant, and PACAC may want to consider particularly the implications and benefits for UK Government departments and agencies of stronger complaint handling to build on our work.

The report concludes by setting out proposals for how we can create a more consistent and responsive complaints handling process that works for everyone. We look forward to PACAC scrutinising the work we have done and sharing its views on how it can be further developed.

How we carried out our research

Thematic review

In order to understand issues in complaint handling more fully, we began by conducting a thematic review of our final investigation reports where complaint handling was an issue complained about. In doing so, we captured the feedback from complainants about their experience of raising a complaint, and how each organisation handled it. These provide a rich source of learning for what complainants expect and whether these were met in their case.

We reviewed 178 final reports of complaints we investigated involving one NHS organisation, and 17 final reports of complaints we investigated involving one UK Government department or agency. We also reviewed 62 final reports of complaints we investigated involving more than one NHS organisation, and 56 final reports involving organisations across the NHS and social care. The results of our thematic review are included in Appendix A.

Developing a Complaint Standards Framework

PHSO formed a working group to co-design a Complaint Standards Framework. This consisted of UK health and social care regulators, other national bodies, and advocacy groups for people using health and social care services. We discussed emerging themes from our thematic review to understand how they resonated within the working group. We spoke to advice and advocacy groups to capture what complainants tell them about their experience of making a complaint about the NHS or Government departments.

These organisations were able to share evidence and insight regarding key issues in frontline complaint handling they saw.

Online surveys

Between October and December 2019, we conducted two online surveys to gather feedback from health staff. We produced two separate surveys for NHS Board members, and GP practices to address issues relating to complaint handling and our Complaint Standards Framework.

We gathered 24 valid responses from our survey of NHS Board members and 44 valid responses from our survey of GP practices. The results of our online surveys are available in Appendix B.

Qualitative research

While our thematic review allowed us to identify key themes in complainant experience during frontline complaint handling, our investigation reports tended to focus on what happened rather than what may be causing the complaint handling failures we found.

To overcome these limitations, we conducted a series of interviews with senior staff and frontline complaint handlers in NHS and Government departments to explore these issues further.

In addition, we spoke to representatives from Patient Advice Liaison Services (PALs), GP Practice Managers and staff from Medical Defence organisations. We also spoke to staff from advice and advocacy organisations to capture their view of the impact of frontline complaint handling impacts on their complainants, and what factors contribute to negative experiences. These interviews took place between May and December 2019.

We conducted most interviews by phone, but we also completed face-to-face interviews where possible. If time or capacity constraints were a factor, we invited people to submit responses to our questions by email. We also attended meetings and network events with a range of NHS complaints staff during this period.

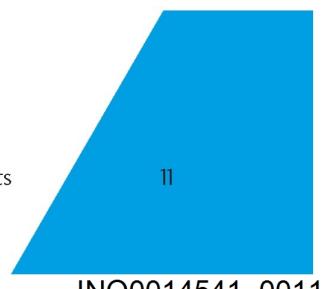
Although we prepared scripted questions for the interviews to ensure we covered the key areas of our emerging research, we also used the interviews as an opportunity to respond to and explore issues raised by interviewees about the wider complaints processes in NHS and UK Government departments, and to probe and understand further the specific issues they saw in the areas they worked in. We were also able to share (anonymously) feedback we had received in the previous interviews we had conducted to see if there were shared experiences around issues concerning complaints and complaint handling.

We used the interviews as an opportunity to gather relevant good practice examples relating to complaint handling. We also shared the emerging key areas we had identified during our working groups on the Complaint Standards Framework with interviewees. We asked whether they would welcome such a framework, the types of issues they would like to see the framework cover, and for their feedback on the key themes that were emerging at the time from the working groups we ran.

We spoke to staff in a wide range of roles related to complaint handling in NHS and UK Government departments across the country. In total, we conducted interviews in person, by phone, and via email with 36 members of staff involved in complaint handling at 17 NHS and UK Government departments. This is alongside numerous visits our Liaison Team made to various NHS Organisations in 2019 to discuss complaint handling issues and the development of the Complaint Standards Framework.

We also attended a Care Quality Commission co-production event in October 2019 to seek their feedback on the state of complaints handling and the Complaint Standards Framework. This event was attended by NHS service users, NHS complaints staff, NHS senior leaders and Advocacy staff, and we were able to capture further experiences of both staff and those who use NHS services.

Our public consultation on the Complaint Standards Framework will be a further opportunity to ensure we hear from complainants and the wider public about their experience of making complaints to public service organisations, and what the Framework must include to meet their expectations.



1. Promoting a learning and improvement culture

- 1.1. A learning and improvement culture is vital for addressing and learning from feedback and complaints. An effective system – led from the top – demonstrates its commitment to promoting a learning culture that values complaints and feedback. When done well, every member of staff knows their role in promoting a ‘learning from complaints’ culture.
- 1.2. This chapter highlights the evidence we heard about whether NHS organisations and their staff are promoting a learning culture.

A learning culture and leadership

- 1.3. Several major reviews covering how the NHS handles feedback and complaints have highlighted the need to embed a culture that embraces learning from feedback. Most notably, the Mid-Staffordshire NHS Foundation Trust inquiry report in 2013,² the Review of NHS Hospitals Complaints System by Ann Clwyd and Professor Tricia Hart,³ and the Health Select Committee 2015 report on Complaints and Raising concerns⁴ consistently stressed the importance of a learning culture where complaints and feedback are valued.
- 1.4. They have also indicated that leadership at every level, particularly from the top, plays a key role in shaping an organisation’s culture.⁵ A member of staff who had managed complaints teams in several NHS trusts summed up the importance of this issue:

“I’ve worked in very challenged organisations and also in very good organisations. In the good organisations senior people take ownership and accountability. It’s a top agenda item and you have senior people leading the agenda to give guidance and advice on how to do it [engaging with complaints and feedback] properly. Where you get into difficulty it’s because there isn’t that senior leadership and it’s not [regarded as] important.”⁶

- 1.5. The importance of leadership in complaints handling is shared by those who complain. Scott Morrish, a father whose three-year old son died from sepsis following failings in his care, spoke movingly at the PHSO Annual Open Meeting in 2017 about his harrowing experience making a complaint, and how culture and leadership are intimately related to how organisations engage with complaints and feedback:

² [Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry Executive Summary HC947, Session 2012-2013](#)

³ [Ann Clwyd and Professor Tricia Hart, “A Review of the NHS Hospitals Complaints System – Putting Patients Back in the Picture” October 2013](#)

⁴ [House of Commons Health Committee “Complaints and Raising Concerns” Fourth Report of Session 2014-15](#)

⁵ [Michael West et al. \(2014\). ‘Developing collective leadership for health care’.](#)

⁶ Interviewee, PHSO qualitative research, May-December 2019

“Complaint handling can be viewed as a barometer for our cultural values. The truth is that it all boils down to leadership. If the complaints themselves are not valued, if they’re not prioritized, you know all you need to know about the culture. [...] It’s summed up by the people who are trying to do their best, but they feel unsupported, undervalued, and they’re under resourced in terms of training as well as money. [...] If you want insight, understanding, learning and ultimately you want to improve you cannot afford to ignore that well of hurt that is out there.”⁷

- 1.6. The staff we spoke to during our research illustrated that leaders in some organisations do not sufficiently value complaints and feedback. The head of an NHS trust complaints team highlighted a failure to listen to the message from the Mid-Staffordshire inquiry that complaints should be an organisational priority. He said that “*very often, the top tier are not interested. They [just] pay a lot of lip service to it*”⁸.
- 1.7. Effective and inclusive leadership to develop and maintain a positive culture for complaints is key. If leaders are not visibly committed to engaging on feedback and complaints, no learning culture can survive or thrive. This can lead

to repeated mistakes and avoidable harm to future service users. In the current context of an unprecedented health crisis, coronavirus, learning from the responses of public service organisations will be crucial to understanding how such services can be strengthened in future.

- 1.8. The Complaint Standards Framework we have developed places a strong emphasis on leadership.

The ongoing culture of defensiveness when handling complaints

- 1.9. Despite the recognition over many years that a learning culture is vital, our review has found that there remains a defensive culture around the handling of complaints in many public service organisations that must be addressed. A recurring theme in the 300+ PHSO investigation reports we analysed was the failure of organisations to acknowledge mistakes in their responses to complainants.
- 1.10. Our investigation findings were supported by wider research. For example, some of the NHS complaint advocacy organisations we spoke to raised concerns about how primary care organisations, such as GP practices, routinely responded to complaints. In some instances, staff “*think they do not need to respond*” to complaints from patients, while others feared they would “*lose their job*”⁹. Advocates we spoke to agreed that NHS organisations were too often resistant to learning from complaints and the mistakes that have been made.¹⁰

⁷ Scott Morrish, PHSO Open Meeting, Manchester November 2017

⁸ Interviewee, PHSO qualitative research, May-December 2019

⁹ Focus group/workshop member, PHSO qualitative research, October-November 2019

¹⁰ Focus group/workshop member, PHSO qualitative research, October-November 2019

- 1.11. Some of the NHS staff we spoke to echo this view. One Practice Manager, for example, told us that staff in his own organisation can be dismissive if a complaint is about them, and may not want to engage due to concern about it highlighting their own failings.¹¹ Such an attitude means failing to learn from what has gone wrong and increasing the likelihood of the same mistake being repeated.
- 1.12. These are not one-off examples in NHS primary care but illustrate a systemic issue across other organisations that we heard repeatedly from those we spoke to. Staff from a Government agency we spoke to acknowledged it needed to do more, noting it wanted to improve the apologies it gives in response to complaints and to be less defensive.¹²
- 1.13. A culture of defensiveness is often manifested when things have gone wrong. Advocates told us that they often see organisations writing to their clients to say “*I’m sorry if you felt that...*” rather than being offered a sincere apology.¹³ At an engagement event we held, an NHS provider told us staff didn’t think that they are allowed to say sorry. This is despite national guidance reinforcing the message that “*saying sorry is not an admission of liability*”¹⁴ and the introduction of a statutory duty of candour for NHS organisations several years ago.
- 1.14. Other advocacy organisations we spoke to noted that NHS organisations are often reluctant to acknowledge failings because of a fear of legal action.¹⁵ This was echoed by what we heard from the organisations that support and indemnify healthcare professionals. They highlighted a fear of blame among clinicians as a barrier to staff engaging with feedback and complaints.¹⁶
- 1.15. One NHS trust Chief Executive said that when a complaint is made it is often viewed personally by staff, who can take it as an attack on their ability and professionalism. She also said that complaint managers are often working in pressured environments and need to get input from clinicians who are themselves extremely busy. As a result, staff sometimes choose to deal with the “*top-coat*” of the complaint, rather than explore the underlying issues. To tackle this, she said it was important to give staff the time to deal with complaints. Staff should also be presented with the perspectives of patients so that they understand the importance of engaging with them.
- 1.16. There has been progress in some organisations, however, with staff feeling more confident to apologise when things go wrong. This reflects the variation we have found in the responses of different organisations to complaints. Nevertheless, the impact of coronavirus represents a potential threat to this modest progress, and places even more importance on clarifying what is expected from organisations and senior leaders delivering NHS services.

11 Survey respondent, PHSO online survey, October-December 2019

12 Interviewee, PHSO qualitative research, May-December 2019

13 Focus group/workshop member, PHSO qualitative research, October-November 2019; Meeting attendee(s), PHSO Forum Meeting, May 2019

14 [NHS Resolution guidance, ‘Saying sorry’](#)

15 Interviewee, PHSO qualitative research, May-December 2019

16 Focus group/workshop member, PHSO qualitative research, October-November 2019

Our Complaint Standards Framework is the first vital step to embedding a unified culture of openness and transparency in complaint handling.

Failure to value complaints and learn from them

1.17. We also saw cultural differences in how organisations approach the value of complaints and how to use the learning from them to push for improvement. One complaint manager in an NHS trust told us that

“We struggle to persuade a significant minority of our clinicians of the value of complaints and learning to be drawn from them. Senior Management are on board but that doesn’t have the degree of traction we would like.”¹⁷

1.18. The head of an NHS trust complaints team told us that “*the NHS remains extremely conservative, it talks a lot about learning lessons and talk is cheap, frankly.*” He provided an example of an emerging theme from their complaints that they found difficult to flag to their colleagues since it is “*not something that [our] organisation wants to hear*”¹⁸

1.19. Other complaint handlers told us that complaints were not prioritised by certain clinical departments in their Trust. Some advocacy organisations told us that they had observed public bodies re-using the same standardised text from previous responses, rather than providing a personalised response to individual complainants.¹⁹

1.20. Several advocacy providers reported that some NHS organisations were mislabelling ‘complaints’ as ‘concerns’, and not prioritising them equally. While all feedback should be valued, the 2009 NHS complaint regulations set out specific requirements for NHS organisations to deal with complaints.²⁰ One advocate raised concerns that these organisations were therefore not recording or providing accurate or meaningful data about the complaints they deal with.

Ways to promote a culture that values feedback and complaints

1.21. Whilst defensiveness remains a prevalent issue, we also heard from NHS organisations and their leaders about some of the ways they are moving towards a culture of learning and accountability. Case Study 1, below, provides an example of how simple change can make a profound difference.

