Parliamentary and Health Service Ombudsman

Listening and Learning:

The Ombudsman's review of complaint handling by the NHS in England 2011-12

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Foreword by Dame Julie Mellor, DBE, Health Service Ombudsman

Listening and learning in a changing NHS

This report comes in the middle of the biggest overhaul to the NHS in over 60 years. The changes to the NHS structure brought about by the Health and Social Care Act 2012, and the ongoing repercussions of the Mid Staffordshire NHS Foundation Trust Inquiry, combine to make this one of the most challenging and demanding times in the history of the health service.

We are the last resort for complaints about the NHS. We listen to individual complaints and, where things have gone wrong, help to get them put right. We see the NHS through the eyes of individual patients who have received poor care or treatment and who have been unable to get things put right through any other means. As the changes in the NHS take shape, our caseload suggests that embedding good complaint handling will be essential to avoid the risk of patient complaints going unheard.

People who complain to us often say that they want to make sure that no-one else experiences the same poor care or treatment that they have. Sometimes the substance of their complaint highlights patient safety concerns. For others, poor service from the NHS can be at best inconvenient or, at worst, devastating, especially if people are unwell or struggling to take care of others. Our work gives them a voice and this report tells some of their stories.

Time and again, poor communication with patients and their families is at the core of what goes wrong. Last year, we received 50% more complaints from people who felt that the NHS had not acknowledged mistakes in care. We received more complaints from people who felt they had not received a clear or adequate explanation in response to their complaints, and more complaints about inadequate remedies, including apologies. This report tells the story of the surgeon who told a patient he was behaving like a baby and quotes a letter sent from the NHS to a bereaved daughter, which said, '*Death is rarely an ideal situation for anyone*.' When patients go unheard the result is careless communication, insincere apologies and unclear explanations.

Changing this requires leadership and embedding good complaint handling at the heart of the new NHS. In future, GP-led Clinical Commissioning Groups will be the main commissioners of NHS services. Together with the NHS Commissioning Board, they will need to ensure that the services they commission, whether from NHS or independent providers, follow our Principles of Good Complaint Handling. This report highlights the standards providers must work towards.

Of concern too is the increase in complaints to us about unfair removal of patients from GP lists, despite our focus on this last year. There needs to be a clear shift in the attitude and practice of some GPs towards complaints.

Good complaint handling means listening to patients. Doing so will help deliver the high-quality, patient-centred care that the NHS is committed to. In this report we highlight some of the ways we will be working with the new NHS to help achieve this. We look forward to working with NHS leaders, commissioners, regulators and providers to share information and help them learn from mistakes.

Dame Julie Mellor, DBE
Health Service Ombudsman
October 2012

Complaints about the NHS in 2011-12

The NHS received 150,859 complaints in 2011-12; a rise of 1.3% on the year before.[1]

People can come to us if they remain unhappy once the NHS has tried to resolve their complaint. This page gives a snapshot of the volume of complaints we received and how we dealt with them. In 2011-12 we received 16,337 complaints from the public wanting to complain about the NHS or NHS-funded services. This was an 8% increase on the year before.

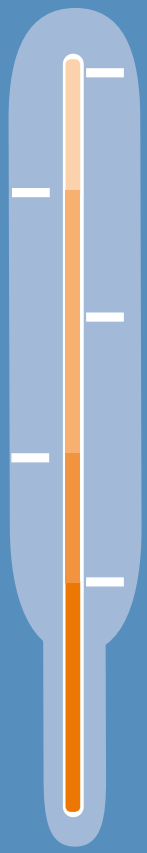
We resolved **16,333** complaints in the year:

299 We gave advice to people on the right organisation to complain to.

10,565 We helped people who came to us before complaining to the NHS directly, who hadn't put their complaint to us in writing (as required by the law) or before the NHS had done all they could to respond. We gave advice on what to do next.

1,070 Withdrawn by the complainant.

4,399 We took a closer look.



[1] *Data on Written Complaints in the NHS 2011-12*, The NHS Information Centre.

A closer look

Of the 4,399 complaints we looked at closely:

In **2,400 complaints** we found that there was no case for the NHS to answer

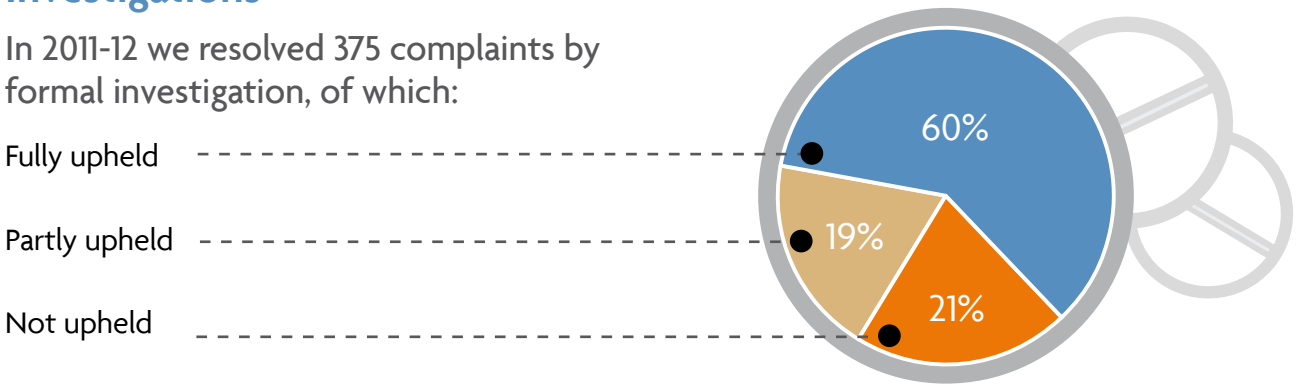
In **950 complaints** we found that things had gone wrong, but had been put right by the NHS

In **649 complaints** we put things right quickly without the need for a formal investigation (compared with 487 the year before)

We agreed to investigate **400 complaints** last year (compared with 351 the year before)

Investigations

In 2011-12 we resolved 375 complaints by formal investigation, of which:



Outcomes

When we found that something had gone wrong, our work led to:

474 apologies

358 wider remedies

333 compensation payments

This includes complaints we resolved without the need for a formal investigation.

Sharing information to help keep patients safe

We share information with the Care Quality Commission (CQC) and healthcare profession regulators to help reduce risks to patient safety.

As a result of our investigations during the year, we shared information about 11 healthcare professionals with their regulators. This included:

- three professionals with each of the General Medical Council, the General Dental Council and the Nursing and Midwifery Council respectively; and
- two professionals with the Health & Care Professions Council.

As a result of these referrals, a doctor was given a warning and a dentist was suspended from practice. An example of the impact of our referrals is shown in the case study on the next page.

In 2011-12 we identified systemic issues in 199 organisations and asked them to produce a detailed action plan setting out how they have learnt and what changes they will make to address them. We shared a summary of those reports with the CQC and we also flagged with them specific NHS organisations where the quantity or seriousness of these issues gave us concerns about patient safety. The organisations provided a copy of their action plans to the regulator so they could be followed up as part of the CQC's inspection and monitoring programmes.

Sharing information with healthcare regulators

We investigated Mr F's complaint that his GP's practice nurse failed to dress his leg ulcers appropriately over a period of three months in 2006, causing the wounds to become infected.

Mr F and the nurse had different recollections of what happened during the appointments, and Mr F was concerned that some of the records had been altered. We decided that the only way to resolve the complaint would be to check the audit trail for the electronic records.

The audit revealed that, following Mr F's complaint to the Practice, the nurse had retrospectively altered Mr F's computer records. This was more than two years after the events occurred. Some of the existing entries had been deleted and replaced with a different version, which said that Mr F had been offered and then refused treatment and a referral to a specialist – something that Mr F vehemently denied. The nurse had also created some new entries for appointments that were not recorded at the time. We interviewed the nurse. She was unable to provide a plausible explanation for the alteration of the records.

We found service failure and that an injustice arose to Mr F in consequence of it. We therefore made recommendations to the Practice, which included an apology, £500 compensation, an addendum to Mr F's records to show what had been altered, and an action plan describing what had been learnt.

Given the seriousness of what we found the nurse had done, we also shared our concerns about the nurse's behaviour with the Nursing and Midwifery Council, in line with our powers to share information in the interests of the health and safety of patients.

What does our casework tell us?

There was an 8% rise in complaints from the public to us about the NHS this year. People come to us because they are unhappy with the responses they receive from the NHS.

This doesn't necessarily mean that local resolution has got worse, it could be due to greater awareness about what we can do or better signposting from the NHS. Our experience in handling this volume of complaints and investigations, however, gives us a clear picture of what needs to improve.

This report highlights our concerns about communication with people who complain and the quality of complaint handling. It flags potential issues about complaint handling by GPs in their changing role and by the growing number of independent providers of NHS-funded services.

We also feature the challenges of complaint handling in the new NHS and we outline how we are working to support better complaint handling and more learning from complaints.

Complaints

We received more complaints about the quality of NHS complaint handling:

50% **more complaints** about the NHS not acknowledging mistakes in care (1,523 compared to 1,014 last year)

13% **more complaints** about the NHS providing poor explanations in response to complaints (1,542 compared to 1,362 last year)

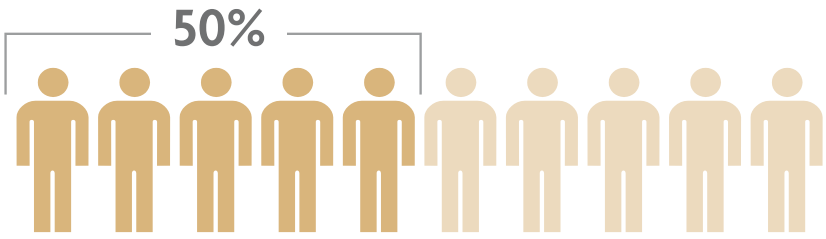
42% **more complaints** about inadequate remedies being offered, including inadequate apologies (1,655 compared to 1,163 last year)

We received:

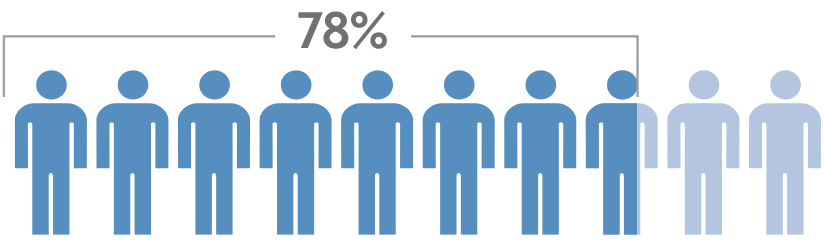
61% **more complaints** about care by independent providers (272 compared to 169 last year)

16% **more complaints** about unfair removal from GP lists (94 compared to 81 last year)

We investigated



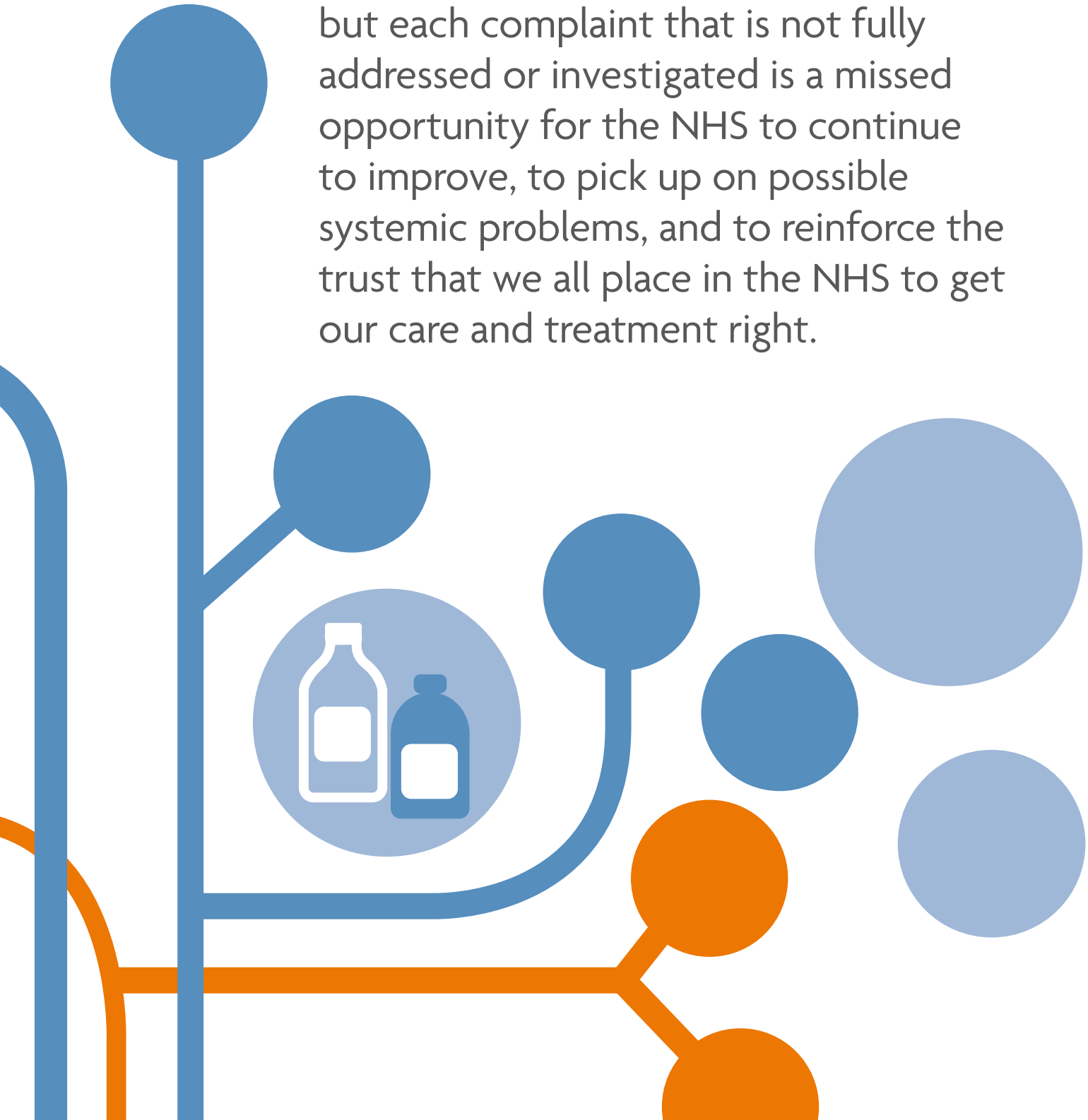
50% more complaints about the NHS not acknowledging mistakes in care (82 compared to 54 last year).