¹⁷ Interviewee, PHSO qualitative research, May-December 2019

¹⁸ Interviewee, PHSO qualitative research, May-December 2019

¹⁹ Interviewee, PHSO qualitative research, May-December 2019

²⁰ Focus group/workshop member, PHSO qualitative research, October-November 2019

Case Study 1

Putting complaints at the heart of governance via a Complaints Panel

Newcastle upon Tyne Hospitals NHS Foundation Trust set up a regular 'Complaints Panel' meeting between senior staff to discuss complaints. The aim of the Panel is to make sure momentum is kept on learning from complaints and monitoring how the Trust is performing.

The Panel meets monthly to scrutinise a range of formal complaints logged within the Trust and review actions and procedural changes highlighted because of these. The Patient Relations Team present quantitative data regarding the number of complaints received, the number of cases re-opened and achievement of acknowledgement and final response deadlines. This discussion gives the Patient Relations Team the opportunity to flag any delayed responses and bottlenecks within the complaint process.

Cases referred to the Parliamentary and Health Service Ombudsman are also discussed. Any recommendations as a result of final reports are shared with the Panel with an update on completed actions. This forum gives the Panel an opportunity to identify any high-risk complaints and those which require wider discussion.

Through this structure, senior leaders come together regularly to oversee what feedback and complaints data is telling them about their service, and what action is being taken on the learning that arises. This has succeeded in keeping the importance of complaints high up the agenda for leadership, which has a positive impact on staff recognising the importance that is placed on this area.

Supporting and valuing staff who handle complaints and feedback

1.22. Another important cultural indicator is the way in which organisations fail to support and value staff who handle complaints or who are complained about, and their status within their organisations. We heard evidence that there was considerable staff turnover in some complaint teams, which suggests that this is an area that requires attention.²¹

1.23. NHS complaint handlers and advocacy providers told us that some complaints teams are not appropriately resourced,²² and that complaints staff are often dealing with extremely challenging caseloads – sometimes managing up to 80 cases each. This level of casework would often result in staff having limited time to deal with each case, and that NHS organisations whose staff are handling smaller caseloads are more likely to provide a personal approach.²³

1.24. Often the pressure of high caseloads is compounded by using numerical targets to manage productivity. The head of an NHS Trust complaints team told us that:

21 Interviewees, PHSO qualitative research, May-December 2019

22 Interviewee, PHSO qualitative research, May-December 2019; Meeting attendee(s), PHSO Forum Meeting, May 2019; also referred to by survey respondents, PHSO online survey, October-December 2019.

23 Meeting attendee(s), Complaint Standards Framework working group meeting, September 2019.

“The obsession in the system is with quantitative targets, not qualitative. [...] And there is intense pressure on blaming or finger-pointing at complaints teams who are under-resourced [and] over-worked to achieve better throughput. I’m only as good as my colleagues. We constantly have people who don’t understand the kind of pressures we’re under being critical of the complaints industry [...]”²⁴

- 1.25. Resourcing and workloads of complaints teams were not the only challenges we identified. The wider pressures on NHS services and other staff is also a key issue that affected how organisations respond to complaints, and whether they are seen as a priority.
- 1.26. In NHS trusts, complaints are often investigated by staff alongside clinical or administrative duties. We heard from hospital ward managers, who said that while their roles included dealing with any complaints raised by patients and their families, staffing challenges were so acute that it had meant they often felt they had to push complaints to the background. We heard similar feedback from GP practices.²⁵
- 1.27. The impact of resource pressures was explained by an NHS Trust Board member we spoke to:

“We’ve got under-capacity and increased demand [...] We very much in the NHS are stressed at an executive-level and having increasing demands placed upon us. And that, I think, is one of the biggest barriers to developing empathy and understanding the real value of listening hard to our service-users, seeing complaints as an opportunity, as opposed to something which is an irritation.”²⁶

- 1.28. It is well-established that the NHS is facing significant pressures. Research by the Kings Fund into the impact of financial pressures on the NHS highlighted that the *“growing gap between demand for services and available resources is clearly increasing the pressure on staff”*.²⁷ The research noted that the need for cuts may well be storing up problems for future service delivery, which can impact on the quality of patient care.
- 1.29. NHS organisations focus on preventive measures to reduce the number of times more resource-intensive care and treatment is needed. Similarly, they could benefit from doing more to capture and learn from complaints. This would help them monitor services and spot emerging trends that could affect the quality of care. Such insight has the potential to play a role in identifying and preventing issues in service quality.

²⁴ Interviewee, PHSO qualitative research, May-December 2019.

²⁵ NHS Representative(s), PHSO Hospital Visit 2019. Also referred to by Survey respondents, PHSO online survey October-December 2019.

²⁶ Interviewee, PHSO qualitative research, May-December 2019

²⁷ “Understanding NHS financial pressures: how are they affecting patient care?” Kings Fund, March 2017

It represents the voice of the local patient community and provides a ‘real time’ view of the quality of services being provided.

1.30. This real-time feedback is critical when pressure on services is most acute, as it can help identify potential ‘fault-lines’ in services and prevent these from becoming longer-term issues. Where some NHS organisations are not adequately resourcing and supporting staff to use insight from complaints to improve services, they are not realising the full potential of their engagement.

1.31. Our research suggests staff do not get protected time to investigate complaints in a way that would provide this insight. A member of staff from a regulator highlighted that investigating complaints can sometimes just be an added task to their ‘business as usual’ responsibilities, meaning that they don’t receive the time and attention necessary.²⁸

1.32. One NHS trust Chief Executive we spoke to recognised the need to support and invest in staff in the current challenging environment if organisations are to provide high quality responses to complaints. He said that NHS staff are extremely busy and often deal with complaints at the “*back end*” of the working day, after demanding clinical shifts. Organisations should make time for staff to do this properly – job plans were identified as a way of giving staff time and support.²⁹

1.33. However, while protected time was identified as a challenge in some areas, other NHS trusts are working to address it. One, for example, told us that they employ additional ward managers to give staffing cover.³⁰

Status of complaints teams and staff within the organisation

1.34. Complaints teams told us that they lack status in their organisations. We were told by an experienced NHS complaint handler that some complaints teams in NHS trusts oversee investigations into complaints, whilst elsewhere other teams perform a more administrative role where they are less able to influence the outcome of a complaint.³¹

1.35. We also heard that complaints teams are not always given sufficient respect, authority or ‘gravitas’ from their colleagues compared to other teams and functions.³² As a result, they are in a weaker position to ensure that colleagues engage with complaints.

1.36. This perspective was also shared by advocacy organisations. One observed that complaints staff do not appear able to challenge clinicians. In their view, this demonstrated the low level of regard for complaint handling in some organisations.³³ Another advocate said that delays could be caused by consultant doctors, “*who see themselves as very important*”, not replying to the junior, non-clinical colleagues who co-ordinate the organisation’s response.³⁴

²⁸ Meeting attendee(s), Complaint Standards Framework working group meeting, November 2019

²⁹ Focus group/workshop member, PHSO qualitative research, October 2019-November 2019

³⁰ Interviewee, PHSO qualitative research, May-December 2019

³¹ Meeting attendee(s), Complaint Standards Framework working group meeting, September 2019

³² Interviewee, PHSO qualitative research, May-December 2019

³³ Focus group/workshop member, PHSO qualitative research, October-November 2019

³⁴ Focus group/workshop member, PHSO qualitative research, October-November 2019

1.37. One advocacy organisation told us that a common problem it encountered is that some NHS staff who investigate complaints are asked to perform a role “above their pay grade and experience”. It was suggested that training would not of itself resolve the situation, and that relevant staff should have the appropriate experience and seniority to get support from their organisation.

Other forms of support and investment needed for complaint handlers

1.38. We also heard about other ways in which complaint handlers do not receive sufficient support. The head of an NHS Trust patient experience team told us that most of their time was spent on a small number of cases involving people with severe mental health conditions. He, and another complaint manager we spoke to, expressed frustration that their staff had not received any specific training to help them support people in these circumstances while also taking care of their own wellbeing.³⁵

1.39. A member of a Patient Advice and Liaison Service team told us that colleagues needed more support for the traumatic issues they deal with. It was felt that appropriate support could be provided by someone from a therapeutic background, such as a counsellor or psychotherapist.³⁶

1.40. The head of an NHS Trust patient experience team told us that:

“I’ve been pushing for the last four years for us to employ a bereavement counsellor that could link in with primary care [...] I would say 40% of the complaints that we receive are around grief and bereavement. [...] We [the complaints team] take the brunt of that.”³⁷

Supporting staff complained about

1.41. As well as supporting and investing in staff who handle complaints, it is essential that organisations provide support to staff that are complained about. In our research we heard about the detrimental impact on staff in this situation. As a practice manager put it:

“It’s difficult for the member of staff being complained about, and it’s how we support them. It’s alright saying, ‘look, we’ll learn from this’, but I think they go away and it is really personal for them because it is a complaint about *them*. [...] It is quite upsetting for them.”³⁸

1.42. Recent research by Dr Chris Gill and Carolyn Hirst has highlighted the impact on staff of being complained about. The research shows that individuals complained about have reported negative changes to their work practice, health and wellbeing.³⁹

35 Meeting attendee(s), PHSO Forum Meeting, May 2019

36 Interviewee, PHSO qualitative research, May-December 2019

37 Interviewee, PHSO qualitative research, May-December 2019

38 Interviewee, PHSO qualitative research, May-December 2019

39 [Hirst C, Gill, C. 2019 “Being Complained About: Good Practice Principles and Guidelines”](#).

1.43. This view is reinforced by other research, notably the prevalence of the 'second victim' phenomenon reported by Kevin Stewart. Clinicians who are unable to cope with the impact of a medical error or adverse event often see this emotion compounded if they have a negative experience in the resulting investigation. A key factor in that experience includes not being properly engaged in the investigation process and getting appropriate support throughout it from their organisation.⁴⁰

1.44. These negative effects can have devastating results, both on future patient safety and care and the wellbeing of individual clinicians. Research from 2015 showed that many doctors who had reported a recent experience with a complaint had a significant risk of developing depression, anxiety and suicidal thoughts. The research suggested numerous improvements to the complaints process, including increased transparency and engagement with staff subject to a complaint, and better management of investigations.⁴¹

1.45. The research in this area highlights the clear need for staff to be treated with the same empathy and sensitivity as complainants. This includes greater transparency and engagement in any investigation that concerns them. We welcome the detailed guidance recently published by Dr Chris Gill and Carolyn Hirst to help organisations provide better support to employees who have been subject to a complaint. This lays a strong foundation for best practice in this area.

1.46. While this has been reflected in the draft Complaint Standards Framework, the more detailed guidance we propose to develop to support the Framework will also build on it. The Framework will include an expectation that organisations ensure staff subject to a complaint have access to a nominated staff member who can provide advice and support.

⁴⁰ Kevin Stewart, Rebecca Lawton and Reema Harrison "Supporting 'second victims' is a system-wide responsibility" *BMJ* 2015

⁴¹ Bourne T, Wynants L, Peters M et al "The Impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey" *BMJ Open* 2015

Case Study 2

Understanding complaints: How Mersey Care adopted a just and learning culture

Mersey Care NHS Trust adopted the principles set out by patient safety expert Professor Sidney Dekker and the idea of a 'just culture' following a high number of complaints about staff. Around 40% of staff faced disciplinary action every year, over 50% of which resulted in there being no case to answer. There were also indications during disciplinary meetings that some staff felt fearful of speaking up when things went wrong for fear of being blamed or punished. Professor Dekker agreed to help Mersey Care design a 'Just and Learning Culture' pilot to support staff through learning and empower them to speak up when things go wrong.

The new approach included conducting activities to engage more with staff and changing the language Human Resources used with staff to be more supportive. The Trust also amended their disciplinary procedure by encouraging managers to investigate and understand the incident in question first, and for staff involved in incidents to contribute information during the disciplinary process. The approach highlighted the importance of understanding what had gone wrong, including the circumstances and existing procedures that had led to serious incidents, rather than seeking out the person responsible for individual mistakes.

The Trust's new approach has led to a significant reduction in disciplinary cases. Although Mersey Care's workforce more than doubled between January 2016 and December 2017 due to a merger with another Trust, the proportion of staff subject to disciplinaries during this period reduced by 59%. The pilot was also able to build trust amongst staff so that, as well as reducing disciplinary cases, staff are encouraged to speak up when things go wrong. Issues can then be raised proactively in a more flexible and informal way.

During 2018/19 the Trust received 338 formal complaints, compared to 415 in 2017/18 and 646 in 2016/17. The Trust's Annual Report highlighted how this improvement reflected their work on learning from complaints, as well as work done by the Patient Advice and Liaison Team in resolving complaints without the need for a formal investigation.

1.47. We found that some organisations are already doing this effectively by supporting staff who receive and handle complaints on the frontline.⁴² A Government agency told us that their complaints team have access to health and wellbeing processes, which includes one-to-one support. We heard the same organisation's call-centre team, who often make initial contact with complainants, also receive specific training on dealing with difficult calls and managing people with mental health conditions.