We upheld, in full or in part, 78% of those complaints.

Poor complaint handling: lessons from our case files

The NHS gets it right most of the time, but each complaint that is not fully addressed or investigated is a missed opportunity for the NHS to continue to improve, to pick up on possible systemic problems, and to reinforce the trust that we all place in the NHS to get our care and treatment right.



Communication

Our case files reveal a significant increase in people who came to us because they felt that the NHS had not acknowledged mistakes in their care – 50% more people came to us for this reason than in the previous year. Better communication would help the NHS understand the needs of patients and allow patients to understand the decisions made about their care and treatment. Inadequate communication was an issue in over 35% of complaints we resolved without the need for a formal investigation.

Good communication demands good explanation of why decisions were made, particularly where there is disagreement between the patient and the NHS. Last year, there was a 13% increase in complainants who came to us saying that they had received poor explanations in response to their complaint.

Getting it wrong

Common pitfalls amongst NHS responses to complaints:

- Equivocal language and sitting on the fence over decisions that were made during the care complained about;
- Getting key facts wrong;
- Using technical language, without appropriate explanations;
- False apologies: for example *'I'm sorry you feel the care wasn't good enough'*.

We see lots of examples of poor communication between the NHS and patients. Some quotes taken from letters from organisations in response to NHS complaints are shown on the following pages.

Quality of care is not just about getting the treatment and care of patients right. It is also about putting things right when mistakes occur. This means handling complaints promptly and sensitively, and carrying out thorough investigations to establish the facts of the case. It also means giving complainants timely and evidence-based responses, ensuring that any failings in care are properly acknowledged and explained.

The case studies in this report are examples of where things have gone wrong and how we've helped to resolve them.

Getting it right in the new NHS

We will work to help trust boards learn from their patients' complaints. We will visit boards of the most complained about trusts to share directly with them our perspective on their patients' experiences of using their services and of complaining to them.

Getting it wrong

Examples of poor communication by organisations in response to NHS complaints.

'In regard to the months leading up to it [sic] *is probably best to chronicle the situation as I have read from his medical records; I have found that this is the best way to explain how the world of medical treatment and evaluation/reading of symptoms and having a working diagnosis, with a view to always keeping a suspicious eye on any background dangers that may be evident (i.e. cancer) that are notoriously difficult to detect when the classical textbook symptoms are missing and other, much more evident and treatment responsive conditions such as chronic obstructive pulmonary disease dominate the picture and are the primary reasons for coming to a doctor.'*

'Unfortunately [the surgeon] *was unwell on* [the day of the appointment], *his operating lists were cancelled but I apologise if we failed to notify you before you left the clinic. Unfortunately you left before another appointment could be arranged.'*

'Death is rarely an ideal situation for anyone and I take comfort knowing that your mum did not die alone and to the contrary spent her last few hours comforted by one of our best carers.

I accept you would have liked to have been there in those last few minutes but in practice this is so hard to achieve and like life itself is left to chance.

Truth be told your mother probably said her goodbyes long before the final moments.'

The importance of explaining decisions properly

The NHS failed to give accurate and complete information to Miss R who was grieving for her father. A formal investigation by the Health Service Ombudsman was the only way that Miss R was able to get the information she sought.

Mr R had a triple bypass operation in June 2008 at a hospital run by Plymouth Hospitals NHS Trust (the Trust). Over the next week he remained in hospital while his condition deteriorated and he developed complications with his breathing and circulation. Tests showed nothing obviously wrong with Mr R's heart. Nine days after the bypass surgery, surgeons carried out exploratory surgery and found nothing. Sadly, Mr R died later that day.

No post mortem examination was carried out. The doctors certified Mr R's death as being caused by inadequate circulation and multiple organ failure caused by pneumonia. Mr R's daughter, Miss R, complained in writing, asking the Trust how her father acquired pneumonia. The Trust told her that they could not comment on whether or not Mr R had contracted pneumonia.

We formally investigated Miss R's complaint and found that the management of Mr R's illness was reasonable. However, despite having good reasons for the two causes of death the doctors recorded, the Trust failed to explain this to Miss R when she complained. We found that because she did not receive an explanation, Miss R's distress at her father's death was exacerbated. The Trust agreed to apologise to Miss R and pay her £250 in compensation.

The importance of making changes when things go wrong

When his GP practice failed to acknowledge that things had gone wrong in his care, Mr L came to us for help.

Mr L complained to his GP practice that despite seeing several GPs on six different occasions, it took them almost ten months to diagnose his skin cancer (a malignant melanoma). During this time, the cancerous growth was twice misdiagnosed and was therefore treated incorrectly.

Although the Practice responded to Mr L's complaints on three separate occasions, they did not acknowledge all the failings in Mr L's care. They did, however, arrange clinical teaching for the GPs from a dermatology specialist to help improve identification of unusual skin cancers.

Mr L complained to us. He wanted an acknowledgement of, and apology for, the misdiagnosis of his cancer, and several improvements to the Practice itself.

After looking at Mr L's complaint and taking advice from an independent GP it seemed clear to us that there had been failings by the GPs at the Practice. These failings had a significant impact on Mr L's life. As a result of the misdiagnosis, Mr L's cancer continued to grow, and he was placed at a greater risk of his cancer recurring or spreading to other organs in his body. He had to go on a trial drug to stop his cancer from spreading, and he was required to undergo periodic reviews to ensure his cancer had not reappeared or spread.

We shared our concerns with the Practice. They accepted all of our criticisms. They agreed to write to Mr L to acknowledge and apologise for the failings we had identified. They agreed to improve their service by introducing a standard template for recording the location, size and nature of unusual skin growths. They tightened up their criteria for cryotherapy treatment (freezing and destroying abnormal skin cells), their treatment timescales, and their communication protocols. They arranged for further learning for the GPs about skin cancers.

Compensating the patient appropriately

Ms D complained to us when her NHS trust missed an opportunity to treat her eye condition.

Ms D should have been screened annually for eye damage caused by diabetes (diabetic retinopathy) at an eye clinic run by the Western Sussex Hospitals NHS Trust (the Trust). However, the Trust failed to provide this for almost two years. When she did have her appointment, damage to the inside of her eye was seen and she had another test the following month. This showed a condition called macular disease (the macula is the central part of the eye responsible for fine vision), which the Trust said was no longer treatable.

We found that the Trust did not act in line with national guidelines, which say that screening should be carried out every 12 months. They did not adequately investigate Ms D's macular disease because they did not use a scan to take a very detailed picture of the inside of her eye. We also found that they did not adequately diagnose Ms D's macular disease, because they said it could not be treated, when in fact treatment was available.

We could not say whether earlier screening would have revealed Ms D's macular disease. When the Trust diagnosed her condition, they missed an opportunity to give her treatment that would have stabilised or even improved her eyesight. Instead, Ms D was left with eye damage that was probably permanent and irreversible.

The Trust agreed to write to Ms D to acknowledge and apologise for their failings and pay her £8,000 in compensation. They took steps to improve their screening service, including compiling a database of all diabetic retinopathy patients and ensuring that referrals from the screening service were monitored by the Trust's eye clinic. They made sure that all patients suspected of having macular disease were given proper scans.

Focusing on outcomes rather than process

Mr H has multiple sclerosis and has a catheter to drain urine from his bladder into a bag. When his supply of catheter bags ran low, Mr H would ring his local primary care trust (NHS Hertfordshire) and they would arrange for replacements to be provided.

One day when Mr H rang NHS Hertfordshire, they told him that they could not send more. Instead, under a new system, he would have to obtain a prescription for catheter bags from his GP before NHS Hertfordshire would provide them.

Mr H rang the Ombudsman. He said he had been given no warning about the change in the prescribing system, and that he was running low on catheter bags. We spoke to staff at NHS Hertfordshire, explained the situation, and asked if they could help. They agreed to continue providing Mr H with catheter bags until he was able to see his GP.

Avoiding duplication and reaching an outcome quickly

The lack of a joined up approach left a couple paying care bills.

Mrs S's husband lives in a care home located in one primary care trust (PCT) area; but his GP is based some distance away in an area overseen by a different PCT - Kingston Primary Care Trust. The PCT for the area in which the care home is located assessed him as eligible to have all of his care paid for by the NHS. However, Kingston Primary Care Trust would have been responsible for paying Mr S's NHS bills because Mr S's GP surgery was on their patch.

Kingston Primary Care Trust said they wanted to assess Mr S themselves before they decided whether or not to pay for his care. This left Mrs S to pay her husband's bills for several months, despite having been told her husband was eligible for NHS funding.

Mrs S rang the Ombudsman to ask for help. We rang Kingston Primary Care Trust. We asked them what was happening and when they would make a decision. We asked them to consider Mrs S's request to fund her husband's care based on the other PCT's assessment. This prompted them to take another look at Mr S's case. They decided that they would fund Mr S's care without reassessing him. They also paid Mrs S over £13,000 for care she had wrongly had to fund.

Having received only one telephone call from Kingston Primary Care Trust in six months, Mrs S was pleased to be telephoned with an update and then, later the same day, with the news that the funding had been agreed.

Making big improvements after very serious failings

A single complaint can lead to dramatic improvements for patients and their families. Miss G's story highlights the ongoing improvements required in the NHS for individuals with learning disabilities, a problem starkly set out in our 2009 report *Six Lives*.

Miss G, a woman in her early 50s with learning disabilities and a history of bipolar disorder, was diagnosed with gallstones and needed surgery. She was admitted to a hospital run by the Pennine Acute Hospitals NHS Trust (the hospital trust). They could not operate immediately due to inflammation and she was sent home until the operation could be done. In the meantime, Miss G was unable to cope with the pain, and she was sectioned to the psychiatrist ward run by Pennine Care NHS Foundation Trust (the care trust) because of her behaviour. Her medical notes were not acquired by them and they would not listen to her family.

She did not have her operation for four months. Following the surgery, she developed a bowel blockage, for which she had another operation. Sadly, she died two weeks later. While these events took place Miss G was transferred back and forth between these two trusts, despite the fact that they were in the same building.

Miss G's brother and sister-in-law, Mr and Mrs A, complained to us, supported by Mencap. We investigated both trusts and found that Miss G's care had not been properly co-ordinated or managed. There was no evidence that the trusts had taken Miss G's disabilities into account when planning her care, although this was a legal obligation under disability discrimination law. In particular:

- Nursing records did not clearly say what care was planned, what decisions had been made, or what care had been delivered.

- Communication between nurses, doctors and other clinical staff and with Miss G and her family was ineffective, and they did not help her to understand what was happening. This meant distressing events were made even more distressing for Miss G.
- Neither trust made adequate use of community learning disability services to make sure Miss G had support for her specific needs.
- When Miss G missed appointments at the hospital trust, they did not consider how to ensure she attended her appointments. This meant that her gallstones were untreated for over five months, which would have made her feel unwell and in pain.
- After surgery, nobody took account of her specific needs, and she ended up very agitated and '*running around*'.
- Doctors at both trusts failed to adequately assess and manage Miss G's condition after the second operation, and she was transferred back to the care trust prematurely.
- The psychiatrist at the care trust did not ensure her care was properly co-ordinated and managed. Staff at the care trust did not listen to the people who knew her best — the team that cared for her and members of her family — or allow them to be involved.

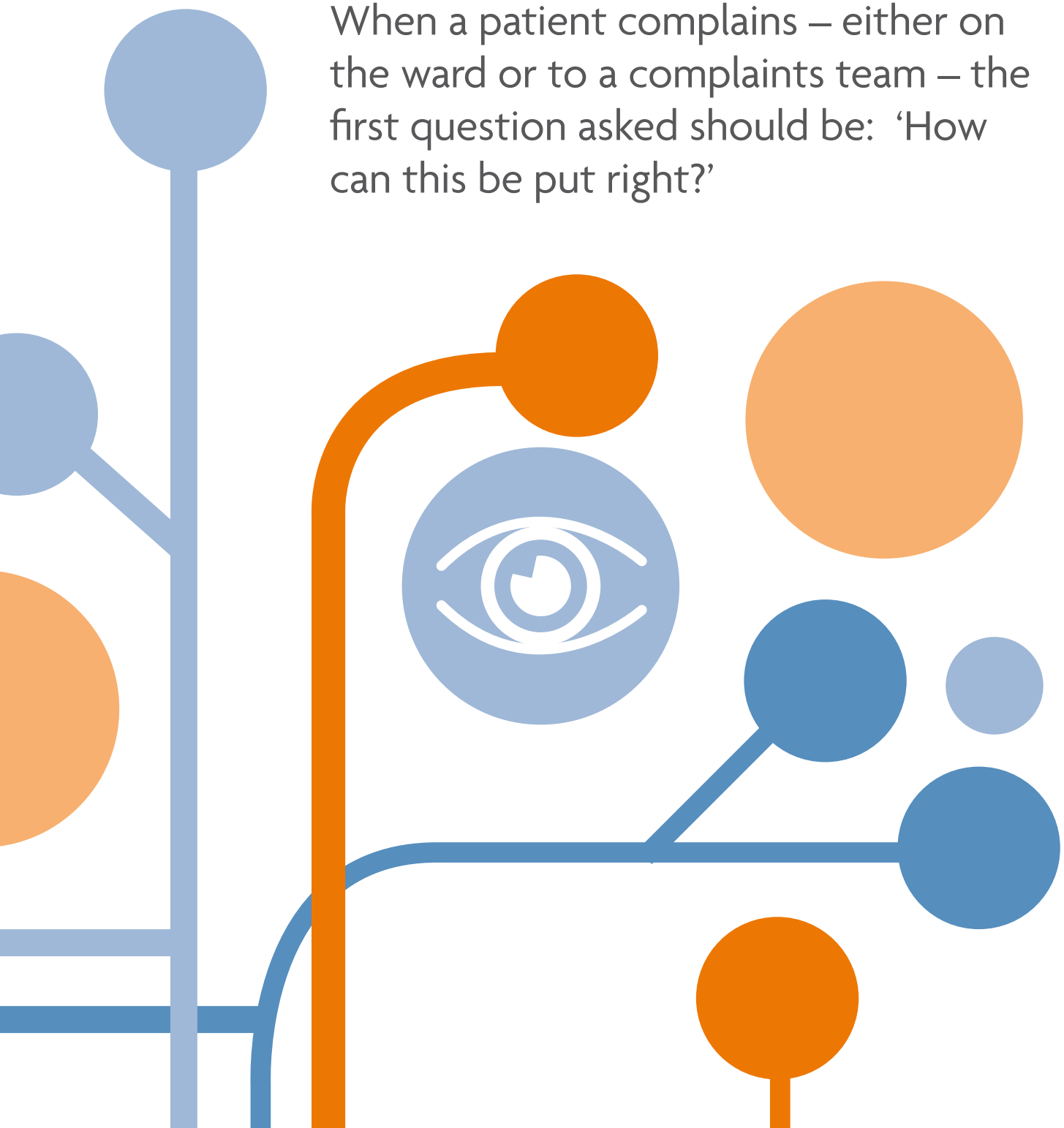
The trusts' failings meant Miss G experienced unnecessary physical and mental suffering. If this period of poor care had not occurred it is likely that Miss G's death could have been avoided. Mr and Mrs A suffered the loss of a much loved member of their family: an injustice that can never be remedied. We upheld their complaints about both trusts.

Both trusts agreed to acknowledge and apologise for their failings and offer Mr and Mrs A compensation of £15,000. Both trusts also agreed to put together action plans that described how they had learnt from their failings and what they would do to stop them happening again.

Six months after the investigation finished, Mencap told us that Mr and Mrs A were very pleased with the action taken by the hospital trust.

Listening and learning: good practice in complaint handling

When a patient complains – either on the ward or to a complaints team – the first question asked should be: 'How can this be put right?'



In some cases, that might be as simple as acknowledging that something went wrong and apologising for that. The sooner any mistakes are identified and acknowledged, the more satisfied the complainant is likely to be.

If the complaint cannot be sorted out on the spot, then speed is still of the essence. The sooner that staff are asked what happened on the issues complained about, the easier it will be for them to describe what occurred.

In some cases, in particular where the complainant requests it, a meeting with the staff involved is helpful. Items for discussion should be shared in advance, and meetings followed up in writing, either with a letter summarising the outcome of the meeting or with formal, accurate and comprehensive minutes, or both. Although not always appropriate, it is worth thinking about recording complaints meetings with the participants' permission.

Investigating complaints

Investigating complaints means listening to the patient and focusing on the key issues and questions raised. Clinical input should be sought on the results of any failings, as well as on the question of what, if anything, went wrong. If clinicians' statements do not make sense, if they are mutually or internally contradictory, if they are inconsistent with what is in the medical notes, or are full of technical jargon, it is not sufficient to simply copy them into the response letter. Any differences must be reconciled and any jargon converted into language a lay person will understand.

Formal responses to complaints

Formal responses to a complaint should state clearly what the investigation found. They should say whether or not any failings were found, and what the result was of any failings. The response should apologise unconditionally for any errors. Apologies should not express regret that the complainant felt that something went wrong. If something went wrong, the apology should be clear and unequivocal.

If the complainant has asked a series of questions, the response should be structured in a way that makes it clear where they can find the answers. An explanation should be provided about what the organisation will do to stop any failures happening again. If a policy change is required, or staffing levels need to improve, or individuals need further training, the response should explain this, and say when it will happen. If the complainant has asked for a specific remedy, it should be considered properly, using the Ombudsman's Principles for Remedy when doing so.

Making an apology

When something has gone wrong, the response to a complaint should be open and accountable and provide apologies that are frank and unqualified. Wherever possible, the response to a complaint should try to return the complainant to the position they would have been in if the events concerned had not happened. These are important steps in rebuilding trust between the patient and the NHS.

For an apology to be complete, it must be accompanied by an explanation of what went wrong and how that happened. The explanation must also address the outcomes sought by the patient, including service improvements or compensation. Where the patient has requested financial redress, decisions not to pay compensation should be well-reasoned and explained.

Such a remedy is not always appropriate. However, it should be carefully considered where the patient has suffered actual financial loss. It can also be a powerful indication that the complaint has been taken seriously and the distress or inconvenience has been recognised.

Action plans

An action plan should describe what has been done to learn lessons after things went wrong and what will be done to prevent the same mistake from happening again.

A good action plan will:

- say what went wrong in the service provided, and identify the cause of the problem;
- explain what action, targeted at the cause of the problem, will be taken to stop it happening again and who will be responsible for ensuring this happens;
- give timescales for when that action took place or will take place;
- where possible, provide objective evidence of those actions; and
- explain how the organisation will check that these actions have been taken, and are working – along with when this will be done, and by whom.

Sharing learning from complaints

Data about complaints, as well as patients' stories, should be shared with NHS trust boards, together with information about how trusts have taken action and learned from complaints.

Getting it right in the new NHS

The Ombudsman's Principles of Good Complaint Handling set out what we expect from the NHS, and NHS-funded providers, when dealing with complaints. Good complaint handling means:

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

The Principles are available on our website at www.ombudsman.org.uk.

Open and accountable

Mr B was admitted for knee surgery at a hospital run by the Doncaster and Bassetlaw Hospitals NHS Foundation Trust (the Trust). He was anxious about having a general anaesthetic and wanted to discuss his concerns with doctors. However, when Mr B saw the surgeon prior to surgery, he said the surgeon was rude to him and said that he should go home if he did not want the surgery. Later, in the anaesthetic room, the surgeon said Mr B was being *'a child or a baby'* and patted his chest with the back of his hand.

Mr B complained to the Trust about the way that he had been treated by the surgeon. The Trust explained that, as Mr B had been anxious, the surgeon had adopted a *'more friendly approach'*. They accepted that the surgeon had referred to him as a *'baby'* while making physical contact. They apologised that Mr B was *'offended by this behaviour'* and said that the surgeon had asked the Trust to *'pass on his sincere apologies if his behaviour caused* [him] *to be upset'*. Mr B was unhappy with the *'passed on apology'*. Mrs B asked for compensation on behalf of her husband, but the Trust declined.

Mr B remained dissatisfied and Mrs B wrote to the Ombudsman to complain. We asked the Trust to review their handling of Mr B's complaint and the Trust agreed. Following this, the Trust apologised unreservedly for the surgeon's behaviour. Mr B was offered an opportunity to meet senior staff, the surgeon or the chief executive. However, following further correspondence with us, the Trust told Mr B that they would not offer compensation.

The Trust showed good practice — albeit belated — in complaint handling. They were open and accountable in acknowledging that their initial handling of the complaint had been poor. They took steps to put things right in reconsidering compensation, but articulated reasons for declining to do so in this case. We took no further action.

Care by independent providers

We look at complaints about NHS-funded care, whether it is delivered by an NHS body or by an independent provider. We expect to receive more complaints about independent providers as more healthcare organisations enter the market and provide care funded by the NHS.

This has proved the case in 2011-12. We received 272 complaints about independent providers in 2011-12, a 61% increase on the number we received the previous year.

Some of these providers will be large organisations entering the market for the first time. Some will be new ventures. Others will be charities or other third-sector organisations. All of these providers must comply with the Department of Health's complaints regulations and need to understand their responsibilities in the NHS complaints landscape, and the values and requirements that underpin the *NHS Constitution*. Patients' rights include the right to bring their complaint to the Ombudsman if they are not satisfied with the way their complaint is dealt with by the NHS, and the right to compensation when they have been harmed by NHS treatment. Providers of NHS care will be expected to inform their patients of these rights where appropriate, and support them in exercising those rights.

Understanding what it means to be an NHS provider

Providing good customer service does not mean the same thing in every sector. Someone complaining about the NHS might have very different motivations and needs than they would if complaining about a less personal or sensitive topic.

As the NHS market expands, providers used to delivering good customer service, and dealing with their complaints in particular ways, have already begun to see — and will continue to see — occasional complaints about their NHS-funded services. When this happens, they need to be flexible and think carefully. Most NHS complaints are not equivalent to legal claims, nor are they comparable to a complaint about the quality of a product.

Learning from our casework tells us that when dealing with complaints about NHS-funded services, providers should:

- explicitly acknowledge when mistakes have been made;
- involve frontline staff, such as the clinicians they employ, in investigations;
- be prepared to make more than one detailed, fact-checked response; and
- meet complainants to discuss their concerns if necessary.

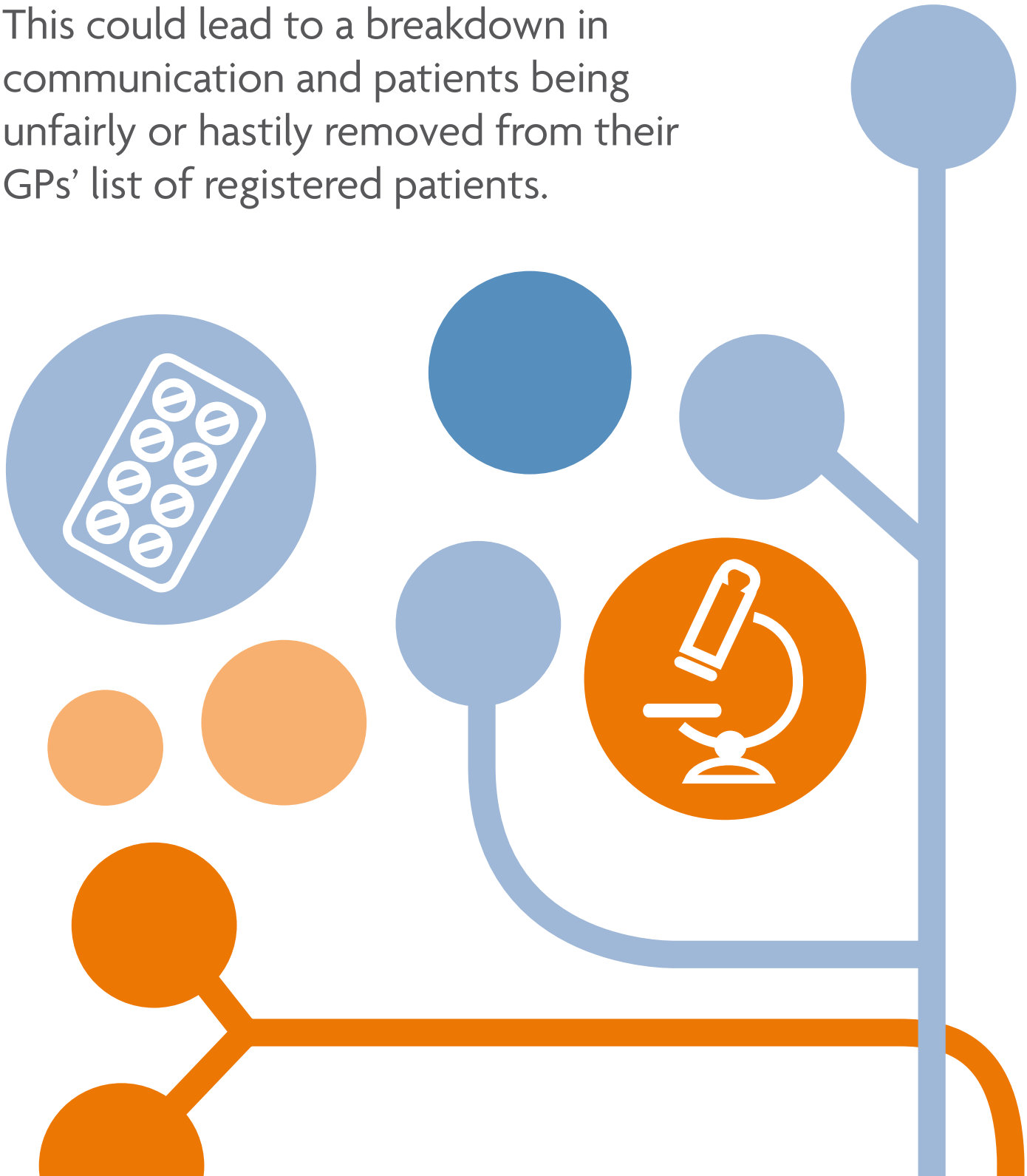
New providers must ensure that they are aware of their responsibilities and requirements for dealing with complaints about their NHS services. Trained staff and processes need to be ready as soon as possible – ideally before they begin providing NHS services.

Getting it right in the new NHS

NHS organisations have asked us how independent providers should handle complaints, and how complaints should be dealt with during the transition to the new system. We expect any organisation providing NHS care to handle complaints well and in line with our Principles of Good Complaint Handling (available from www.ombudsman.org.uk), both during and after the transition period.

Complaints about GPs

Last year we highlighted our concern that some GPs were failing to manage relationships with patients properly. This could lead to a breakdown in communication and patients being unfairly or hastily removed from their GPs' list of registered patients.