1.48. We also heard about the impact that simply handling complaints can have on staff. Some complaint handlers from NHS trusts and GP practices⁴³ talked about the level of abuse, intimidation, threats and unreasonable behaviour that they receive from complainants. The most recent NHS Staff Survey echoes this, with more than one in four NHS staff (28.5%) saying they had experienced harassment, bullying or abuse whilst at work.⁴⁴

42 Survey respondent, PHSO online survey October-December 2019

43 Survey respondent, PHSO online survey October-December 2019

44 <https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results/>

1.49. This is a real and unacceptable problem. One NHS trust complaint manager told us that

“The amount of abuse and threats that I and my staff take has increased four-fold in the last five years. Even to the point of people threatening to come to my building and attack me”⁴⁵

1.50. Another complaints manager said that, in her experience, some staff shy away from contacting certain complainants because of the abuse and intimidation they can receive. They felt that support was lacking for complaints teams.⁴⁶

Complaint handling as a chosen career path

1.51. An advocacy organisation suggested that the role of NHS complaints staff is not always a chosen career path.⁴⁷ Related to this, the head of an NHS Trust complaints team told us that there were limited career development opportunities for members of a complaints team in NHS trusts. He felt that a professional qualification would make staff feel more valued.⁴⁸

1.52. An experienced NHS complaint handler also highlighted the lack of such a professional qualification to recognise the role of complaint handlers. In particular, she expressed concern that handling complaints may not be seen as an appealing job if complaint handlers do not feel recognised as valued professionals.

1.53. This concern about career progression and formal qualifications is replicated in what we hear from our own staff and the wider Ombuds community. Staff working on complaints resolution are often dealing with extremely sensitive and complex issues, and sometimes supporting people who are suffering from extreme trauma. At the same time, they help senior leaders understand what has gone wrong and how organisations can learn and improve from this. They need support in this difficult work with a higher status, better training and clearer career paths.

Publicly reporting on insight and learning from complaints

1.54. We heard evidence that NHS organisations are not sufficiently publicising the insight and learning they have taken from complaints. The head of an NHS Trust complaints team told us that

“Each trust should be looking at [reporting] more qualitative outcomes, rather than just quantitative all the time. [...] Throughput is one thing, but you also need to show us what learning you’ve achieved.”⁴⁹

1.55. Research from Healthwatch England has similarly found a lack of transparency in how NHS hospitals are publicly reporting on complaints they handle. Healthwatch England found that only 38% of NHS Hospital trusts publicise information of what changes they've made in response to complaints. When

45 Interviewee, PHSO qualitative research, May-December 2019

46 Meeting attendee(s), PHSO Forum Meeting, May 2019

47 Interviewee, PHSO qualitative research, May-December 2019

48 Meeting attendee(s), PHSO Forum Meeting, May 2019

49 Interviewee, PHSO qualitative research, May-December 2019

there is information, it is “...still only high level, telling us little detail about what has changed and only stating that ‘improvements have been made’”⁵⁰

- 1.56. Healthwatch England’s analysis also highlighted that NHS trusts often focus on simply counting the number of complaints, rather demonstrating learning and improvements made following complaints.
- 1.57. This is concerning given the findings of 2019 research from the Care Quality Commission. This found that almost 7 million people in England who had accessed health or social care services in the last five years had concerns about their care but had not raised them. Over a third of people felt that nothing would change as a result.⁵¹
- 1.58. These findings are reiterated in research we conducted into mental health services earlier this year. This found that 1 in 5 patients did not feel safe in their care setting and more than half had suffered delays in treatment. Despite this, 48% said they would be unlikely to complain if they were unhappy with the service provided and 70% saying they had not been told how to complain by NHS staff. 32% of people also said that would not complain as they did not think it would be taken seriously, while a quarter were worried complaining would affect how they were treated.⁵²
- 1.59. This illustrates the importance of organisations both valuing complaints as an essential source of learning and improvement and reporting publicly on how giving feedback and making

complaints can make a difference. Staff must also improve at making sure vulnerable patients know their rights and how they can raise a complaint, signposting them to the support available to do this where needed.

- 1.60. Other research has highlighted similar concerns connected with reporting on complaints. A recent academic study found little evidence that NHS organisations use complaints data to identify priority areas for quality improvement in their services. The study noted that *“leadership commitment to perceive complaints as a valuable, independent data set for improvement is necessary to increase their impact.”*⁵³ This research also concluded that transparent, accountable reporting on learning from complaints will reassure complainants that learning is taken forward to improve services, and will encourage others to provide their feedback too.

Sharing learning or approaches with other organisations

- 1.61. In our research we heard that the Boards of NHS trusts are not always using intelligence from complaints or engaging with other Boards to understand and benchmark their performance on complaint handling.⁵⁴ The evidence we have heard underlines the real benefit to be gained from sharing insight and best practice to promote a culture of learning and accountability that values complaints as vital insight to help stimulate improvement in services.

50 Healthwatch England, “Shifting the Mindset: a closer look at NHS complaints”, January 2020

51 CQC research 2019

52 <https://www.ombudsman.org.uk/publications/survey-experiences-nhs-mental-health-care-england>

53 van Dael J, Reader TW, Gillespie A, et al “Learning from complaints in healthcare: a realist review of academic literature, policy evidence and front-line insights” *BMJ Quality & Safety* 4 February 2020.

54 Survey respondent, PHSO online survey October-December 2019.

1.62. The Complaint Standards Framework we have developed for the NHS sets out clear expectations about how organisations can demonstrate a learning culture, report on learning from complaints, and share best practice with others. This will be developed further through the creation of detailed guidance, as well as creating a standardised method of reporting on learning from complaints that can be used nationally. We will also develop it further for the Parliamentary bodies in our jurisdiction, which our initial research indicates suffer from similar issues to those experienced across the NHS.

2. Positively seeking feedback

Seeking and resolving feedback and concerns

2.1 When organisations proactively seek feedback from people who use their services, and resolve any concerns they raise promptly, it can help prevent issues escalating into a protracted complaints process.

2.2 At PHSO we have recognised this is important not only for the organisations we investigate but also for the service we provide. So, as well as regularly seeking feedback from the complainants who use our service and the organisations they complain about, we are also working to resolve cases more quickly and proportionately. For example, we are currently piloting new alternative dispute resolution techniques and are committed to sharing any learning with other public services.

2.3 Evidence gathered during our research highlighted that organisations are missing opportunities to proactively seek feedback and resolve concerns at an early stage. We heard that NHS organisations need stronger processes to deal with people's concerns as they arise.⁵⁵

2.4 A Medical Director from an NHS trust suggested that more formal complaints could be avoided by senior staff giving an early response to people's concerns.⁵⁶ An advocacy organisation told us that they had spoken to different Trusts about finding ways to resolve concerns without going through a more protracted complaint investigation. Automatically offering bereaved families a meeting with appropriate staff to address any outstanding questions or concerns about their loved-one's care was a suggestion they made.⁵⁷

2.5 Whilst NHS organisations often look to arrange meetings with those who raise a complaint, these can be poorly planned or seen as an afterthought. Two complaints advocates told us that these meetings were often held too late during the complaints process for their clients. If held earlier on in the process, *"for some people that conversation would nip things in the bud quickly"*.⁵⁸ One advocate said that not holding these meetings in a timely way meant a lengthy and frustrating process for their clients that involved writing letters and getting responses that did not always answer their concerns, which then needed to be followed up via further correspondence.

2.6 When planned well, we have seen that earlier interactions with patients has a significantly positive effect. Case Study 3 highlights the impact that a Patient Advice Liaison Service (PALS) team outreach scheme has had in resolving issues proactively and reducing the number of formal complaints that people make.

⁵⁵ Focus group/workshop member, PHSO qualitative research, October 2019/November 2019.

⁵⁶ Survey respondent, PHSO online survey October-December 2019.

⁵⁷ Interviewee, PHSO qualitative research, May-December 2019; Focus group/workshop member, PHSO qualitative research, October 2019-November 2019.

⁵⁸ Focus group/workshop member, PHSO qualitative research, October 2019-November 2019.

Case Study 3

It's good to talk: How taking a proactive approach to patient engagement has helped resolve concerns in real time and improve services

The PALS Outreach service at Macclesfield District General Hospital began in 2014 and is unusual among UK hospitals. It involves staff from the Customer Care Team, who were previously mostly office-based, going out to hospital wards and departments to speak with patients, relatives and carers about their experiences. This initiative is done in collaboration with clinical staff, to ensure the team do not visit patients for whom it would not be appropriate, such as those who are very unwell or recovering from an operation.

This proactive approach offers those using services the opportunity to informally raise concerns they may have about their care or share more general feedback. The team take 'real time action' with clinical staff to address issues identified or they may pass on positive feedback to staff and their managers. Where appropriate the team will take action themselves or will seek other outcomes.

The PALS team find this outreach approach very rewarding and it has fostered closer working relationships with clinical teams. Ward staff have given the scheme their seal of approval and the feedback from patients and relatives about the care provided is positive, with one staff member noting: *"The scheme is very good – the patients like it, the staff like it and it's rewarding for us to do. The vast majority of feedback is very positive which is great to hear and nice for us to pass on to the ward staff"*.

Through this scheme, concerns are addressed quickly and at an earlier stage, minimising the inconvenience to patients. In addition, responding to feedback in this way may prevent unresolved concerns developing into formal complaints which are time-consuming for the trust to investigate do not address matters as they are occurring.

Since this initiative was introduced in 2014, the number of formal complaints the trust received has reduced by 32.3% (64 complaints) from 198 in 2013 to 134 in 2018. The trust views the embedding of PALS outreach to have contributed to this, with the further benefit of raising ward staff confidence to engage and seek out feedback.

Barriers to early resolution

2.7 We heard that many staff would readily commit to making more attempts to resolve complaints earlier, but that the real issue was that there is limited capacity to do this effectively. A member of a PALS team from an NHS Trust felt that clinical staff in their organisation were willing to help resolve issues raised by patients early on, but they lack the time, capacity, and authority to do so.⁵⁹

2.8 NHS staff told us that NHS organisations should carefully consider how best to make sure staff have the time and resource to resolve complaints earlier in the process. For example, a member of PALS suggested that there should a person within each ward or clinical department dedicated to early resolution. This would be similar to the common arrangements in some NHS trusts, where each ward or department has an assigned lead for complaints.⁶⁰

⁵⁹ Interviewee, PHSO qualitative research, May-December 2019

⁶⁰ Interviewee, PHSO qualitative research, May-December 2019

2.9 PALS teams also told us that all frontline staff would really benefit from basic training on early dispute resolution skills to support them to proactively seek feedback and help resolve concerns at an early stage. This would ensure that there are more resources available to make earlier resolution a reality, rather than simply relying on a smaller number of specially trained staff to take this forward.

2.10 This feedback was given to us in the context that, while it could be useful for their PALS team to proactively seek feedback from patients on wards, their team would struggle to deliver this alone given their current capacity.⁶¹ A member of a patient experience team from another Trust, whose role including visiting inpatients with concerns, also indicated that their team would lack capacity to deliver this consistent level of engagement to every ward if it was solely down to them.⁶²

2.11 The importance of widening the scope of responsibility in resolving concerns early was also raised by an NHS trust complaint handler, who told us that *“a lot of time”* and resource was currently placed into investigating complaints and that if it was *“put into resolution before a formal complaint, we would stop a lot of complaints.”*

2.12 This perspective was shared by the head of a patient experience team at another NHS trust. She felt that NHS organisations were putting insufficient resource into resolving feedback and complaints when they first arise, which would prevent issues coming to the complaints team. She told us that there needs to be a greater focus on frontline staff being prepared to deal with patient feedback, and to communicate effectively to resolve issues. We heard a similar perspective from an advocate that NHS organisations could do more to prepare their frontline staff for the impact that complaints may have on them, and to support staff to deal with complaints professionally.⁶³

2.13 The need for frontline staff to have the capacity to deal effectively with patient feedback and concerns has been recognised by previous reports, from the Health Select Committee in 2011 and of Ann Clwyd and Tricia Hart in 2013.⁶⁴

A more personalised approach

2.14 While the experience of Newcastle upon Tyne NHS Foundation Trust (Case Study 4, below) highlights the benefits of resolving issues as early as possible, it also points to how adopting a more personalised approach could improve the experience of people using services and staff. The Trust realised that their traditional approach of investigating and providing written responses to complaints did not always provide a good experience.

2.15 By conducting face-to-face ‘early intervention’ meetings in response to formal complaints or other concerns raised, the Trust can provide a more personalised experience for people who use services. It avoids what can be a long and frustrating process of communication by letter. The Trust also emphasised to us that early resolution is especially important when responding to concerns raised by people who may be terminally ill.

61 Interviewee, PHSO qualitative research, May-December 2019

62 Interviewee, PHSO qualitative research, May-December 2019

63 Focus group/workshop member, PHSO qualitative research, October-November 2019

64 [Health Select Committee, Complaints report \(2011\)](#), p.36; Clwyd-Hart review (2013), p.27

Case Study 4

Early intervention: how early, direct engagement improved the experience of staff and complainants at Newcastle upon Tyne Hospitals NHS Foundation Trust

Newcastle upon Tyne Hospitals NHS Foundation Trust piloted Early Intervention Meetings (EIMs) in 2016. Complainants had expressed frustration at how long it took the Trust to respond to complaints. They also felt that the written responses they received sometimes felt cold and defensive. Staff also expressed concerns regarding the length of time taken for investigations, as incidents being investigated had often taken place many months or even over a year before.