Complaints to us about unfair removal from GP patient lists have continued to rise. We saw more in 2011-12 — 94 in total — than we did last year, when we saw 81. We concluded 10 formal investigations about unfair removal this year, the same number as the year before.

We warned last year that as GPs prepare to take on greater responsibility for commissioning patient services, some were failing to handle even the most basic complaints correctly. The failure to improve in this area gives us wider concerns about GP-led Clinical Commissioning Groups effectively delivering their responsibilities for dealing with complaints.

Guidance on removing a patient from a GP patient list

GPs need to follow the British Medical Association's guidance on removing patients from practice lists, as well as their obligations under their contracts with commissioners.

In all but the most exceptional cases, a GP must:

- warn the patient that their behaviour is putting them at risk of being removed from the GP's patient list;
- ensure the warning clearly sets out what is inappropriate about the patient's behaviour (for example, frequently not attending appointments without cancelling); and
- ensure the warning clearly sets out what the patient must do in order to avoid being removed from the GP's patient list.

Getting it right in the new NHS

The NHS Commissioning Board will need to make sure that both GP practices (as providers) and Clinical Commissioning Groups (as GP-led commissioners of other health services) handle complaints well.

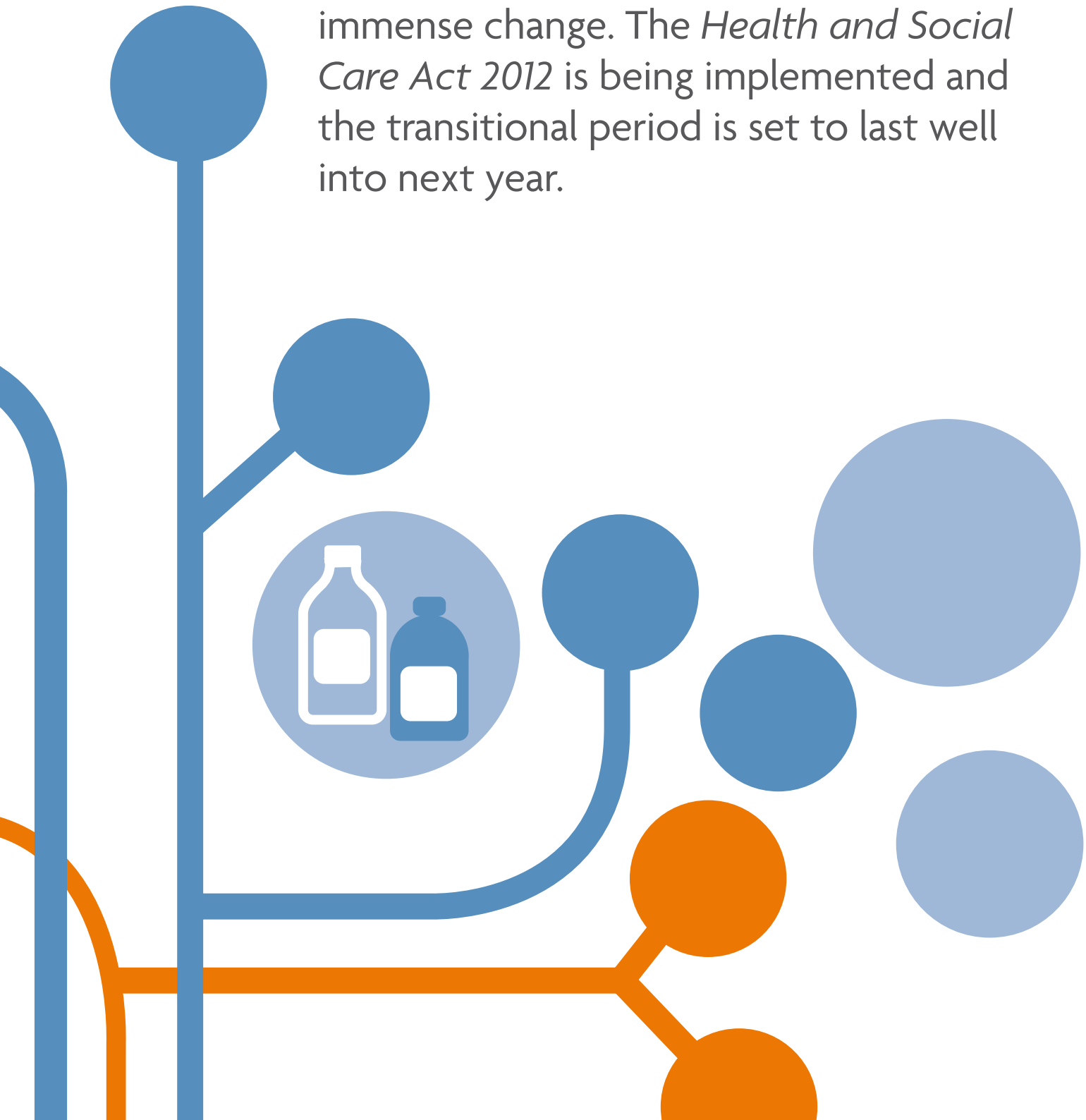
Clinical Commissioning Groups will be responsible for:

- Dealing with complaints about their commissioning decisions
- Ensuring providers they contract with deal with complaints well
- Using complaints data from providers to inform future commissioning decisions.

We are working with the NHS Commissioning Board to help embed good complaint handling across the NHS.

Complaint handling in the new NHS

The NHS is undergoing a period of immense change. The *Health and Social Care Act 2012* is being implemented and the transitional period is set to last well into next year.



During the time of transition, some NHS organisations are being wound up and new ones will take their first steps. A number of things need to happen to ensure effective complaint handling in these new organisations: leaders will need to take responsibility for embedding effective complaint handling and learning; new staff in new organisations need to ensure that complaints do not fall between the gaps during these critical transition periods; and organisations need effective mechanisms to manage and learn from all complaints, including those about choice.

The government has proposed, as part of the NHS reforms, that patients should have greater involvement in decisions about their care. In particular, patients' choice of GP will be less restricted by where they live, and patients should be told what options are available at referral, diagnosis and treatment, as well as being involved in deciding which options best suit them.

Under the new arrangements for commissioning care, each clinical commissioning group (CCG) has a duty to commission the care it *'considers necessary to meet the reasonable requirements'* of the patients for whose care it is responsible. With this focus on meeting the needs of local populations and greater patient expectations about choice, it is possible that CCGs will begin to receive complaints about the choices they make, particularly where individuals feel that these decisions have impacted negatively on them.

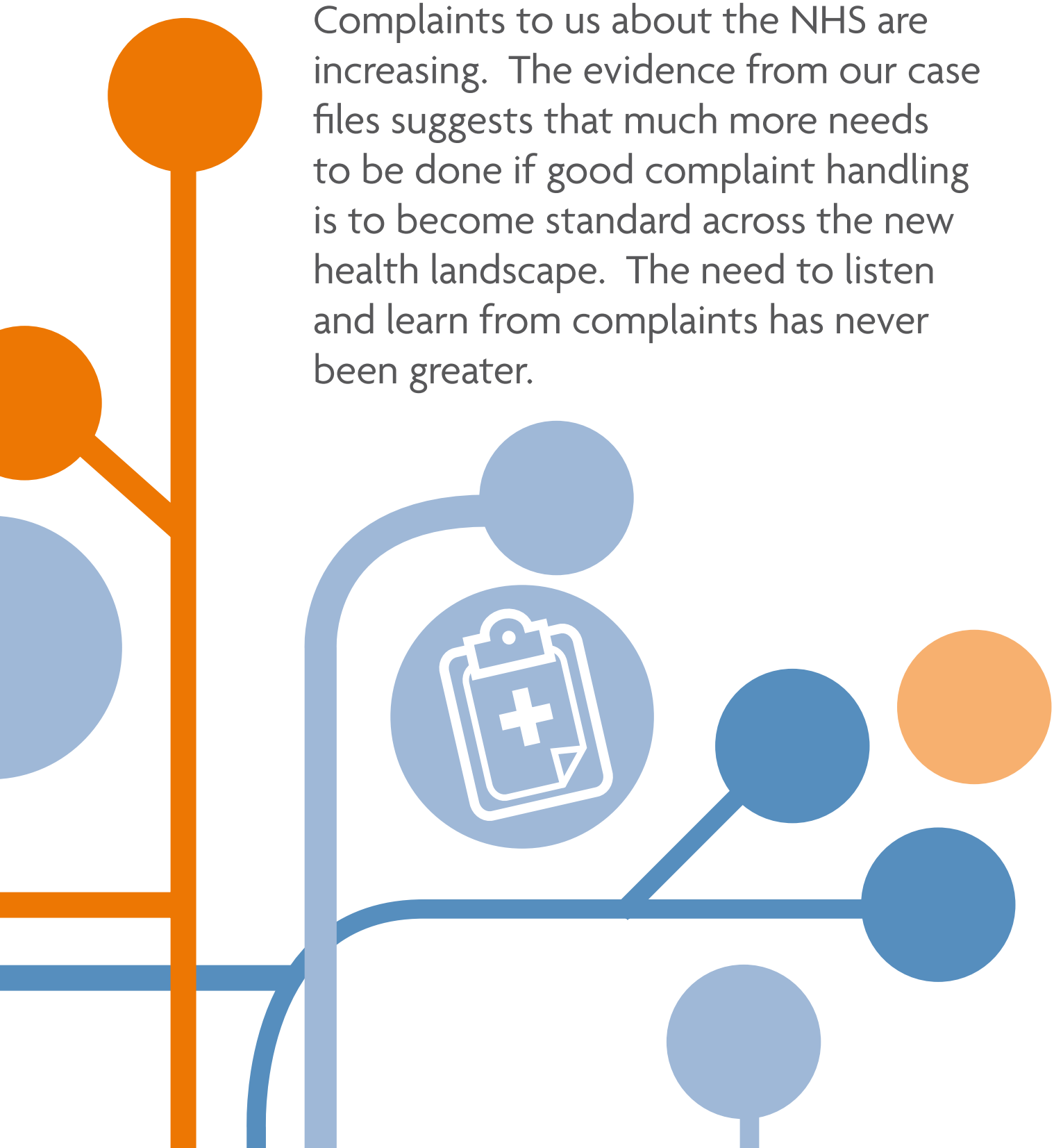
As for any NHS complaint, the Ombudsman would be the arbiter in a complaint about denial of choice and would be able to make recommendations for the individual concerned. We would also share information with other organisations such as Monitor to support their role in safeguarding choice and competition.

Getting it right in the new NHS

In dealing with patients' complaints about denial of choice we will share the learning from such complaints with providers, commissioners and regulators. This will help inform wider evaluation of how the new choice agenda is working, and how services can be improved.

Getting it right: our work in the new NHS

Complaints to us about the NHS are increasing. The evidence from our case files suggests that much more needs to be done if good complaint handling is to become standard across the new health landscape. The need to listen and learn from complaints has never been greater.



As NHS structures and systems are overhauled, the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry is expected in January 2013. The Inquiry, into devastating failings in care at Staffordshire Hospital, examines the broader NHS monitoring system: the commissioning, supervisory and regulatory organisations. Its goal is to find out why problems at the Staffordshire Hospital were not identified and acted upon sooner.

Last year, the then Ombudsman, Ann Abraham, gave evidence to the public inquiry. Explaining that we are not a regulator or an early warning system, she emphasised the importance of acting on intelligence gained from complaints. She said:

> *'Patients and their families need to be empowered and encouraged and enabled to have their say. When they do speak up, they need to be listened to and what they say needs to be acted on. And that won't happen if NHS boards don't demand regular information about complaints, and their outcomes, and ask to be told what trusts are doing differently as a result of learning from complaints.'*[2]

As the Health Service Ombudsman, we listen to the experiences of individual patients and make judgments on their complaints. Often the people who contact us feel that what happened to them has not been listened to and their voice has not been heard. The information and data we hold can help to ensure that the experiences of individual patients are heard and acted upon more readily in future.

We want to share the information we hold more widely, with providers and commissioners, regulators, MPs and Parliament and patients. By doing so, we can help others evaluate services and inform commissioning decisions; provide data about service quality and choice to the health sector regulators; and provide insight to regulators and to Parliament on system-wide failures within the NHS. We will continue to alert the professional regulators to patient safety concerns resulting from the practice of individual clinicians and will seek to collaborate with voluntary or other organisations to influence service improvements.

To do this, we want to collect and publish more data about the complaints that we receive. We aim to publish summaries of all investigations and provide periodic complaints data to NHS organisations. Alongside this work, we will continue to publish reports such as this one, putting information about NHS complaint handling in the public domain while highlighting good and bad practice.

As the new NHS arrangements are implemented, we will provide information about patients' experiences to the new NHS commissioners – both to the local clinical commissioning groups that directly buy services from the NHS and independent providers, and to the national NHS Commissioning Board that will commission primary and specialist care. We will do this to help inform their commissioning role. We will also work with the NHS Commissioning Board to assist in embedding good complaint handling across the NHS.

We are looking at ways we can improve both our response to complaints and the service we provide. This includes looking at the language we use when communicating our work to complainants and to the wider public. In the coming months, we will review our processes to see how we can investigate more complaints, and conclude those investigations more quickly.

[2]Ann Abraham's oral evidence to the public inquiry, 29 June 2011.

Among the most serious complaints we receive are those where someone believes that NHS failings contributed to a patient's death. To ensure that our work in this area is of most benefit to our complainants and to the wider public, we have commissioned an external review of the way in which we handle cases involving potentially avoidable death. The review will make recommendations about how we can respond to such complaints in future, including how we can best identify and share patient safety concerns and lessons learnt with service providers and the regulators. More information about the review is available on our website.