To resolve these issues, the Trust introduced face to face meetings between complainants and Trust staff to address concerns raised as early as possible.

To pilot EIMs, a small team of existing complaints staff were formed. The team also included a part-time clinician who chaired meetings and provided support to staff and complainants. To ensure that complainants' concerns were addressed in full, face to face meetings were held where possible. Before meeting, a 'no blame' policy was also agreed to encourage constructive discussion. EIMs were also recorded and a written summary was provided to complainants.

The Trust initially trialled EIMs with people who had made complaints involving highly sensitive or distressing issues, and where a timely response in person would be more appropriate due to the issues being discussed. The Trust told us that these meetings were particularly important for patients receiving end of life care as it prevents them waiting several weeks or months for a written response to their complaint.

The Trust held EIMs within 4 – 8 weeks of people making a complaint and routinely evaluated these meetings. Internal surveys of 118 staff and 10 complainants demonstrated that staff felt supported and that the meetings had been helpful. 98% of respondents also said that they would attend future meetings. Feedback also showed that face to face meetings helped complainants understand the issues related to their complaints more fully. Since the pilot, EIMs have now become an established element of the complaints process at the Trust, with staff and some patients requesting them to ensure their complaint is dealt with quickly.

2.16 Others we spoke to share the perspective that NHS organisations can do more to provide a more personalised approach – especially through face-to-face engagement.⁶⁵ For instance, a Director of Nursing told us that some people can make a real industry out of responding to complaints and gave the example of a 16-page complaint response she felt was unnecessarily long. She added that "*I think it's about*

picking up the phone and speaking to people. A lot of time is taken up. You're better having it [the conversation with a complainant] face-to-face".⁶⁶

2.17 A clinical lead for complaints at another NHS trust told us more can be done to keep the individual at the heart of the complaint.⁶⁷ He felt that their organisation often focuses on the process of providing a written

⁶⁵ Focus group/workshop member, PHSO qualitative research, October 2019/November 2019

⁶⁶ Interviewee, PHSO qualitative research, May–December 2019

⁶⁷ Interviewee, PHSO qualitative research, May–December 2019

response rather than talking to people to understand how they can best resolve their concerns. Although the 2009 NHS complaint regulations require organisations to respond to complaints in writing, there is nothing to prevent them from seeking to resolve patients' and families' concerns in person or over the phone and then following up in writing.

2.18 In the absence of a clear, shared understanding of what good complaints-handling looks like, it may be harder for NHS staff to have the confidence to take a more personalised, human approach to respond to complaints.

Providing multiple channels to gain feedback

2.19 It is important that organisations make it easy for people so they can raise concerns and give feedback in a way that suits them. As people increasingly go online to view information on local services and to share their experiences with others, obtaining digital feedback in a meaningful and engaging way will become more important. The examples given in case study five below come from organisations using a dedicated patient feedback platform, and which highlight how – when done well – digital engagement can have a significant and lasting impact.

2.20 It cannot be the only solution, however. It is essential that organisations provide inclusive ways to provide feedback and make a complaint to accommodate the diverse communities they serve. This includes human contact and support for the most vulnerable. These expectations are covered within the Complaint Standards Framework.

Case study 5

Engaging online: How embracing patient feedback is helping to make improvements in patient care

For both primary care services and Trusts, online feedback offers an opportunity to address issues swiftly and encourage a culture of learning. For patients, it also provides a vehicle for their voices to be heard.

In 2018, City and Hackney GP Confederation provided funding for 10 self-selected GP practices to pilot using a dedicated online patient feedback platform to gather patient feedback about their services. By April 2019, 81 stories had been posted online by patients across the ten practices. They had been read over 1,400 times. Over two-thirds of the stories that patients have shared so far have been positive.

The practices have also used any negative feedback to improve their services. In one instance, a patient shared an experience in which it was found difficult to book appointments at a practice because of unclear information on their website. A partner at the practice responded online and thanked the patient for highlighting the issue. They also updated the information on their website to ensure it is accessible for all patients and provided a timeframe for completing the action.

Nottinghamshire Healthcare Foundation Trust has also been working to encourage and use patient feedback since 2009. In 2012 the Trust won the national Patient Feedback Challenge and was the first Trust in the UK to create a website to gather feedback from their staff and the public. As well as using a dedicated patient feedback platform, the Trust's website also invites patients and their families to take a survey or get in touch directly with the Patient Advice and Liaison Service with any feedback they have. Over 6,000 stories have been posted so far online about the Trust. Staff aim to respond within 2 days, and use the feedback gathered from PALS and their survey to improve the experience of patients and families and make improvements where necessary.

- 2.21 As we see more public service organisations using digital channels to seek feedback, others are taking this further to understand how digital engagement can help bring staff and users closer together by communicating with 'digital stories'.
- 2.22 For example, Swansea Bay University Health Board, are currently running a pilot that enables patients to tell medical staff of their stories of poor care and how that has affected them. This direct connection, which helps to better convey the emotional impact of the issues raised by complaining,
- 2.23 has had a profound effect on staff and senior leaders, and has led to a series of improvements on both hospital wards and policies.⁶⁸
- 2.23 The use of digital stories to capture the feedback of patients and their families is replacing the need for people to write 'formal complaints' and enables people to communicate their concerns in a way that suits them. Equally, digital stories enable staff to get a clearer sense of how services impact patient experience, which leads to a better understanding of the issues and – most importantly – how these can be resolved.

⁶⁸ 'Patients use digital stories to tell tales of poor care' The Times, 17 February 2020

2.24 We are encouraged by the best practice being developed across the NHS and the wider public sector in this area, which can be embedded more widely through the Complaint Standards Framework and the training and sharing of best practice – including the use of dedicated feedback platforms – to help embed it.

Ensuring people have access to independent advice and support

2.25 It is vital that organisations make sure people know how to access independent advice or support to raise a concern or make a complaint. Advocacy organisations play a crucial role in supporting individuals who may find it hard to access the current complaint system to raise their concerns. The impact of coronavirus on people's lives makes access to advocates and advisers even more critical. Many more people are expected to seek help in raising concerns about how the pandemic has affected them.

2.26 Yet some advocacy organisations we spoke to highlighted wide variation in NHS organisations signposting to their services.⁶⁹ They told us that there were far too many people who did not know about the advocacy support available in their areas.⁷⁰ Many primary care staff we spoke to were themselves unaware of their local advocacy services, as well as the requirement in the NHS complaint regulations to signpost individuals to appropriate support.⁷¹

2.27 When speaking to complaints managers about having a consistent set of complaint standards, one NHS Complaints Manager told us about her personal experience of trying to raise concerns about the care provided for her terminally ill husband:

“I am an intelligent, strong woman, but I struggled to raise concerns about my husband’s care whilst caring for him. At no time was it explained to me that advocacy support was available. [...] I feel it is imperative that NHS complaint handlers ensure all complainants are informed that advocacy support is available, and I would like to see this highlighted [in complaint standards].”⁷²

2.28 As access to local advocacy services can vary across England, we were told that staff in NHS organisations sometimes do not always know who to direct people to.⁷³ Advocates and the head of an NHS patient experience team also told us that it is difficult to find advocacy services online, with one advocate describing the benefit of having a “local area guide”⁷⁴ for advocacy services available in different parts of the country.

69 Interviewee, PHSO qualitative research, May-December 2019; Focus group/workshop member, PHSO qualitative research, October 2019-November 2019

70 Focus group/workshop member, PHSO qualitative research, October 2019-November 2019

71 Meeting attendee(s), Primary Care Event, November 2019

72 Interviewee, PHSO qualitative research, May-December 2019

73 Focus group/workshop member, PHSO qualitative research, October-November 2019

74 Focus group/workshop member, PHSO qualitative research, October-November 2019

2.29 These issues are not new. Ann Clwyd and Tricia Hart's 2013 review of the NHS complaints system previously found low levels of public awareness about NHS advocacy services and support available. It also highlighted that the lack of a national brand unifying all complaints advocacy services contributed to this problem.

2.30 While we heard evidence about NHS complaints advocacy, access to independent specialist advice and advocacy was also raised with us.

2.31 Action against Medical Accidents (AvMA) highlighted the lack of advice and advocacy services for people with complex complaints or those who are involved in complaints processes outside the NHS, such as NHS patient safety investigations and inquests. A key issue is that while there is a statutory duty for local authorities to commission NHS complaints advocacy, these services are often limited to helping people navigate the NHS complaint process. Unlike specialist services, complaints advocacy providers cannot give advice on the clinical aspects of a complaint or on other processes that a complainant might be involved in or be considering.⁷⁵

2.32 The evidence we heard highlights ongoing issues in relation to public awareness of NHS complaints advocacy and how organisations signpost people to these services. While NHS organisations can do more to improve their signposting, there is also a need to make sure the landscape for NHS advocacy is sufficiently clear for both organisations and the public to understand. We have also heard about some concerning gaps in access to more specialist services. While it is important that individuals are supported to navigate the NHS complaints process, they may also need other forms of support and advice.

⁷⁵ AvMA feedback, PHSO qualitative research, May-December 2019

3. Being thorough and fair

A lack of consistency on how to deliver excellent complaints handling

3.1 An effective complaint handling system requires all complaints to be resolved via an open, transparent, and responsive process that thoroughly examines the issues raised in a timely and proportionate way. Staff responsible for resolving complaints should be properly trained and ensure that all parties – including staff who are cited in the complaint – are kept involved and engaged throughout.

3.2 Analysis of our casework often tells us that not all organisations meet these expectations. There are many reasons for this, but a recurring theme in our research is that these investigations are often carried out by staff who have limited or no training, or who lack appropriate support to carry out this important role. This often leaves them under significant pressure.

3.3 The 2009 NHS Complaint Regulations provide a high-level framework for how NHS organisations are expected to handle complaints. Whilst this may provide staff with a wide amount of discretion, our casework and research found that it often results in very different qualities of experience for complainants and advocacy services across local areas. Many NHS organisations have their own local policies for handling complaints, which can vary in practice, and there are no national guidelines for how to carry out a detailed investigation. There is also no consistent guidance on what service standards staff should be meeting, including how long it should take to receive a response to a complaint.

3.4 It is right that organisations should be able to tailor their responses to complaints to meet the needs of different people, but everyone should be able to expect the same core standards of service. A lack of consistency in guidance and approach can have a negative impact on the experience of those who raise complaints. In this chapter we explore some of the key challenges we identified in our research.

Delays in responding to complaints

3.5 The most common theme identified in a review of our investigation reports was delays in NHS organisations and UK Government departments responding to people's complaints. Most notably, it featured in 53% of the 178 we reviewed involving one NHS organisation, and in 41% of the 56 reports we reviewed involving organisations across the NHS and social care.

3.6 In one case we investigated,⁷⁶ a GP practice took two years to give a final response to a person's complaint about an incorrect prescription by a locum GP. We also found that the practice did not communicate to the complainant that they were chasing the locum GP for an explanation. It would have been straightforward for the practice to simply acknowledge and apologise for the incorrect prescription. The amount of time the practice took to respond to the complaint, and the lack of regular updates, caused unnecessary stress and inconvenience to the complainant.

76 Case reference C2004367

3.7 NHS complaints advocacy organisations told us significant delays could have a detrimental impact on their clients, including their health and wellbeing.⁷⁷ We heard that some complainants may even become convinced that delays are part of a strategy “to make them give up”⁷⁸. One advocate told us that delays were so common that they are often “...lowering peoples’ expectations of the process before you have even started it”⁷⁹.

Causes of delays

3.8 In some of our investigation reports, we observed that poor handling of investigations contributed to delays. For instance, in one case⁸⁰ an individual complained about the care of their relative. As part of their complaint they asked questions about the care given by doctors. However, the doctors involved did not appear to have been involved in the NHS Trust’s initial response to the complaint. We also found that, during a meeting, the Trust was unable to answer the complainant’s questions regarding medication and communication by staff. This was despite the complainant sending an agenda, which included these specific issues. This caused delays in the complainant receiving a response to the specific issues they had raised.

3.9 We spoke to staff from NHS organisations and advocacy organisations to get further insight into what causes delays in responding to complaints. We heard that the following issues contribute to delays:

- insufficient resourcing⁸¹ of NHS complaints teams
- extremely challenging workloads⁸²
- in NHS trusts, complaints are often investigated by staff where handling complaints is just part of their role, alongside their clinical or administrative duties. We often heard that significant pressures on NHS services impacted staff investigating and responding to complaints in a timely way.⁸³ A few organisations acknowledged that these pressures may lead to a de-prioritisation of complaints.⁸⁴
- GP practices also frequently highlighted how service pressures led to delays in responding to complaints.⁸⁵
- Complaints teams and investigators in NHS trusts often need input from clinicians, especially if they are relevant to, or the subject of, a complaint. We heard that service pressures can contribute to clinicians not responding in a timely way.⁸⁶

77 Focus group/workshop member, PHSO qualitative research, October-November 2019

78 Focus group/workshop member, PHSO qualitative research, October-November 2019

79 Focus group/workshop member, PHSO qualitative research, October-November 2019

80 Case reference C2012461

81 Interviewee, PHSO qualitative research, May-December 2019; Meeting attendee(s), PHSO Forum Meeting, May 2019; Survey respondent, PHSO online survey October-December 2019.