This report outlines the learning from our casework in 2011-12, and suggests how the NHS can improve its complaint handling in some of the most troublesome areas. It also sets out ways in which our own work is changing to enable us to share more information more widely.

The NHS provides high-quality health care for thousands of us every day. When things go wrong, good complaint handling will help restore high-quality, patient-centred care. To achieve this, high standards of complaint handling need to be part of the new landscape — championed and understood by practitioners, commissioners and senior executives across the NHS. We hope this report will help to make this happen.

Appendix

This section of the report contains statistical information on the complaints that we have received about the NHS as a whole in 2011-12.

It shows what people complained to us about and how their complaints were resolved. It also includes statistical breakdowns by Strategic Health Authority (SHA) region and by type of organisation. At the back, there is a complete list of all NHS organisations and statistical information on the complaints we received about them.

Volume of complaints can provide an early warning of failures in service delivery, but a high number of complaints does not necessarily mean poor performance. It could mean that information provided by organisations about how to make a complaint is good. Many other factors can affect the volume of complaints, including the size of the organisation and the size and make-up of the population it serves.

Reasons for complaints

Issues raised about the NHS

These figures are based on the 4,739 complaints where we identified issues and resolved the complaint without the need for a formal investigation. Complaints which are taken forward for formal investigation are assigned further keywords according to the issues we identify when investigating the complaint.

The numbers add up to more than 100% because some complaints involve more than one issue.

Issues raised about NHS complaint handling

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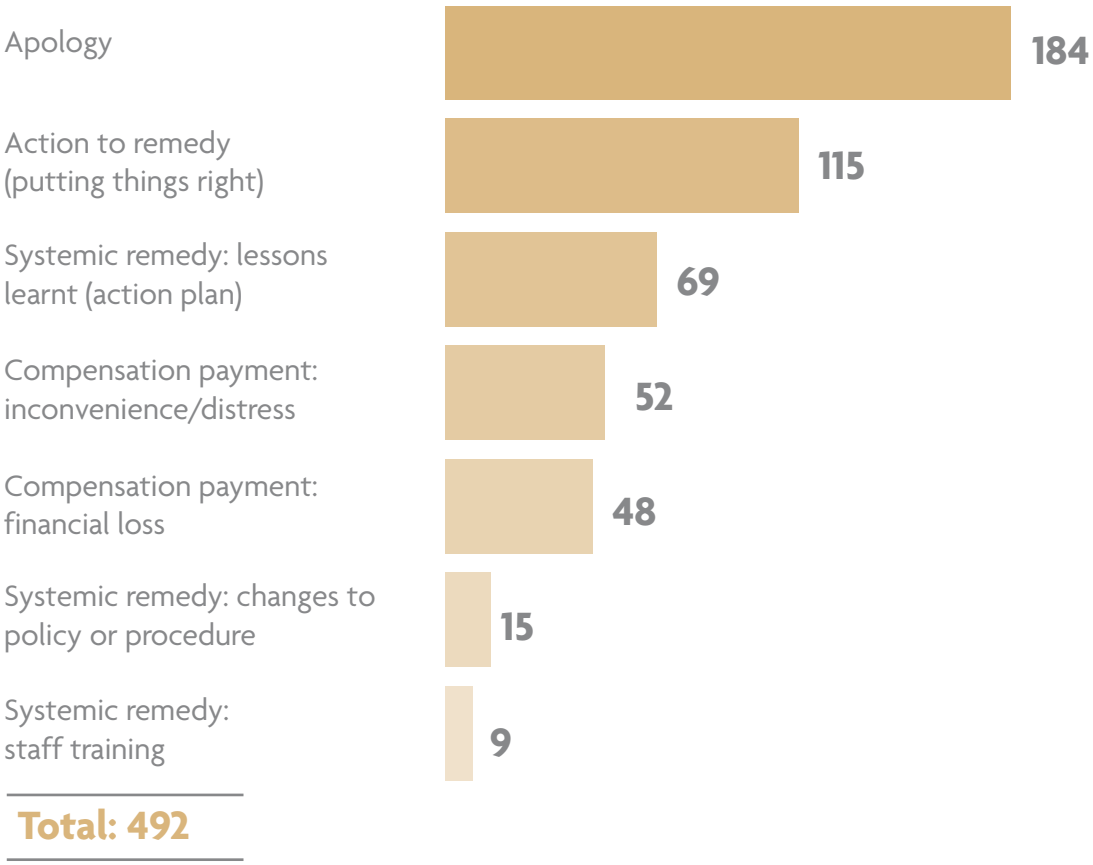
The numbers add up to more than 100% because some complaints involve more than one issue.

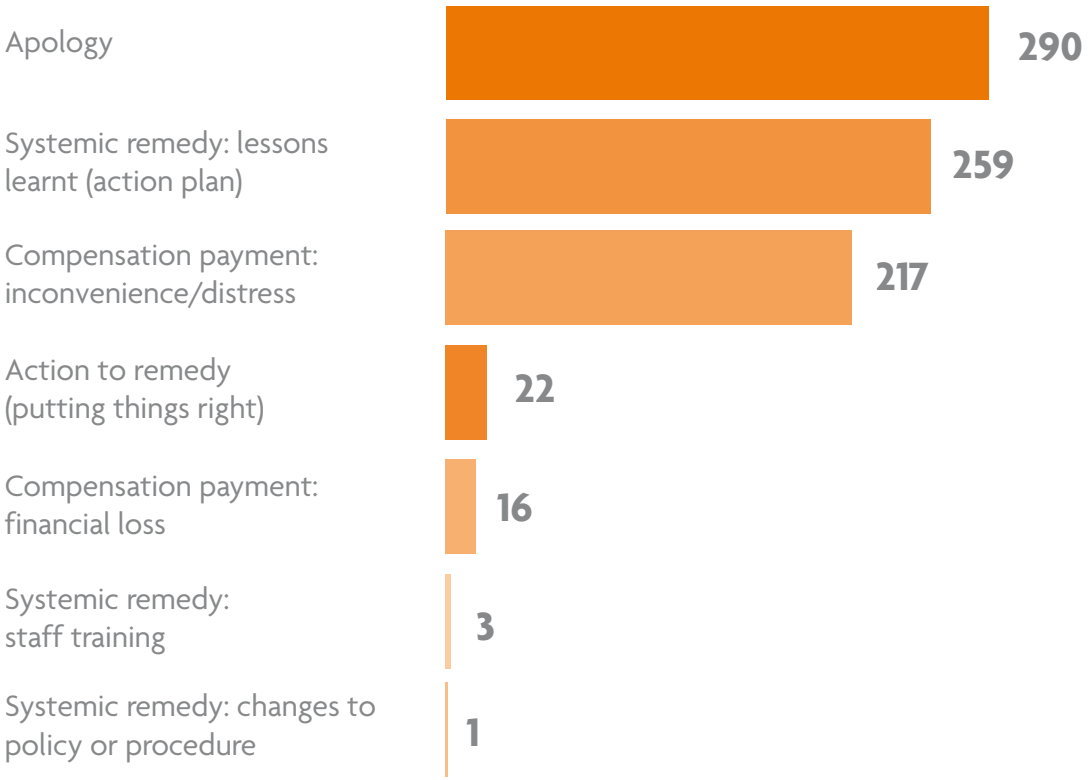
Complaint outcomes

Intervention outcomes



Where a complaint is resolved, there may be more than one outcome, for example, an apology, a compensation payment, and action to prevent the same problems happening again. This is why the total number of outcomes is greater than the number of complaints resolved by intervention.

Investigation outcomes



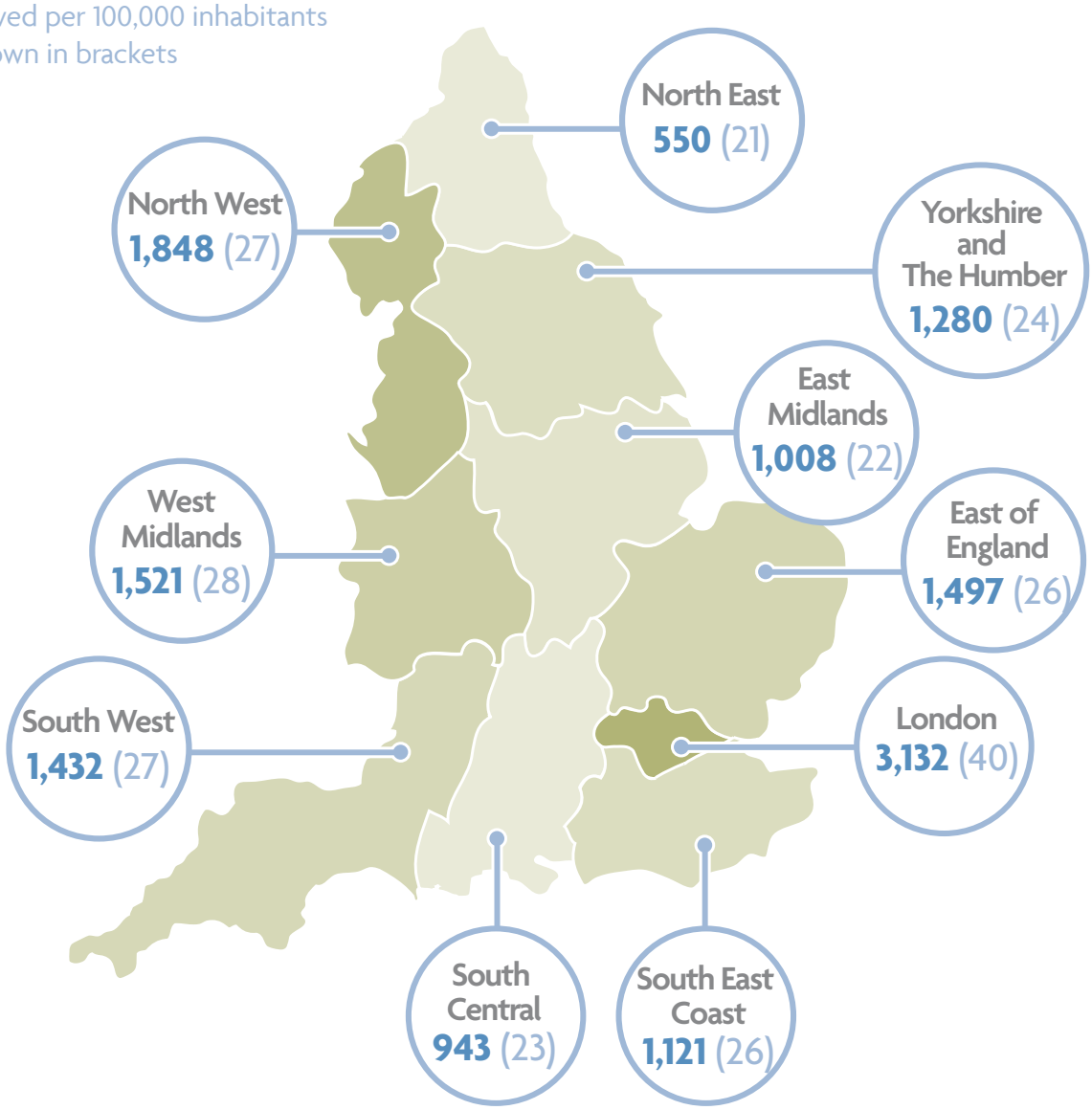
Total: 808

Where a complaint is resolved, there may be more than one outcome, for example, an apology, a compensation payment, and action to prevent the same problems happening again. This is why the total number of outcomes is greater than the number of complaints resolved through investigation.

NHS complaint handling, by SHA region and by organisation type

Complaints received, by SHA region

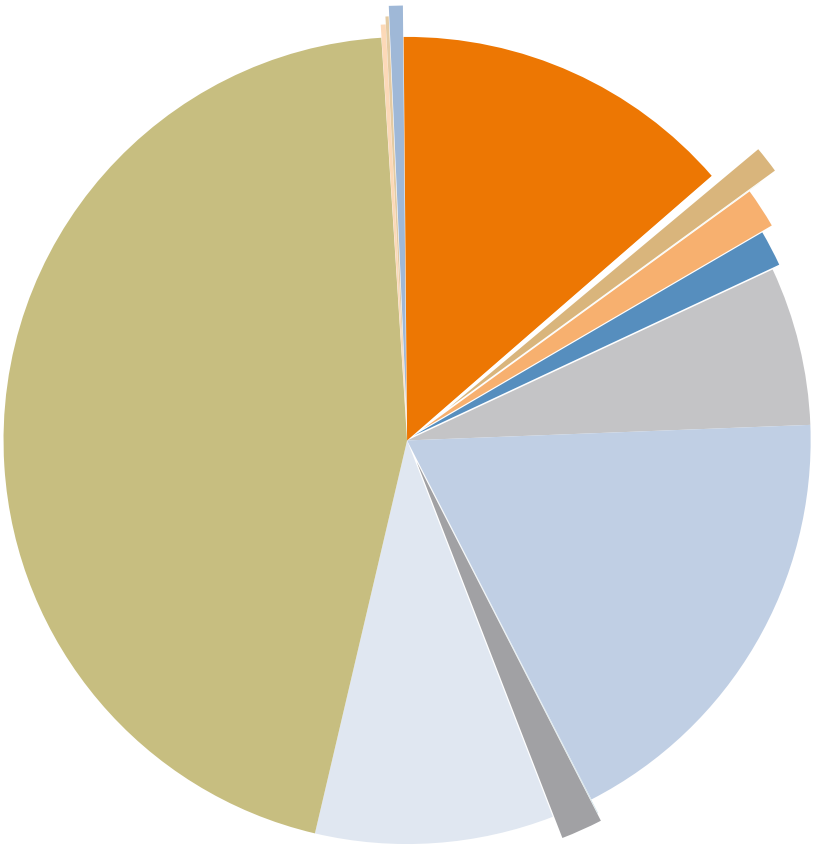
The number of complaints received per 100,000 inhabitants is shown in brackets



This shows the complaints we received about the NHS in 2011-12, grouped by the strategic health authority region in which they originated. To account for the difference in population in each region, the figures in brackets show the number of complaints received per 100,000 inhabitants. This is worked out using the Office of National Statistics' 2009 mid-year population estimates.