82 Meeting attendee(s), Complaint Standards Framework working group meeting, September 2019; . Interviewee, PHSO qualitative research, May-December 2019; Feedback on increasing workloads were also highlighted in responses to PHSO’s online surveys, October-December 2019

83 Interviewee, PHSO qualitative research, May-December 2019. Feedback on this theme also taken from various visits made by PHSO to NHS Trusts during 2019. This theme was also raised in feedback from Advocacy groups during our research, as well as being raised during workshops held between October-November 2019

84 This theme was raised by multiple sources during the interviews held between May-December 2019. The specific issue of complaints being pushed down list of priorities were also raised in a visit PHSO made to an NHS Trust in 2019, and in the Advocacy Workshop held in November 2019, as well as feedback given in PHSO’s online surveys

85 Survey respondent, PHSO online survey October-December 2019

86 Interviewee, PHSO qualitative research, May-December 2019

3.10 Advocacy organisations told us that common reasons they heard from NHS organisations for delayed responses included staff relevant to the complaint being on annual or sick leave. Relevant locum or agency staff having left an NHS organisation was also cited as an issue.⁸⁷ One advocate felt that NHS organisations could set more realistic timeframes for responding to complaints that took account of staff unavailability, rather than sticking to unrealistic deadlines they could not meet.⁸⁸

3.11 However, while it is important for people to receive a timely response, some NHS complaint handlers and other staff told us that they need to balance this with doing a thorough and high-quality investigation. This is especially the case when staff have limited capacity. Their experience was that complainants are less concerned about delays if they are kept updated and the response to their complaint is thorough and personalised.⁸⁹ This shows regular and effective communication with complainants is essential, no matter how long it takes to resolve their concerns.

Timeframes – the need for greater clarity and consistency

3.12 Delays in investigating are often compounded by a lack of national service standards for how long investigations should take. The 2009 NHS Complaints Regulations do not include a standard timeframe for organisations to respond to complaints. However, they require organisations

to give people an estimation of when they will respond to complaints, and to tell complainants why they have not provided a response if they have not done so within six months.

3.13 In the absence of detailed national standards, timeframes vary significantly between NHS organisations. Several NHS complaint handlers and advocacy organisations told us that they would welcome greater clarity or consistency regarding timeframes.⁹⁰ An NHS trust complaint manager told us that

“At the moment we can only say: ‘this is our internal target as set by the Board’. If we had something in addition to that I think [our clinical] divisions would be far more responsive to work to the timeframes. [And] in the event that capacity for investigating managers was an issue, that would [...] be something they would have to address head-on if there was best practice around that.”⁹¹

3.14 This suggests that clear standards around timeliness would help NHS complaints managers leverage influence within their organisations to make sure clinicians and other colleagues helped resolve complaints in a timely way.

3.15 The need for clarity regarding ‘reasonable’ and ‘unreasonable’ delays when responding to complaints was also raised with us. A Director at an

⁸⁷ Focus group/workshop member, PHSO qualitative research, October-November 2019

⁸⁸ Focus group/workshop member, PHSO qualitative research, October-November 2019

⁸⁹ Interviewee, PHSO qualitative research, May-December 2019. Feedback on this theme also given by workshop members, PHSO qualitative research, October-November 2019

⁹⁰ Interviewee(s), PHSO qualitative research, May-December 2019

⁹¹ Interviewee, PHSO qualitative research, May-December 2019

NHS Trust said that 'reasonable delays' could occur where other organisations involved in a joint complaint were not being responsive to requests from one of the other organisations named in the complaint. She felt that the Complaint Standards Framework could provide greater clarity in this area.⁹²

Not keeping people updated

- 3.16 Poor communication is one of the most common reasons for poor complaint-handling overall. It is important that organisations agree how people will be kept informed when they look into their concerns or complaints. However, our evidence shows that this does not always happen.
- 3.17 Organisations not keeping individuals updated was the second most common issue we identified in our thematic review. It appeared in 38% of the 178 investigation reports we reviewed involving one NHS organisation. This theme frequently featured in cases where there were delays in organisations responding to a person's complaint. In these cases, NHS organisations could often have communicated better with the complainant and managed the delays appropriately. We often found that organisations doing this would have alleviated the concerns and frustration that complainants experience during protracted complaint investigations.
- 3.18 Advocacy organisations also shared their experience of NHS organisations not updating their clients. They told us that their colleagues spent significant time chasing NHS organisations for updates, which caused unnecessary frustration for both advocates and their clients.⁹³

Causes

- 3.19 Complaints teams often communicate directly with the complainant and keep them updated on the progress of their complaint. As with delays in responding to complaints, the capacity of complaints teams was also cited as a reason for why people are not always kept updated.⁹⁴

Ensuring co-ordinated responses to complaints

- 3.20 The 2009 NHS Complaints Regulations state that NHS and adult social care organisations must cooperate to ensure that an individual receives a co-ordinated response to any complaint about more than one organisation. It also requires organisations to agree which of them should take the lead in co-ordinating the handling of the complaints and communicating with the complainant. This is often called the 'lead organisation'.
- 3.21 Best practice in adult social care has been developed through the Quality Matters initiative.⁹⁵ Quality Matters is the result of a number of key stakeholders with responsibility for overseeing and delivering adult social care working together to create a single vision for delivering high quality, person-centred Adult social care.
- 3.22 As part of Quality Matters, guidance has been developed to support adult social care organisations in complaints handling, which includes co-ordination of complaint responses between health and adult social care providers.

92 Interviewee, PHSO qualitative research, May-December 2019

93 Focus group/workshop member, PHSO qualitative research, October-November 2019

94 Interviewee, PHSO qualitative research, May-December 2019

95 [Department for Health and Social Care \(2017\). Quality Matters](#)

3.23 Despite these requirements and guidance, our casework shows that complaints involving multiple organisations across health and social care are not always well co-ordinated. To help us understand this issue, we reviewed our investigation reports in which more than one NHS organisation had been complained about. We also reviewed investigation reports of our Joint Working Team. This is made up of caseworkers from the PHSO and Local Government and Social Care Ombudsman (LGSCO). It investigates complaints that cover organisations across both health and social care.

3.24 Our thematic review found that the organisations sometimes did not provide a co-ordinated response to the individual's complaint. For instance, in two Joint Working Team investigations, the NHS Trusts and Councils involved sent out separate responses, rather than a single joint response. As a result, the complainants had to reply to each organisation separately and did not fully understand which organisations were responsible for each specific area of their complaint. We found that this caused those affected significant frustration.

3.25 This problem has been well-known for several years but is yet to be adequately addressed. The poor co-ordination of complaint investigations, as well as investigations into incidents of avoidable harm, has been recognised in previous reports. The review by Ann Clwyd and Tricia Hart in 2013 found that the NHS complaints system did not deal "adequately with issues that were the responsibility of more than one organisation".⁹⁶

3.26 Our own 2016 report, 'Learning from mistakes', reported on our second investigation into the tragic death of Scott Morrish's three-year old child, Sam.⁹⁷ We highlighted the failure of the organisations responsible for Sam's care to co-ordinate and co-operate with each other in investigating his death. Our report also found that the organisations failed to collectively identify and act on what they learnt from the case. Parliament's Public Administration and Constitutional Affairs Committee later held a follow-up inquiry into the issues we had raised. The Committee highlighted "*an immediate need to improve [...] the co-ordination of multiple-body investigations*" in the NHS.⁹⁸

3.27 However, advocacy organisations told us that they still often see poorly co-ordinated responses to complaints and it sometimes fell to advocates to try to co-ordinate the response.⁹⁹

96 Clwyd-Hart review (2013), p.22

97 [PHSO \(2016\) Learning from mistakes](#)

98 [PACAC \(2017\) Will the NHS never learn?](#), p.23

99 Focus group/workshop member, PHSO qualitative research, October-November 2019

Causes of poor co-ordination

3.28 We explored with NHS complaint handlers and advocacy organisations why organisations often struggle to provide a co-ordinated response to complaints. We repeatedly heard about the following issues:

- Organisations lack a shared understanding or appreciation of the need to work in a co-ordinated way.¹⁰⁰ We heard that some organisations do not appreciate the requirement to provide a joint response, and instead respond to complainants separately.¹⁰¹ This can result in people receiving inconsistent or contradictory responses and a poor experience overall.
- A perceived lack of authority or power for the lead organisation to ensure that other organisations cooperate.¹⁰² A complaint handler told us that she would welcome greater powers or authority for the lead organisation.¹⁰³

- Inconsistent approaches to how NHS organisations investigate and responds to complaints make it more difficult for the lead organisation to effectively co-ordinate investigations and provide a holistic and timely response.¹⁰⁴ We heard about differences in how organisations explain their decisions. Specifically, we frequently heard that the different timeframes that organisations work to when responding to complaints often contribute to delays.¹⁰⁵
- Complaint handlers and advocacy organisations highlighted a need for greater guidance around how organisations should handle complaints.¹⁰⁶ Beyond the brief requirements in the NHS Complaints Regulations, there is a lack of guidance.
- Some complaint handlers also told us that they would welcome more consistent timeframes for organisations to follow when responding to these types of complaints.¹⁰⁷ Many we spoke to told us that a Complaint Standards Framework could deliver greater guidance and, ultimately, more of a shared understanding in this area.

¹⁰⁰ Interviewee, PHSO qualitative research, May-December 2019; Survey respondent, PHSO online survey October-December 2019

¹⁰¹ Interviewee(s), PHSO qualitative research, May-December 2019

¹⁰² Interviewee, PHSO qualitative research, May-December 2019. Survey respondent, PHSO online survey October-December 2019

¹⁰³ Interviewee, PHSO qualitative research, May-December 2019

¹⁰⁴ Examples of inconsistent approaches to complaint handling were raised in a number of interviews held between May-December 2019.

¹⁰⁵ Interviewee, PHSO qualitative research, May-December 2019; Focus group/workshop member, PHSO qualitative research, October-November 2019

¹⁰⁶ Interviewee, PHSO qualitative research, May-December 2019; Focus group/workshop member, PHSO qualitative research, October-November 2019

¹⁰⁷ Interviewee(s), PHSO qualitative research, May-December 2019

Collaboration across organisations

3.29 NHS complaint handlers and advocacy organisations often reported a negative experience of joint complaints. However, we have seen examples of where organisations had worked collaboratively with social care providers. For example, Derbyshire Healthcare NHS Foundation Trust have created a joint working agreement with Derby City Council and Derbyshire County Council, which has helped them to provide co-ordinated responses to joint complaints.¹⁰⁸

3.30 Yet several NHS trust complaint handlers told us about their negative experience of joint complaints. They said they wanted to work more collaboratively with other complaints teams in the future.¹⁰⁹ Another NHS trust complaint manager highlighted that while her team communicated with other organisations via email, “there is not a lot of direct communication and interaction”.¹¹⁰ A Director from an NHS Trust also told us that she struggled to get “everybody round the table”.¹¹¹

3.31 The issue of better co-ordination and collaboration between organisations when handling complaints is a central expectation in the Complaint Standards Framework. This is particularly so for complaints that cover both Health and Social Care issues. We are working with the Local Government and Social Care Ombudsman to ensure the Complaint Standards Framework aligns with their guidance for local authorities on handling complaints.

¹⁰⁸ <https://www.derbyshire.gov.uk/site-elements/documents/pdf/council/complaints/joint-working-agreement.pdf>. Feedback on working collaboratively was given during Interviews held between May-December 2019 and by workshop members, PHSO qualitative research, October-November 2019

¹⁰⁹ Interviewee, PHSO qualitative research, May-December 2019

¹¹⁰ Interviewee, PHSO qualitative research, May-December 2019

¹¹¹ Interviewee, PHSO qualitative research, May-December 2019

4. Giving fair and accountable decisions

4.1 An effective complaint handling system places emphasis on delivering fair and accountable outcomes. Organisations should give people a fair, balanced, evidence-based account of what happened against what should have happened, and what conclusion they have reached as a result. When mistakes or shortcomings are identified, the organisation should also include any actions it needs to take to put things right and to prevent problems happening again.

4.2 However, in almost 1 in 5 of the investigation reports we reviewed involving one NHS organisation, and over a quarter of the investigation reports involving NHS and social care organisations, we found that organisations often gave an incomplete or inadequate response to a person's complaint. Under this broad theme, we saw several issues, including

- Not responding to the points raised by the complainant
- The investigation of the complaint not being adequate or thorough enough to understand what went wrong
- Not acknowledging failings
- Not giving clear, evidence-based explanations or reasons for the organisation's decisions and actions.

4.3 In one case we investigated, an individual complained about the care and treatment provided to their elderly relative by an NHS Trust. The Complainant was also unhappy with the way that their complaint had been handled. The complainant made an initial complaint about the plan that the Trust had put in place to feed their relative. We found that the Trust provided an evidence-based explanation to this part of the complaint. However, the Trust did not respond to the further issues raised, such as concerns about how the relative was helped when choking occurred and heart medication stopped.

4.4 We found that the complainant experienced distress as a result of not having a full response to the complaint made. We asked the Trust to acknowledge and apologise for these failings, as well as provide evidence of how it intended to improve its complaint handling.¹¹²

4.5 Responses that are incomplete, impersonal and hard to understand were highlighted by people we spoke to. An advocacy organisation told us they found the quality of written complaint responses varies significantly between, and even within, organisations. They emphasised that "the quality of a complaint response should not be dependent on who ... is the lead investigator".¹¹³

4.6 We heard numerous issues regarding written complaint responses from NHS organisations. In particular, responses are often cold and impersonal, lacking empathy or using standardised text given in previous responses.¹¹⁴ Often

¹¹² Case reference C2010478

¹¹³ Interviewee, PHSO qualitative research, May-December 2019

¹¹⁴ Meeting attendee(s), Complaint Standards Framework working group meeting, November 2019. Also raised during visits PHSO made to several NHS Trusts in 2019

responses contain medical jargon and ambiguous wording¹¹⁵ and people need help from an advocate to explain the organisation's response to them.¹¹⁶ Most worryingly, responses often fail to address the key points raised by the complainant, which we explore in more detail later in this chapter.¹¹⁷

4.7 One advocacy organisation summed up the impact that poor responses can have on people:

“Sloppy or ambiguous wording may go unnoticed by the writer of a letter. But for our clients – already distressed enough to make a formal complaint – the clarity of communication can make the difference between understanding and accepting the explanations given or feeling even more deeply aggrieved.”¹¹⁸

Causes of incomplete or inadequate responses

4.8 In our experience, poor responses can be caused by how NHS organisations decide to manage complaints. Many NHS trusts have complaint teams who oversee all complaints about the various clinical departments in the Trust. This often involves the team asking staff within those departments to look into the issues and draft a response.

4.9 Once this is done, to make sure these draft responses avoid medical jargon and address the issues raised, complaints teams can act as a 'gatekeeper' by reviewing these draft responses before they are sent to the complainant. This often means several different people are involved in first looking into the issues and then agreeing on what response will be given.

4.10 Complaints staff who work in these central teams told us that a significant part of their work therefore includes querying and improving poorly drafted responses by staff from clinical departments.¹¹⁹ This suggests that many clinical staff in NHS Trusts would benefit from training in complaints handling. This often does not happen, however, as investigating and responding to complaints is not seen as a central part of their roles.

4.11 This 'double handling' also means complaints staff often do not have direct or key involvement in the investigation itself. This may impact on their ability to contribute to drafting an effective response before it is issued.

¹¹⁵ Interviewee(s), PHSO qualitative research, May-December 2019; Focus group/workshop member, PHSO qualitative research, October-November 2019

¹¹⁶ Meeting attendee(s), Complaint Standards Framework working group meeting, November 2019

¹¹⁷ Interviewee, PHSO qualitative research, May-December 2019; Survey respondent, PHSO online survey October-December 2019

¹¹⁸ Interviewee, PHSO qualitative research, May-December 2019

¹¹⁹ Feedback given during visits PHSO made to several NHS Trusts in 2019

4.12 In any event, this approach to complaints handling often ensures there is a lack of a focus on professional development, support and recognition for NHS staff who handle complaints, which will clearly contribute to poor responses. NHS complaints staff told us they would welcome consistent guidance on formulating an effective complaint response.¹²⁰ An NHS trust complaint manager told us that:

“Because there’s no best practice for how a response should look and should read, we’re at the mercy of whoever is signing off that response”¹²¹

Quality assurance

4.13 NHS staff also told us that inconsistent approaches to how organisations quality assure their complaint responses were also a contributory factor to poor decision making.

4.14 A Director of Governance at an NHS Trust spoke of his experience of checking the quality of complaint responses. He emphasised the importance of effective and consistent processes and involving senior staff in checking the quality of responses to complaints. For example, in his Trust, a senior clinician checks the response before the Trust’s complaints team performs an additional check. The Director of Governance then gives final approval to ensure consistency and quality across the organisation.

4.15 This robust approach to quality assurance is not consistently seen across the wider public sector jurisdiction. One NHS complaints advocacy organisation told us that many of the complaint responses they see are rarely reviewed by anybody outside of those directly involved in the investigation of the complaint.¹²²

Poor communication and failing to answer all the key issues

4.16 The thematic review of our casework highlighted that complaint responses do not always address all the key issues or questions that people have raised. This means we often have to ask organisations to carry out further work, or for us to answer the issues within our own investigations.

4.17 When we explored with NHS staff why this can happen, the common cause was a lack of effective communication. The head of an NHS Trust complaints team emphasised the importance of staff regularly communicating with complainants to check understanding and ensure that their response addresses the issues that matter to the complainant.¹²³ However, we often heard from complaint staff that it is challenging to be able to achieve this in all cases.

4.18 Another recurring theme from our research was that there is sometimes a significant gap between the expectation of patients and complainants and what the NHS complaints process can achieve.¹²⁴ For instance, complaint

¹²⁰ NHS representative(s), PHSO Hospital Visit, 2019; Interviewee, PHSO qualitative research, May-December 2019; Survey respondent, PHSO online survey October-December 2019

¹²¹ Interviewee, PHSO qualitative research, May-December 2019

¹²² Interviewee, PHSO qualitative research, May-December 2019

¹²³ Interviewee, PHSO qualitative research, May-December 2019

¹²⁴ Interviewee, PHSO qualitative research, May-December 2019; Survey respondent, PHSO online survey October-December 2019

handlers told us that often complainants wanted staff to be disciplined. Such action would usually be achievable only if the complaint triggered HR processes, or via a fitness to practise route. Often this gap in expectation is not resolved due to inadequate communication between staff and complainants about what can and cannot be achieved.

4.19 A member of an NHS Trust's complaints team said it was difficult to identify which specific issues were most important to each complainant. This was especially difficult where people raise many issues, or the complaint was very complex. Again, this is best resolved through meaningful engagement, but staff often lack the skill or guidance to do that. We were told that it would be useful if a Complaint Standards Framework could address how to effectively scope a complaint investigation and make sure there was a shared understanding of what the complainant wanted to achieve and what the complaints-process could provide.¹²⁵

4.20 Ongoing, regular and open communication between NHS organisations and complainants is essential to make sure there is a shared understanding of what the complainant is concerned about and what the organisation is doing as a result. Staff currently lack the guidance – and confidence – to do this effectively and this can lead to confusion between organisations and the complainant during the complaint process.

4.21 This lack of effective communication can often lead to a rapidly deteriorating relationship between the parties and can often make it harder for staff to explain the reasons for their decisions – particularly when they have concluded that nothing went wrong. This can lead to complainants not accepting the explanations given, which often leads to continued conflict that further damages the relationship.

4.22 It is important that staff are given the confidence and support to communicate effectively to ensure they provide full answers to the issues raised. Staff must also be clear with complainants about reaching a final response and letting them know how they can come to the Ombudsman if they remain dissatisfied. Our Complaint Standards Framework focuses on these key communication skills and how staff can best apply those during their handling of a complaint.

4.23 Overall, the impact of failures to communicate effectively was best summarised by the Chair of an NHS Trust, who felt his organisation did not always address the complainant's points because

“[...] we’ve not listened with care and empathy; we’ve not really heard what they’re [complainants] trying to say. We’ve interpreted it inappropriately and therefore we’ve investigated the problem that we wanted to investigate, and not what [the complainant] wanted us to investigate.”¹²⁶

¹²⁵ NHS representative(s), PHSO Hospital Visit, 2019

¹²⁶ Interviewee, PHSO qualitative research, May-December 2019

Acknowledging failings

4.24 Organisations must make sure staff have confidence to be open and honest when things have gone wrong, or where improvements can be made. In the investigation reports we reviewed, we often found that organisations did not always acknowledge their failings. As described earlier in this report, defensiveness remains an issue and recognised as a fundamental problem by many of the NHS staff and advocacy organisations we spoke to.

Putting things right

4.25 When things do go wrong, it is important that organisations encourage staff to identify suitable ways to put things right for those raising feedback and complaints. This should always include providing meaningful apologies and showing what learning can be taken from the complaint that can be translated into action that will improve services. However, as mentioned earlier in this report, we are told that organisations often fail to give genuine or meaningful apologies, despite having access to specific guidance published by NHS Resolution on 'Saying sorry'.¹²⁷

Learning from complaints and demonstrating improvement

4.26 Complaints are a valuable source of insight which can help promote improvement in the quality and safety of services. When organisations respond to complaints, it is essential that they are clear about how they will learn from these, including how they will practically achieve the necessary improvements. As highlighted in the previous chapter

on culture, we heard evidence that organisations are not always learning from complaints.

4.27 An NHS advocacy organisation told us that, while they saw examples of NHS Trusts acknowledging failings:

"What we do not see enough of is 'and this is what we are going to do about it' and copies of action plans etc. If anything [...], our main concern is that we do not see the actions that close the loop."¹²⁸

4.28 It is crucial that organisations monitor any actions to ensure that they are implemented, report on their progress, and involve the people who are affected. An NHS complaints advocate emphasised that organisations should provide evidence that improvements have been made. She told us that her clients had been invited to see improvements made to hospital wards and organisations' policies. This can restore people's faith that they have been taken seriously and that something positive has been done.¹²⁹ Many of the people who come to PHSO tell us that the reason they made their complaint was to help make sure that what happened to them didn't happen to anyone else.

Providing financial remedies

4.29 Accountability and learning are extremely important, but staff should also consider what other action may be required to provide a complete remedy to the individual(s) who have been directly affected by any identified

¹²⁷ <https://resolution.nhs.uk/resources/saying-sorry/>

¹²⁸ Interviewee, PHSO qualitative research, May–December 2019

¹²⁹ Focus group/workshop member, PHSO qualitative research, October–November 2019

mistakes. It is therefore important that organisations consider making a financial payment to recognise the impact their failures have had on people, such as when a mistake has caused distress or inconvenience to someone. These payments are called financial remedies, and they are different from compensation that might be paid out through legal action.

4.30 Within our own casework, we continue to see a lack of consistency in how NHS organisations approach financial remedies. Previous research we undertook highlighted that some NHS staff do not believe they should make financial remedies in response to complaints, especially if those payments are intended to recognise distress and inconvenience. We heard that some NHS organisations do not believe such money should be drawn from their already stretched budgets.¹³⁰

4.31 During our research, we heard that NHS staff do not always feel confident about when or how they should offer financial remedies to complainants. An NHS trust complaint manager told us that:

“We’re all unsure as to what we should be offering, when we should be offering, whether it would be seen as good practice to offer a financial payment and how that interrelates with a legal claim.”¹³¹

4.32 A medical defence organisation also highlighted the need for greater clarity about when a financial remedy is appropriate.¹³²

4.33 In 2018 we published information to provide greater clarity on the Ombudsman’s approach to recommending organisations give financial remedies. During our research, some complaint handlers told us they had started to use this guidance to inform their own approach to making payments. There is currently no national guidance on this topic. Complaint handlers told us that they would welcome greater guidance on this issue and that it would be¹³³ another area in which the Complaint Standards Framework can provide greater certainty.

4.34 It is also important NHS organisations always look at offering a complete remedy to complainants at the earliest possibility, so to avoid the need for those who have been negatively impacted to take further action. We strongly support the work of NHS Resolution in their role in providing expert support and advice to NHS organisations on providing suitable financial remedies that resolve disputes earlier and in their entirety. Working in partnership with NHS Resolution and others, the Complaint Standards Framework will provide further support to NHS staff in this area.

¹³⁰ Feedback given from NHS to inform PHSO 2016/17 Financial remedy guidance project

¹³¹ Interviewee, PHSO qualitative research, May-December 2019

¹³² Feedback given during a PHSO visit to a medical defence organisation in 2019

¹³³ Interviewee, PHSO qualitative research, May-December 2019

5. A unified vision for good complaint handling

The problem: inconsistency and a lack of shared view

- 5.1 In our role of making final decisions on complaints that have not been resolved by the NHS in England, we see significant variation in both the quality and consistency of how organisations approach complaint handling.
- 5.2 This is because the current statutory framework for NHS complaint handling is too broad in the requirements it sets, alongside a lack of national guidance to help the NHS carry out high quality investigations.¹³⁴ One example of where we see considerable variation is the different timeframe targets that organisations set for responding to complaints. Our desktop review of published complaint policies of NHS trusts in England found that there was a range of timeframes across these organisations.
- 5.3 This lack of consistency about how complaints should be handled has played its part in compounding the problems highlighted in this report. Further, there is a lack of clarity in what is expected from senior staff in embedding a culture of learning from complaints.
- 5.4 Various organisations, including the Ombudsman, have contributed to overlapping guidance and information on what good complaint handling looks like. While well-intentioned, this has caused confusion, with complaint staff unsure which guidance to rely on, and

has led to differences in approaches to complaint handling. As one complaints manager put it, having just one set of national guidance would be welcomed “so I don’t have 42 versions of what I’m supposed to do.”¹³⁵

- 5.5 Concerns that there needs to be a more consistent approach to complaint handling in the NHS are not new. In 2015 the then-Chair of the National NHS Complaint Managers Forum highlighted to a Parliamentary Select Committee the need for a “*more unified*” approach to complaint handling, underpinned by “*clearer central guidance*”.¹³⁶

One key answer: providing consistency through a Complaint Standards Framework

- 5.6 Our research found significant consensus on both the problems faced, and what can be done about them. Our work with partners to develop a Complaint Standards Framework for NHS complaints in England has gathered significant momentum. When speaking to staff about the Framework, NHS complaints staff told us that they would welcome one version of what ‘good looks like’.¹³⁷ This perspective was endorsed by advocacy organisations that we spoke to.¹³⁸
- 5.7 The head of an NHS trust complaints team supported the Framework, telling us “*everybody has an opinion on how complaints should be managed and this is why I’m so delighted the Ombudsman is leading this work to*

¹³⁴ The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

¹³⁵ Interviewee, PHSO qualitative research, May-December 2019

¹³⁶ John Dale, Written evidence to Public Administration Select Committee, January 2015. Available at: <http://data.parliament.uk/writtenEvidence/committeeevidence.svc/evidencedocument/publicadministration-committee/nhs-complaints-and-clinical-failure/written/17420.html>

¹³⁷ Interviewee, PHSO qualitative research, May-December 2019

¹³⁸ Focus group/workshop member, PHSO qualitative research, October-November 2019

unify the guidance.”¹³⁹ Other complaints managers we spoke to highlighted that a Framework could have a significant impact in this particular area by encouraging a unified approach.¹⁴⁰

5.8 We heard that a consistent set of complaint standards would be beneficial because complaint handlers could then move between different NHS organisations (or new staff could be recruited) without the need to ‘re-learn’ new policies and procedures.¹⁴¹

5.9 Complaint handlers also highlighted specific areas that they did not feel were sufficiently addressed through existing guidance. For instance, unreasonable or disproportionate behaviour from complainants, and consent when handling complaints from third parties, were frequently cited as areas where complaint handlers needed greater guidance. As well as unifying existing but separate guidance, the Framework is therefore also an opportunity to provide greater clarity in specific areas.