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

Complaints received, by organisation type



Ambulance trusts	**262** (2%)
Care trusts	**235** (1%)
General dental practitioners	**1,037** (6%)
General practitioners	**2,951** (18%)
Healthcare Commission (not shown above)	**1** (<1%)
Independent providers	**272** (2%)
Mental health, social care and learning disability trusts	**1,560** (10%)
NHS hospital, specialist and teaching trusts (acute)	**7,403** (45%)
Opticians	**32** (<1%)
Other health authorities	**21** (<1%)
Pharmacies	**91** (1%)
Primary care trusts	**2,247** (14%)
Special health authorities	**49** (<1%)
Strategic health authorities	**175** (1%)
Unknown (not shown above)	**1** (<1%)

Total: 16,337

Complaints received, by SHA region and organisation type

	Ambulance trusts	Care trusts	GDPs[1]	GPs[2]	Healthcare Commission	Independent providers	Mental health, social care and learning disability trusts
East Midlands SHA	23	16	52	136		14	155
East of England SHA	28	29	53	196		43	144
Healthcare Commission					1		
London SHA	64	28	136	508		37	363
North East SHA	11	8	16	80		21	50
North West SHA	27	6	84	249		17	206
Other Health Authority							
South Central SHA	8	35	41	139		16	79
South East Coast SHA	17	26	76	177		22	120
South West SHA	33	19	90	229		24	126
Special health authority							
Unknown SHA	9		342	860		21	76
West Midlands SHA	23	51	87	191		16	127
Yorkshire and The Humber SHA	19	17	60	186		41	114
Grand Total	**262**	**235**	**1,037**	**2,951**	**1**	**272**	**1,560**

[1] General dental practioners

[2] General practitioners

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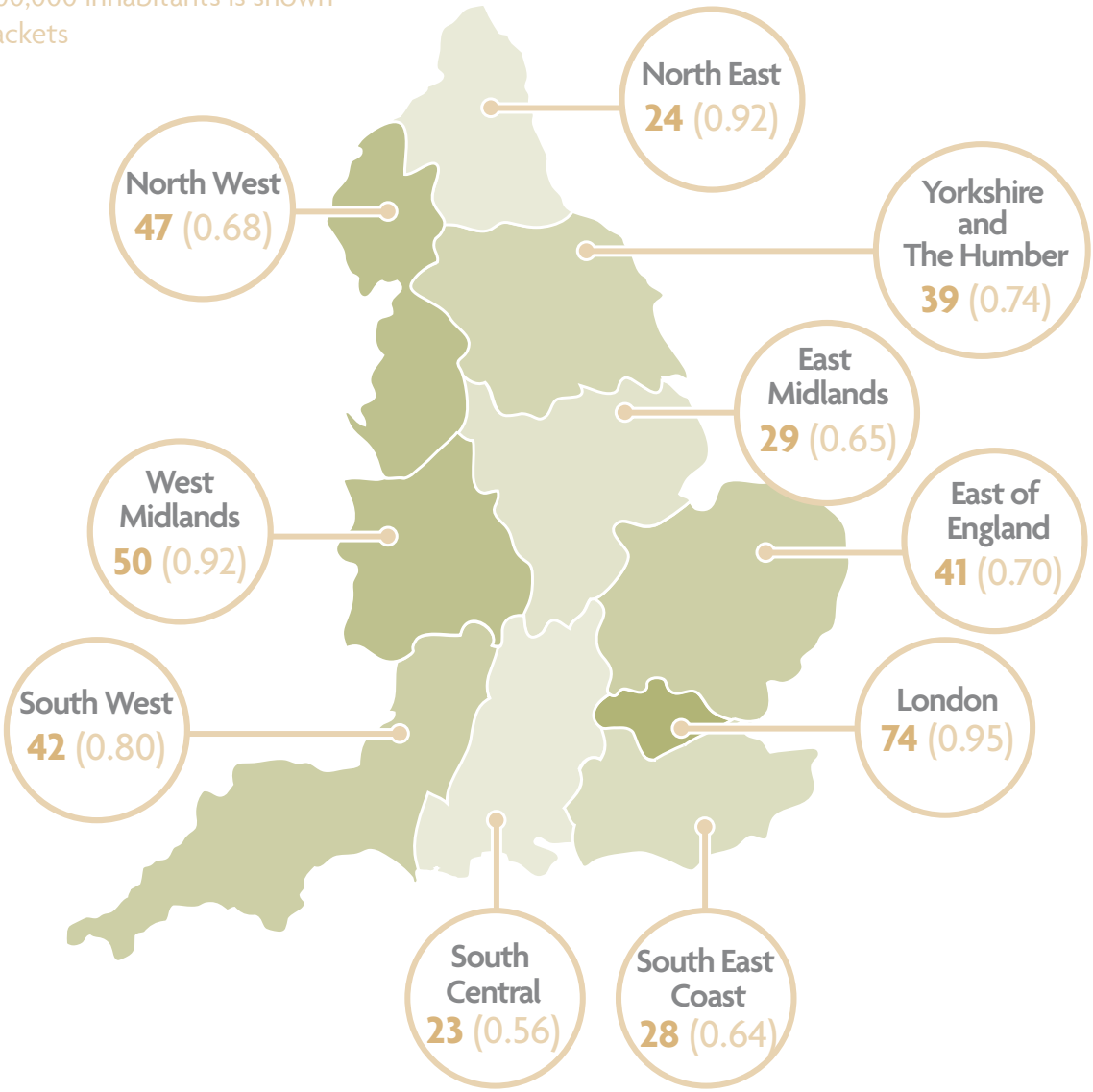
NHS hospital, specialist and teaching trusts (acute)	Opticians	Other health authorities	Pharmacies	PCTs[3]	Special HAs[4]	SHAs[5]	Unknown	Total
409	3		1	177		22		**1,008**
734	1		3	250		16		**1,497**
								1
1,678	4		3	295		16		**3,132**
303				56		5		**550**
930	1		5	308		15		**1,848**
		21						**21**
377	1		6	214		27		**943**
480	1		8	177		17		**1,121**
645	1		6	229		30		**1,432**
					49			**49**
415	18		48	141		4		**1,934**
801	1		7	198		18	1	**1,521**
631	1		4	202		5		**1,280**
7,403	**32**	**21**	**91**	**2,247**	**49**	**175**	**1**	**16,337**

[3] Primary care trusts
[4] Special health authorities
[5] Strategic health authorities

Interventions, by SHA region

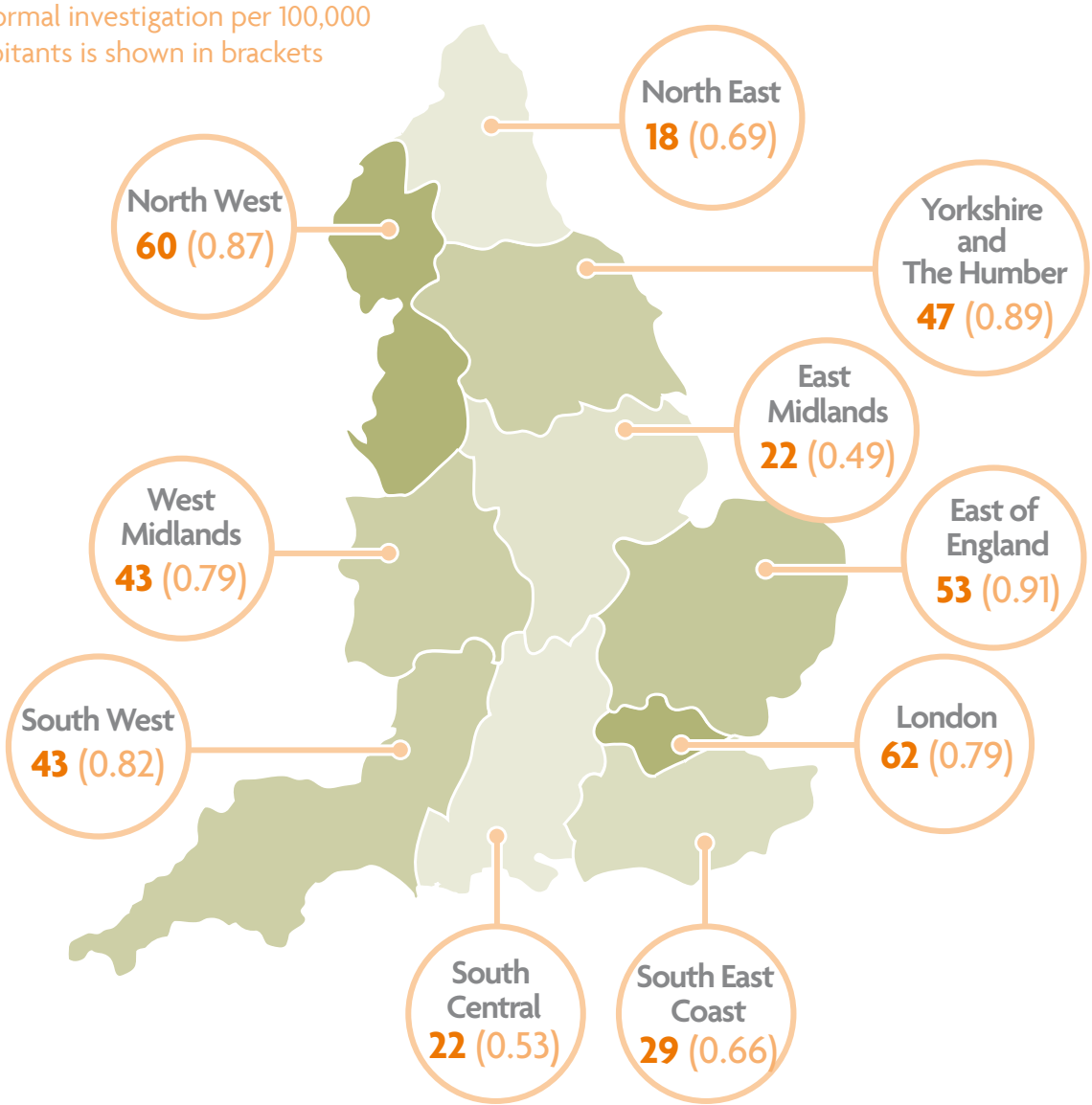
The number of interventions per 100,000 inhabitants is shown in brackets



We resolved 399 complaints through intervention in 2011-12. Two of these involved the NHS Business Services Authority which works at a national level and so these are not included in the figures shown above. To account for the difference in population in each region, the figures in brackets show the number of interventions per 100,000 inhabitants. This is worked out using the Office of National Statistics' 2009 mid-year population estimates.

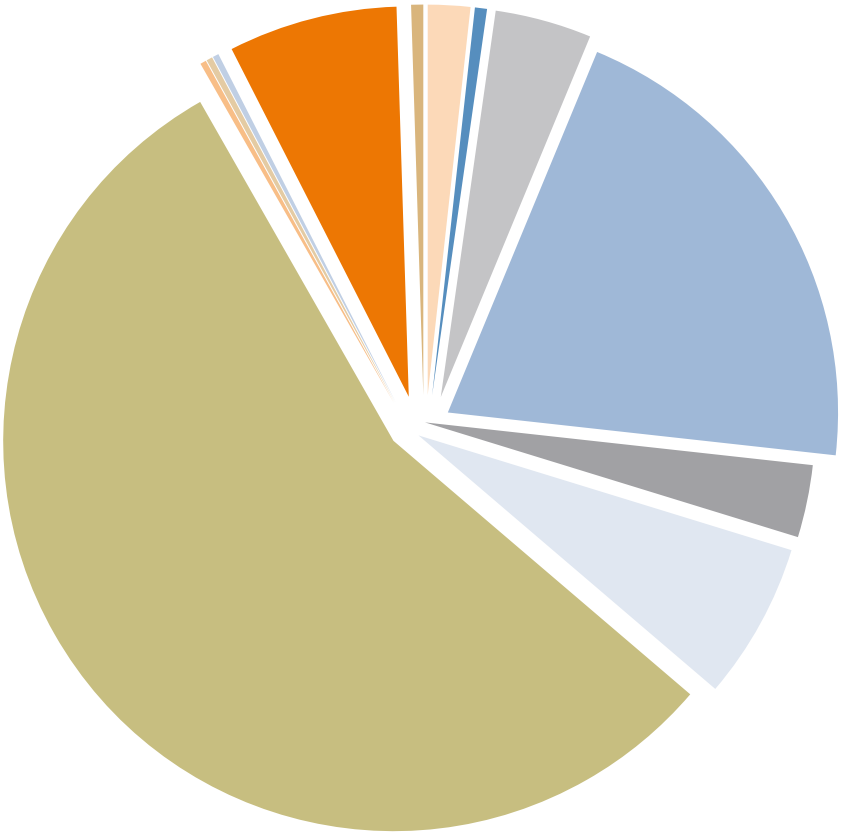
Complaints accepted for formal investigation, by SHA region

The number of complaints accepted for formal investigation per 100,000 inhabitants is shown in brackets



We accepted 400 complaints for investigation in 2011-12. The figures shown above only add up to 399 because one of these complaints was about NHS Direct, which works at a national level. To account for the difference in population in each region, the figures in brackets show the number of complaints accepted for investigation per 100,000 inhabitants. This is worked out using the Office of National Statistics' 2009 mid-year population estimates.