5.10 The need for better consistency on expected timeframes for handling complaints was a common issue heard during this research. However, there were residual concerns given by NHS complaint handlers more generally that having a standardised set of timeframes across the NHS may not suit every NHS organisation, and that you cannot have a “one-size fits all” approach.¹⁴²

5.11 Greater consistency was not the only benefit of a central Framework among those we spoke to. The head of an NHS Trust complaints team said that unified guidance could empower complaints teams across the country, giving them greater credibility when they tell their colleagues in clinical departments what good complaint handling looks like.¹⁴³

Developing a unified set of Complaint Standards for public services

5.12 Building on the momentum we have seen across the NHS, there is now a unique opportunity to develop a single, unified framework for best practice in complaints handling that can apply across other areas of our work. This is a key building block to ensuring there is a clear cultural alignment towards openness and learning from complaints across the public sector. Crucially, it can ensure that anybody who wishes to make a complaint or give feedback about a public service will experience the same, high quality service, and will see feedback making a real difference to improving public services for all.

5.13 Through our initial engagement with the UK Government departments and its agencies, there is shared consensus on the value this work can bring to our wider public sector jurisdiction. We have already begun to work in partnership to adapt and embed the Complaint Standards Framework into this sector in the period ahead.

¹³⁹ Interviewee, PHSO qualitative research, May-December 2019

¹⁴⁰ Interviewee, PHSO qualitative research, May-December 2019

¹⁴¹ Interviewee, PHSO qualitative research, May-December 2019

¹⁴² Interviewee, PHSO qualitative research, May-December 2019

¹⁴³ Meeting attendee(s), PHSO Forum Meeting, May 2019; Interviewee, PHSO qualitative research, May-December 2019

Other issues and how to address them

Variable access to training and professional development

5.14 Another issue we identified is that complaint handlers do not routinely receive professional skills training or continuous professional development in relation to handling complaints. Some told us that they instead have to '*learn on the job*'.¹⁴⁴ This leads to inconsistent practice across the system.

5.15 A lack of professional training means that there are missed opportunities for complaint handlers to develop, aside from the practical experience they gain in their roles. We heard from an NHS complaints manager that a lack of training "*leads to people not feeling very confident to speak to people and manage complaints*".¹⁴⁵

5.16 Barriers to providing skills training included cost and the time of staff to attend. Lack of awareness of available training or courses was also an issue.¹⁴⁶

5.17 Currently there is not a single overarching provider of training relating to complaint handling in the NHS in England. There are various private sector providers that offer unregulated training to NHS organisations. Having a fragmented training offer presents a risk of inconsistency, particularly as there is not currently a single framework or vision for good complaint handling to base training on.

5.18 As with the problem of consistency, professionalisation of complaint handlers in the NHS is an issue that has been highlighted by others. Notably, Ann Clwyd and Tricia Hart's review into how the NHS handles complaints reported that complaints managers are "not sufficiently trained and need proper accreditation." The review also recommended "NHS accredited training for people who investigate and respond to complaints."¹⁴⁷

5.19 NHS complaint handlers we spoke to agreed that a specific gap is the lack of professional training and an overarching qualification or form of accreditation for complaint handlers.¹⁴⁸ We heard that in the absence of specific complaints training and other forms of professional development, complaint managers have to "rely on each other"¹⁴⁹ for their professional development. One Practice Manager told us that staff would be happy to attend training if it was available from a respected and central provider.¹⁵⁰

¹⁴⁴ Survey respondent, PHSO online survey October-December 2019; Interviewee, PHSO qualitative research, May-December 2019; Meeting attendee(s), PHSO Forum Meeting, May 2019

¹⁴⁵ Interviewee, PHSO qualitative research, May-December 2019

¹⁴⁶ Survey respondent, PHSO online survey October-December 2019

¹⁴⁷ Clwyd-Hart review (2013)

¹⁴⁸ Interviewee, PHSO qualitative research, May-December 2019

¹⁴⁹ Interviewee, PHSO qualitative research, May-December 2019

¹⁵⁰ Survey respondent, PHSO online survey October-December 2019

The need to professionalise frontline complaint handling

5.20 While training was identified as important to enable complaint handlers to develop, we also heard from complaint handlers that training and a professional qualification or accreditation would ensure that they are recognised as having professional skills in their job.¹⁵¹

5.21 The head of an NHS trust complaints team told us that

“I don’t think people appreciate the level of skill that is required from complaints officers and patient experience managers. You have to have the personable and approachable manner in terms of communicating with complainants, equally you have to be in a position to quality assure quite complex complaints reports and then communicate that in a way that is sensitive. Having accreditation and a competency framework would be really great from our perspective.”¹⁵²

5.22 Related to this, we heard that career development opportunities are limited for complaints staff in NHS trusts. The head of an NHS Trust Complaints Team told us that complaints staff may be able to only progress if another member of the team leaves and creates a vacancy. He felt that a professional qualification could have a significant impact by creating more of a career pathway and making complaints staff feel more valued.¹⁵³

5.23 As previously highlighted in this report, we have identified concerns that complaint handlers do not always have sufficient authority, respect or status within their organisations. We heard that greater professionalisation, via training and accreditation, could help address this.

5.24 At our 2017 Open Meeting event the then Chair of the National NHS Complaint Managers Forum emphasised this issue. He highlighted the need for *“a proper degree course for investigators and complaint managers where it gives them some gravitas with their directors that, what they say, goes.”* An NHS complaint manager we spoke to told us that having a recognised qualification could help complaints staff demonstrate to their clinical colleagues that they are qualified to handle complaints.¹⁵⁴

¹⁵¹ Meeting attendee(s), PHSO Forum Meeting, May 2019; Interviewee, PHSO qualitative research, May-December 2019

¹⁵² Interviewee, PHSO qualitative research, May-December 2019

¹⁵³ Interviewee, PHSO qualitative research, May-December 2019; Meeting attendee(s), PHSO Forum Meeting, May 2019

¹⁵⁴ Meeting attendee(s), PHSO Forum Meeting, May 2019

Ensuring consistency: the role of a Complaint Standards Authority

Case Study 6

A new Complaint Standards Authority: How using a single set of standards has improved efficiency in the Scottish public sector

The Scottish Public Service Ombudsman's Complaints Standards Authority (CSA) has developed a simplified, standardised Model Complaints Handling Procedure (MCHP) for the Scottish public sector. Almost all Scottish public services have adopted and apply the MCHP. The MCHP includes a shared definition of a complaint and places value on complaints as an opportunity for learning and improvement, requiring organisations to report on and publish complaints information. The model procedure includes a two-stage process focused on early resolution within five days. If early resolution is not possible, organisations have an investigation stage of 20 working days to provide a response and signpost to the Scottish Public Services Ombudsman (SPSO).

The SPSO recently conducted a review of the MCHP, including a survey in which 156 public bodies took part. Results indicated high satisfaction with the MCHP, with 84% of respondents stating that the MCHP's definition of a complaint is helpful. Emerging findings also indicated that the guidance and tools provided by the SPSO were useful. However, the survey also indicated areas for improvement and in December 2019 the SPSO revised the MCHP to offer greater clarity around areas like complaints via social media and the time limit for making a complaint. It changed the model to place greater emphasis on the importance of contacting the complainant at the outset of an investigation, and on encouraging organisations to consider opportunities for resolution throughout the two-stage process. Accompanying guidance will outline the requirements for each sector to record and report on complaints and demonstrate a positive learning culture.

At our Annual Open Meeting in 2019, the Scottish Public Services Ombudsman, Rosemary Agnew, reflected on the achievements of the CSA in achieving consistency and transparency for complainants. She also acknowledged that there was still progress to make and improvements to achieve, noting that: 'It's about trying to achieve consistency, not just of service, but also helping people understand what right they have to a response within in the timescales'.

5.25 We can learn from the experience of the Scottish Public Services Ombudsman (SPSO), which has created a unified complaint handling framework for public services in Scotland. One historic issue was the significant variation in how organisations handled complaints in Scotland. As case study 6 highlights, the unified Framework developed by the SPSO has helped to produce greater consistency in how complaints are handled across public services.

5.26 Significantly, the SPSO was given statutory powers to be a 'Complaint Standards Authority'. In practice, this means that it has the power to set standards for local complaint handling processes within the public sector in Scotland. As well as setting clear standards, this includes a role for SPSO in delivering training and other forms of support to public service providers.

5.27 Similar statutory powers for PHSO, or a future Public Service Ombuds, which we called for three years ago, would allow us to set and monitor recognised standards for public service providers. It would encourage organisations to improve their complaint handling based on a unified vision of good practice.

5.28 While we are committed to working with our partners to embed the Framework, we are conscious that in the absence of it having statutory force, it will be more challenging to monitor performance and maintain consistency. However, in England and Wales the Higher Education Ombudsman (the OIAHE) has, after extensive consultation, implemented its Good Practice Framework on handling complaints in Universities and Further Education Colleges. This has been done successfully on a voluntary basis with the full consent of the parties involved.¹⁵⁵

Implementing a unified vision for complaint handling – the need for effective and inclusive leadership

5.29 While our research shows a clear opportunity to bring greater consistency to how complaints are handled by NHS organisations, and potentially other public services, a Complaint Standards Framework itself will not transform culture and practice. This will require effective and inclusive leadership and a willingness to use the momentum that has been created to make change happen.

5.30 There needs to be commitment across the system to embed the principles outlined in the Complaint Standards Framework, and for senior leaders and staff to address directly the barriers to creating a culture of learning. The head of an NHS trust complaints team emphasised the importance of leadership within organisations, highlighting that frontline staff would struggle to “influence the agenda” on their own:

“You can write all the frameworks and policies that you want. You have to have your senior leadership on board with implementing it and making sure the culture is right.”¹⁵⁶

5.31 We are also conscious that, as well as NHS organisations, PHSO, system-leaders, regulators and commissioners also have vital roles to play in embedding the Framework across the system.

5.32 The need to professionalise complaint handling has been recognised by stakeholders we have engaged with. By creating a unified approach, a Complaint Standards Framework will serve as a central reference point for future training, professional development and accreditation. In this sense, a Framework is the first step towards professionalising complaint handling. However, developing training and professional accreditation will require significant investment, if the NHS and others are to unlock the full potential of this opportunity.

¹⁵⁵ <https://www.oliahe.org.uk/resources-and-publications/good-practice-framework/>

¹⁵⁶ Interviewee, PHSO qualitative research, May-December 2019

6. Next steps

- 6.1 The experience of people whose cases we have reviewed, as well as the feedback given by a wide range of public sector staff within this report provides a clear view that more must be done to support and strengthen the quality and consistency of frontline complaints handling within the NHS and our wider public sector jurisdiction. Through our engagement with advocacy organisations, complainants and staff across the English NHS and UK Government on these themes, it appears this view is widely shared.
- 6.2 Despite the over-long delay within Government to implement the legislation needed to bring about Ombuds reform at the UK and England level, there is a clear appetite for a single, shared vision of best practice in complaints handling via the Complaint Standards Framework. This need is now amplified by the impact that coronavirus is having on all aspects of public services. In particular, the pandemic profoundly affected people's access to care and treatment in the NHS across a wide range of services. It has also led to more people wanting to access help and support from public services. This increase in demand will almost certainly lead to a rise in complaints.
- 6.3 More needs to be done to make sure demand on the complaints system is met effectively, that concerns are resolved and remedied quickly, and that the experience of users is captured and acted on to learn and improve public services.
- 6.4 There are several practical steps we will take to make that happen.