Complaints accepted for formal investigation, by organisation type

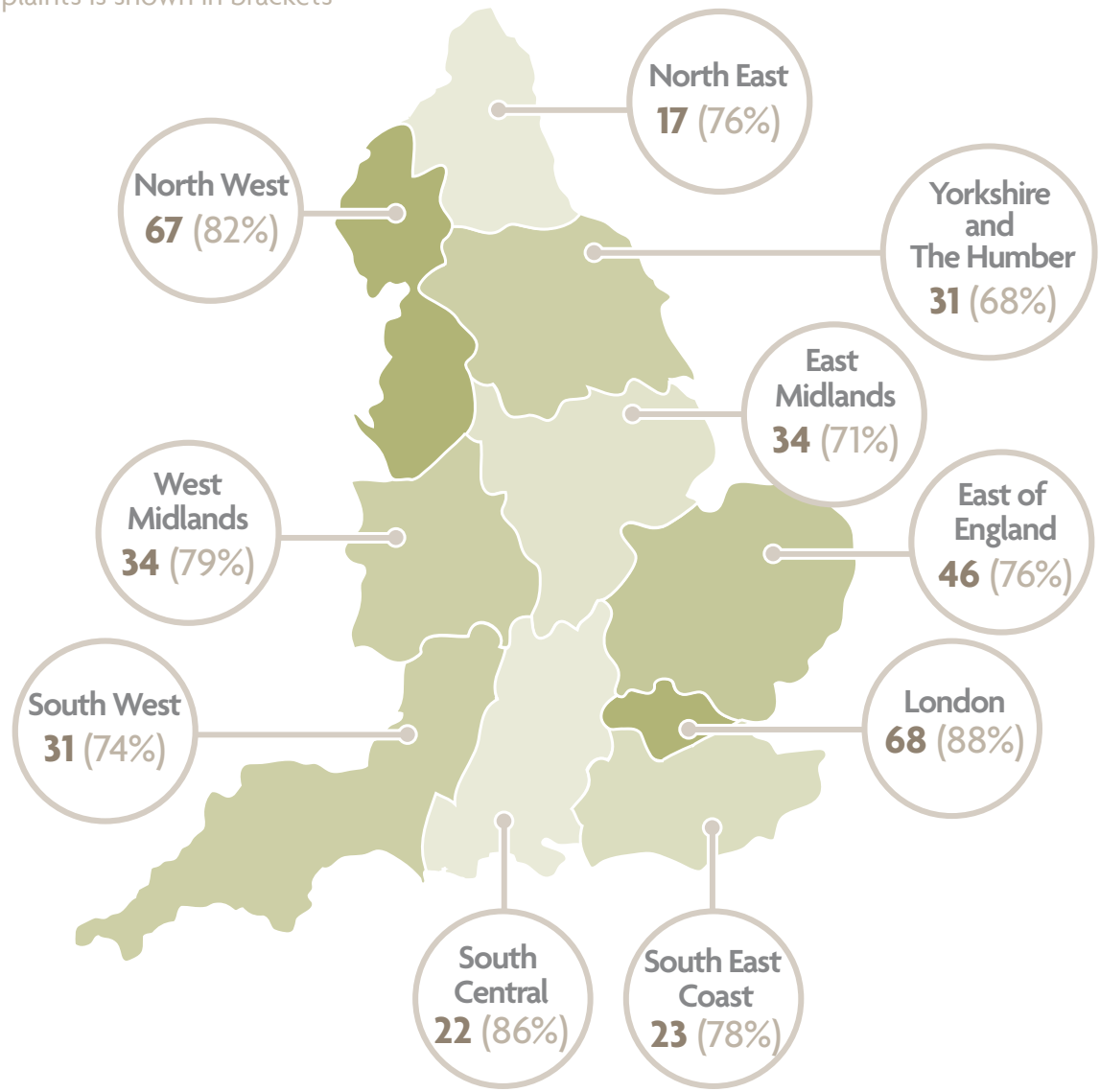


Ambulance trusts	**7** (2%)
Care trusts	**2** (1%)
General dental practitioners	**16** (4%)
General practitioners	**82** (21%)
Independent providers	**12** (3%)
Mental health, social care and learning disability trusts	**26** (7%)
NHS hospital, specialist and teaching trusts (acute)	**222** (56%)
Opticians	**1** (<1%)
Other health authorities	**1** (<1%)
Pharmacies	**1** (<1%)
Primary care trusts	**28** (7%)
Strategic health authorities	**2** (1%)

Total: 400

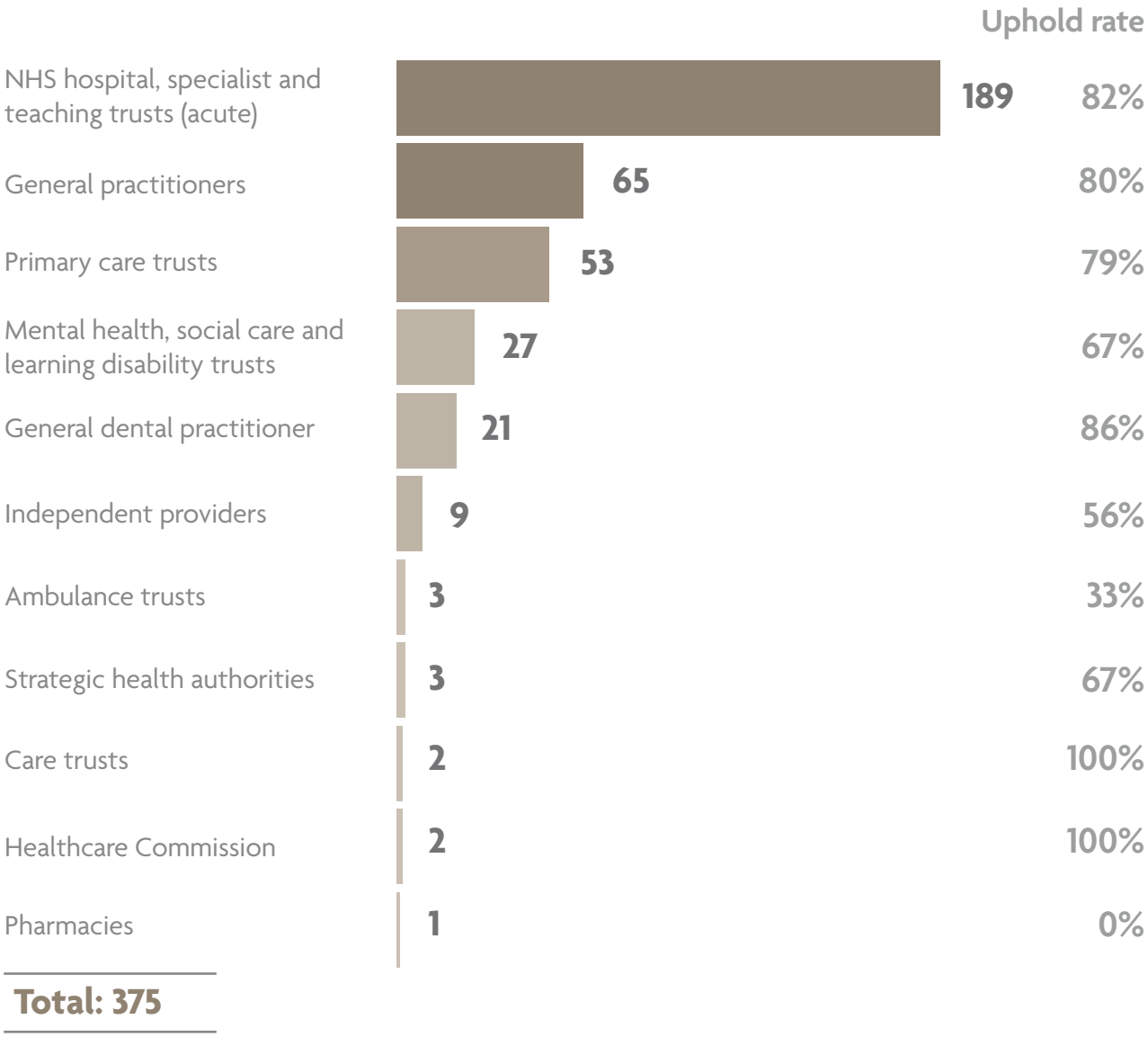
Complaints investigated and reported on, by SHA region

The percentage of upheld complaints is shown in brackets



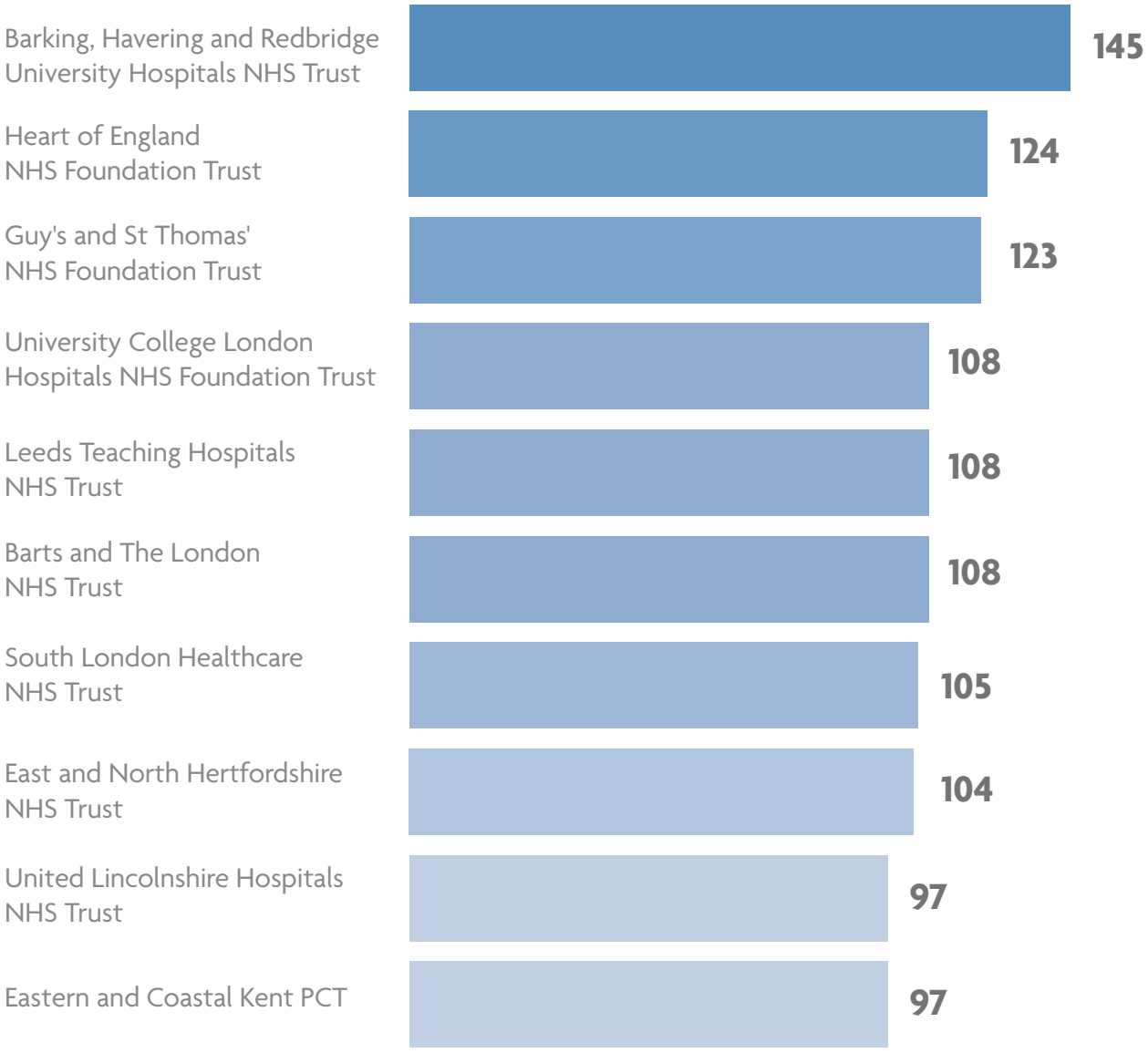
The uphold rate is the total of fully upheld and partly upheld complaints. We completed 375 investigations in the year. The figures shown above do not add up to 375 because two of these investigations were about the Healthcare Commission which worked at a national level. Both of these were upheld.