Public consultation on the Framework

- 6.5 Carrying out a public and stakeholder consultation on the Complaint Standards Framework we have developed for the NHS is a vital first step. No framework on complaints can be credible without significant public, user and complainant contribution to its construction. We have sought and received a wide range of views to this point, but now is the right time to seek even broader feedback before the first iteration of the Framework is finalised. Once this process is complete, we are confident the Framework will help create a stronger culture in which complaints are genuinely learned from. At the same time, it will build a single, flexible, effective complaints system to embed across our wider public sector jurisdiction.
- 6.6 Upon completion of our public consultation on the draft Complaint Standards Framework, we will act on the submissions and feedback we receive to revise and improve it. We will then launch the final version of the Framework as quickly as possible, with an initial focus on supporting the NHS staff embedding it, while clarifying expectations around the standards of service they should expect for the public.

Embedding the Framework into our work

- 6.7 PHSO and its partners are committed to embedding the Complaints Standards Framework into PHSO's own work, initially focusing on the NHS. We welcome the engagement we have had from UK Government departments around developing a similar framework for this area, which we intend to be ready in the near future.

6.8 To begin with, the Framework will set the appropriate benchmark of best practice for front-line service providers and service users. In parallel, the Framework should be used by NHS Commissioners and Regulators in their assessment of the effectiveness of how NHS organisations approach complaints handling. The Framework would inform, as far as possible, how NHS Regulators measure and assess performance on complaints of NHS organisations, and how NHS Commissioners hold NHS providers to account regarding learning from complaints.

6.9 As the Framework is embedded in both front-line delivery and through NHS oversight and regulatory activity, we expect organisations to begin to capture and report on data that demonstrates how they are meeting these new expectations. This should be done in a way that does not create onerous new reporting requirements, particularly for smaller organisations that receive few complaints. For example, national bodies that are required to produce annual reports could simply include a section addressing the volume of complaints they have received, how their service has improved in light of the lessons they have learned and their assessment of performance against the Framework. This is just one possible approach, however. We invite feedback on how embedding the Framework and monitoring it could best be achieved as part of the public consultation.

6.10 During the consultation, PHSO will also explore how we can identify trends in implementation to help support organisations to place the Framework at the heart of their approach to listening to – and learning from – feedback from service users. In this way, and based on partnership, the Framework can be developed as a living document of direct relevance to the public.

6.11 It is right that the needs of the people who are complaining sit at the heart of the Framework, but it is also important that support is given to staff who are subject to a complaint. The Complaint Standards Framework begins to clarify what that should look like. Yet PHSO cannot do this alone.

6.12 We recognise that this is a serious issue that requires action as quickly as possible. To that end we are proposing that as part of embedding the Framework, every NHS organisation should ensure that staff subject to a complaint have access to a member of staff who can provide advice and emotional support. This would mirror the support that should also be available to all complainants through the statutory advocacy and other services that are in place.

6.13 We are also committed to ensuring the Framework is used constructively and proportionately within our own casework when holding both the NHS and (eventually) UK Government Departments to account for the quality of their complaints handling. Once the Framework is finalised, we will update our Service Model and training for our staff to achieve this.

Supporting staff through high quality complaints handling training

6.14 Our research highlights the need to invest in supporting and training staff to deliver best practice in complaints handling. At present, access to – and quality of – training is patchy and there is little recognition that handling and resolving complaints is a complex skill. Staff are left feeling unsupported and under-valued and this can have a negative impact on service users who make a complaint.

6.15 Working in partnership with key stakeholders, PHSO will develop a core learning and development programme on complaints handling that provides staff delivering NHS services with access to high quality training and development aligned with the Framework's expectations.

6.16 Ultimately this approach can lead to externally accredited training and professional qualifications in complaint handling. Such an approach can also offer a route for staff wishing to specialise in complaints handling to clearer career paths, from being on the frontline in smaller organisations, to delivering complex, multi-disciplinary investigations and managing teams delivering such work.

6.17 Developing and co-ordinating delivery of training on such a scale is ambitious. It constitutes a revolution of expectations. If it is to be achieved, there will need to be support from Parliament and relatively modest investment from Government to realise the scale of ambition required. We will make a clear and realistic assessment of what resources will be required to achieve this as we look to develop our new corporate strategy for 2021-4. This will help inform our discussions with HM Treasury as we approach the next Comprehensive Spending Review.

Piloting how the Framework will work in practice

6.18 Ensuring that the Complaint Standards Framework works for all NHS service users and staff will be key. We will therefore be running pilots following the Framework's launch. These will focus on working with service users and a small number of NHS organisations that represent the different areas of healthcare (for example, Primary Care, Hospitals, Ambulance Trusts, Mental Health Trusts).

6.19 These pilots will focus on how the Framework can be embedded in each pilot organisation's culture and processes and how service users and complainants will benefit. They will include, in general terms, working to

- Review and adjust their complaint handling process to align with the Framework
- Work with senior leaders on how the Framework can be embedded into their organisation's culture and governance systems

- Co-develop and test training materials relevant to supporting staff (and senior leaders) to deliver the Framework's expectations.
- Ensure that service users and complainants understand how the Framework will work and monitor the impact that it has on their experience.
- Test ways of collating and publishing material to illustrate the impact of the Framework on how organisations handle complaints, and what this has meant to the complainant experience.

6.20 The pilots are expected to last 12 months to make sure that we can identify any challenges to embedding the Framework, and to make sure that the training we design is relevant and meets everybody's needs. During this time, we will be carrying out wider engagements across the NHS and the wider public to set out how service users will benefit from the Framework and how NHS staff can use the Framework to support and strengthen complaints handling.

6.22 The Framework we have initially developed for the NHS owes a debt to *My Expectations*,¹⁵⁷ which sets out a user-led vision for what complainants expect to experience when they want to raise a concern or complain about health and social care providers. As part of our piloting phase, we will work with our partners to carry out a review of *My Expectations*, to ensure it continues to reflect modern user needs and is expanded to cover making a complaint about UK Government departments.

6.23 This review will also explore how NHS organisations and others can incorporate feedback from complainants into their consideration of how effectively the Framework is embedded in their organisation. Similarly, it will consider how this feedback can be incorporated into the reporting that organisations should do to demonstrate how the Framework has been embedded into their approach to handling complaints.

Capturing complainant feedback on how the Framework benefits them

6.21 Ensuring that the Framework can operate in the different environments across the NHS and constitute real change for complainants will be critical. We will therefore develop a robust approach to seeking feedback from complainants on the impact of the Framework as part of the piloting phase.

¹⁵⁷ [My Expectations for raising concerns and complaints \(2014\)](#)

7. Issues for Parliament to consider

7.1 The progress we have achieved to date is substantial, but more needs to be done. Coronavirus has radically transformed public life and will give rise to far-reaching changes to how public services can and will be delivered and accessed. This should not be ignored. There is a need to ensure we do not lose the momentum to develop a more effective, more open public sector complaints system.

7.2 In this final chapter we outline what the Public Administration and Constitutional Affairs Select Committee may wish to consider as part of any inquiry it launches in response to this report.

Reform of existing legislation on complaints handling in the NHS

7.3 **The Department for Health & Social Care should review the 2009 NHS Complaint Regulations** with a view to amending them to better reflect modern best practice in complaints handling. These regulations are outdated and lack detail on what is required from NHS organisations when handling complaints, which have contributed to the variability in approach evidenced in this report.

7.4 The development of the Complaint Standards Framework provides an opportunity for any reform of the 2009 Regulations to codify a number of key expectations, particularly ensuring that every NHS organisation reports in a standardised way that places focus on what learning they have identified from handling complaints. Similarly, the Regulations must outline requirements for NHS organisations to signpost complainants, particularly the most vulnerable, to the support that is available to them locally if they want to make a complaint.

7.5 We ask Parliament to explore this proposal further as part of any inquiry it holds into our report. This should also cover the role of the Regulations if or when the Ombuds service is granted statutory Complaints Standards Authority powers as well as how a system of reporting on the Standards is working in practice in the interim.

Strengthening oversight on complaints handling and learning from complaints

7.6 There is currently no single organisation that has overall responsibility for developing complaints standards in England and overseeing how these are embedded. Instead, such responsibility is spread across a wide circle of organisations, and this can cause overlap and confusion in ensuring consistency in best practice in complaints handling.

7.7 We agree with Healthwatch England's conclusions in their recent report *"Shifting the Mindset"* that there needs to be a single organisation empowered in law to act as a national complaints standards authority, responsible for not only setting the standards expected, but also for overseeing how organisations within its jurisdiction are performing against these standards.

7.8 Devolved nations across the UK have addressed this point by empowering their national Public Services Ombuds offices with complaint standards authority powers. This core element remains missing from the complaints landscape in England and at the UK level, which means citizens making complaints at these levels are at a disadvantage compared to those elsewhere.

7.9 Both PACAC and PHSO have repeatedly called in recent years for the UK Government to facilitate a Joint Committee to conduct pre-legislative scrutiny of the Public Service Ombudsman Bill. This would have been the natural place for Parliament to consider whether PHSO should be given statutory responsibility to become a Complaint Standards Authority.

7.10 In the absence of this scrutiny taking place, now would be a natural time for PACAC as part of any inquiry into this report to explore the merits of how we can best catch up with the rest of the UK in this area. While more fundamental reform may take more time to deliver, **we would welcome PACAC's views on whether now is the right time for PHSO to be granted statutory complaint standards powers through any other relevant legislative vehicle into which it could be incorporated.** To achieve this, a sector by sector approach may be necessary, most likely starting with the NHS.

Appendix A: Thematic review

Complaints involving one NHS organisation or one UK Government or agency

We reviewed 178 final reports of complaints we investigated involving one NHS organisation where complaint handling was an issue complained about and identified that the poor complaint handling related to the following themes

- In **53%** of investigations, delays in organisations responding to complaints
- In **38%**, a failure to keep complainants updated
- In **19%**, incomplete complaint responses

We also reviewed 17 cases final reports of complaints we investigated involving one UK Government department or agency where complaint handling was an issue complained about and identified that the poor complaint handling related to the following themes

- In **47%** of investigations, incomplete complaint responses
- In **41%**, delays in organisations responding to complaints
- In **24%**, a failure to respond to points raised by the complainants
- In **24%**, organisations failing to provide clear and evidence-based explanations for their decisions and actions in response to complaints

The lower number of final reports concerning UK Government departments and its agencies reflects the wider trend of our casework.

Complaints involving several NHS organisations

For ‘multi-body’ complaint handling in the NHS, we looked at investigation reports where more than one NHS organisation was involved. We identified 62 cases where complaint handling was an issue complained about and identified the following themes

- In **27%** of the investigations, incomplete complaint responses.
- In **26%**, delays in organisations responding to complaints
- In **18%**, poor co-ordination of the investigation and response to the complaint

Complaints involving organisations across the NHS and social care

In 2015 the Local Government and Social Care Ombudsman (LGSCO) and PHSO established a Joint Working Team. The team is made up of investigators from both organisations that investigate complaints that span services delivered by NHS and social care services. We reviewed a selection of the Joint Working Team’s published reports. We identified 56 cases where about the Team has specifically investigated people’s complaints about the quality of the organisations’ complaint handling. We found the following themes

- In **41%** of the investigations, delays in organisations responding to the complaint
- In **27%**, incomplete complaint responses.
- In **23%**, poor co-ordination of the investigation and response to the complaint

Appendix B: Online survey results

Of the 24 respondents to our NHS trust board members survey:

- **63%** agreed that their Board makes effective use of intelligence from complaints and feedback from people using their services to improve performance (4% disagreed, and 29% neither agreed nor disagreed)
- **42%** stated that their Board engaged to share and discuss approaches to complaint handling (50% stated their Board did not, and 8% stated they did not know)
- **58%** stated that their Board engaged with other Boards to benchmark performance (33% stated their Board did not, and 8% stated they did not know)
- **67%** stated that their organisation made professional skills training and continuous professional development available for complaint handlers and other staff that deal with feedback and complaints from people using services (29% stated their organisation did not, and 4% stated they did not know)
- **88%** agreed that to improve performance, their organisation engages effectively with feedback provided by patients (4% disagreed and 8% neither agreed nor disagreed)
- **75%** agreed that their organisation puts feedback and complaints 'front and centre' into learning and service improvement (13% disagreed and 13% neither agreed nor disagreed).

Of the 44 respondents to our GP practices survey:

- **77%** stated that their organisation made professional skills training and continuous professional development available for complaint handlers and other staff that deal with feedback and complaints from people using services (18% stated their organisation did not, and 5% stated they did not know)
- **77%** agreed that to improve performance, their organisation engages effectively with feedback provided by patients (5% disagreed and 18% neither agreed nor disagreed)
- **77%** agreed that their organisation puts feedback and complaints 'front and centre' into learning and service improvement (2% disagreed and 20% neither agreed nor disagreed)

Key concerns that respondents felt were most likely to occur were investigations of complaints that span a patient's care pathway not being well co-ordinated by the organisations involved (44%), and delays in responding to complaints (39%).

The key concerns considered least likely to occur were: Not responding to the points raised by the complainant, Failings not being acknowledged in the complaint response and explanations provided by organisation for their decisions/actions not being sufficiently clear or evidence-based (14% each).

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Parliamentary and Health Service Ombudsman

Citygate
Mosley Street
Manchester
M2 3HQ
United Kingdom

Telephone: 0345 015 4033

Textphone: 0300 061 4298

Fax: 0300 061 4000

Email: phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

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