Complaints investigated and reported on, by organisation type



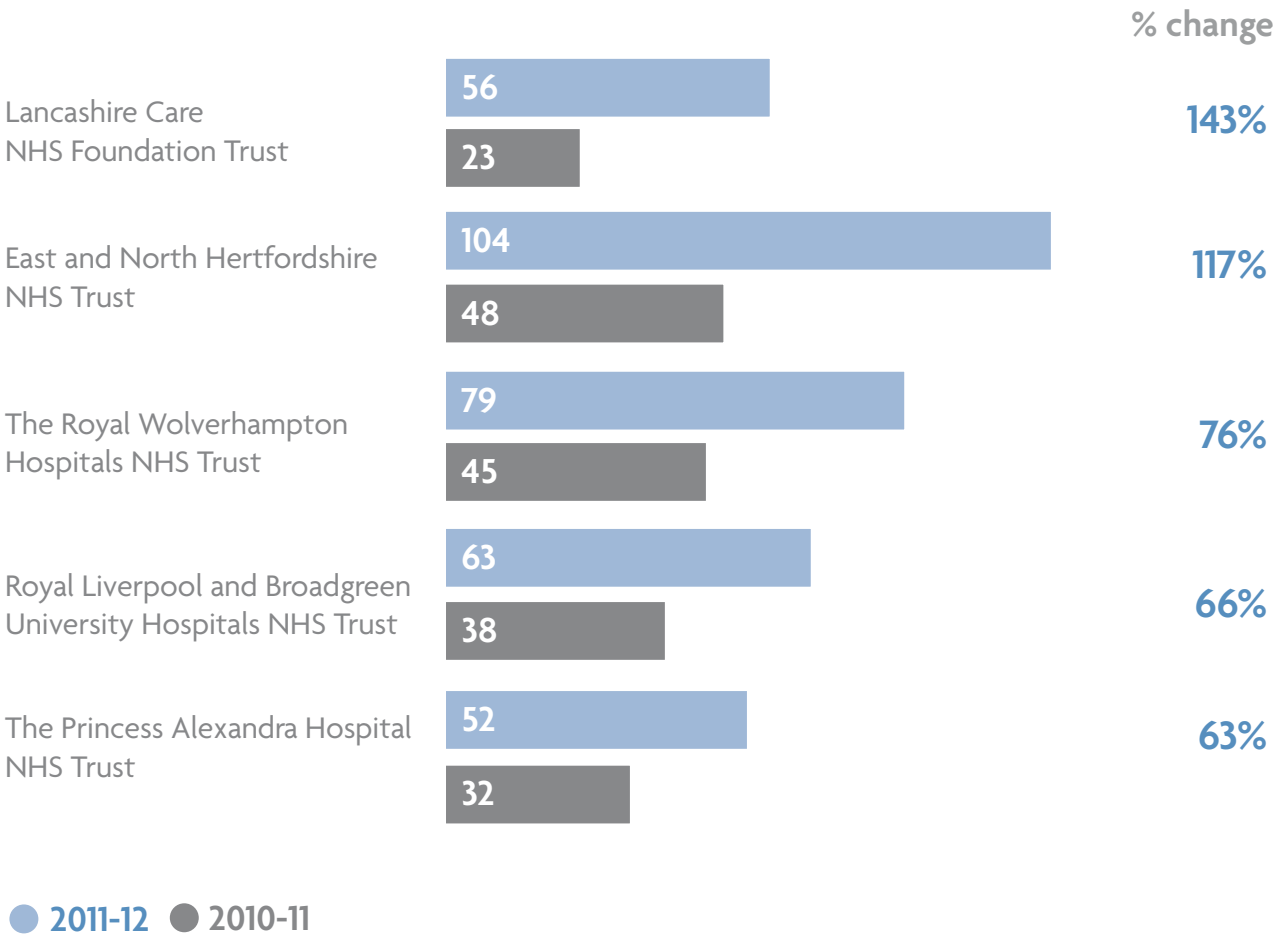
The uphold rate is the total of fully upheld and partly upheld complaints.

Top health organisations, ranked by complaints received

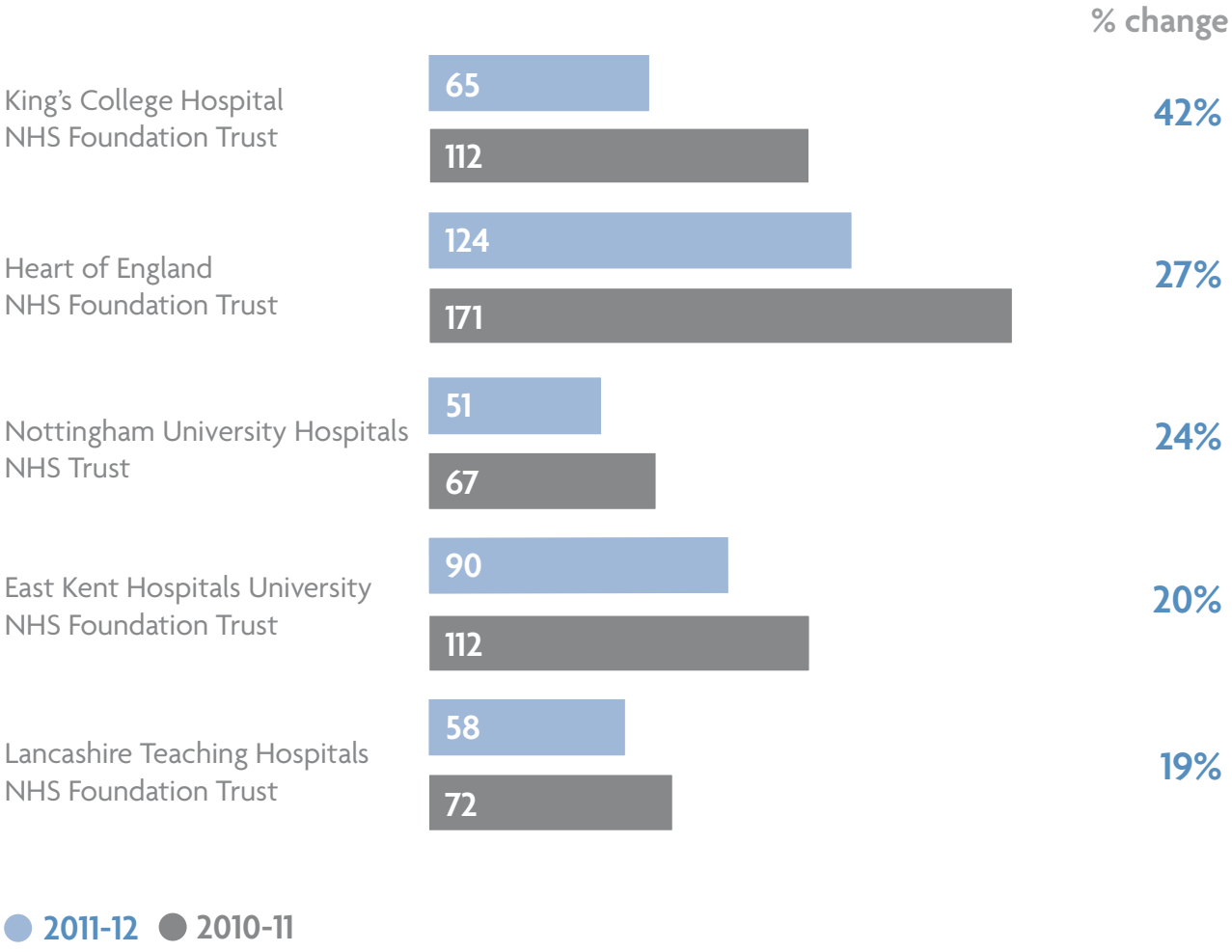


Volume of complaints can provide an early warning of failures in service delivery, but a high number of complaints does not necessarily mean poor performance. It could mean that information provided by organisations about how to make a complaint is good. Many other factors can affect the volume of complaints, including the size of the organisation and the size and make-up of the population it serves.

Highest % increase in complaints received



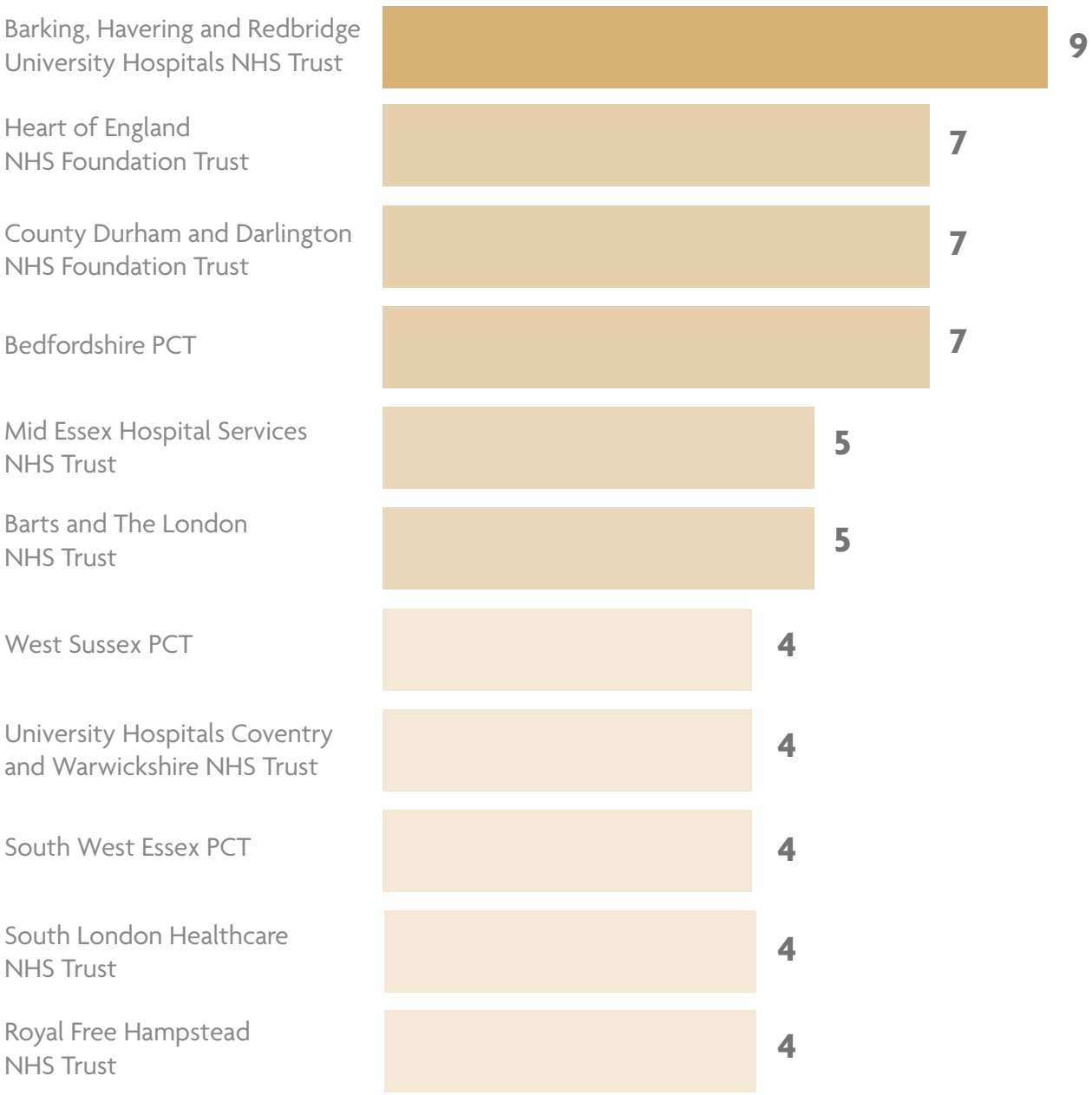
Highest % decrease in complaints received



These charts show the top five organisations about which we have seen the highest percentage increase or decrease in the numbers of complaints. We have only included organisations if we have received at least 50 complaints about them. We changed the way we recorded statistics about primary care trusts in 2011-12, which means figures for this year and the previous year are not directly comparable. Primary care trusts are therefore not included in these charts.

Volume of complaints can provide an early warning of failures in service delivery, but a high number of complaints does not necessarily mean poor performance. It could mean that information provided by organisations about how to make a complaint is good. Many other factors can affect the volume of complaints, including the size of the organisation and the size and make-up of the population it serves.

Top health organisations, ranked by interventions



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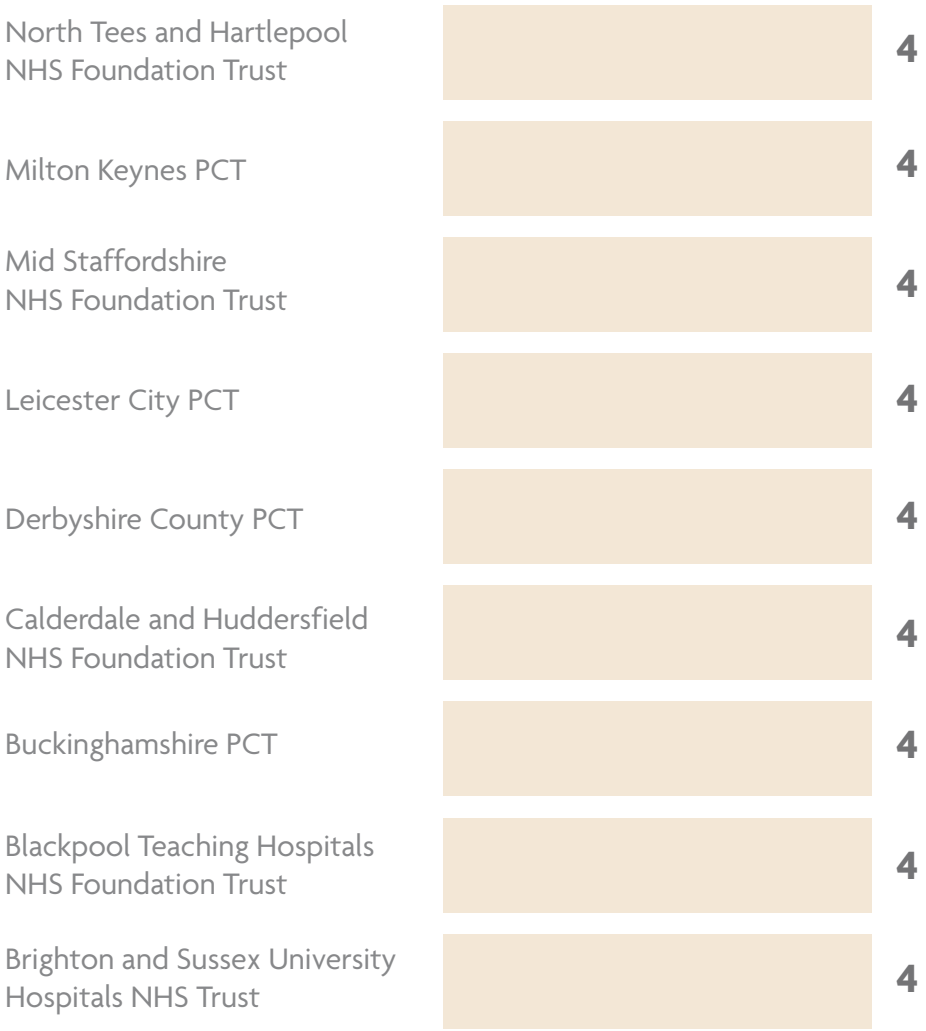
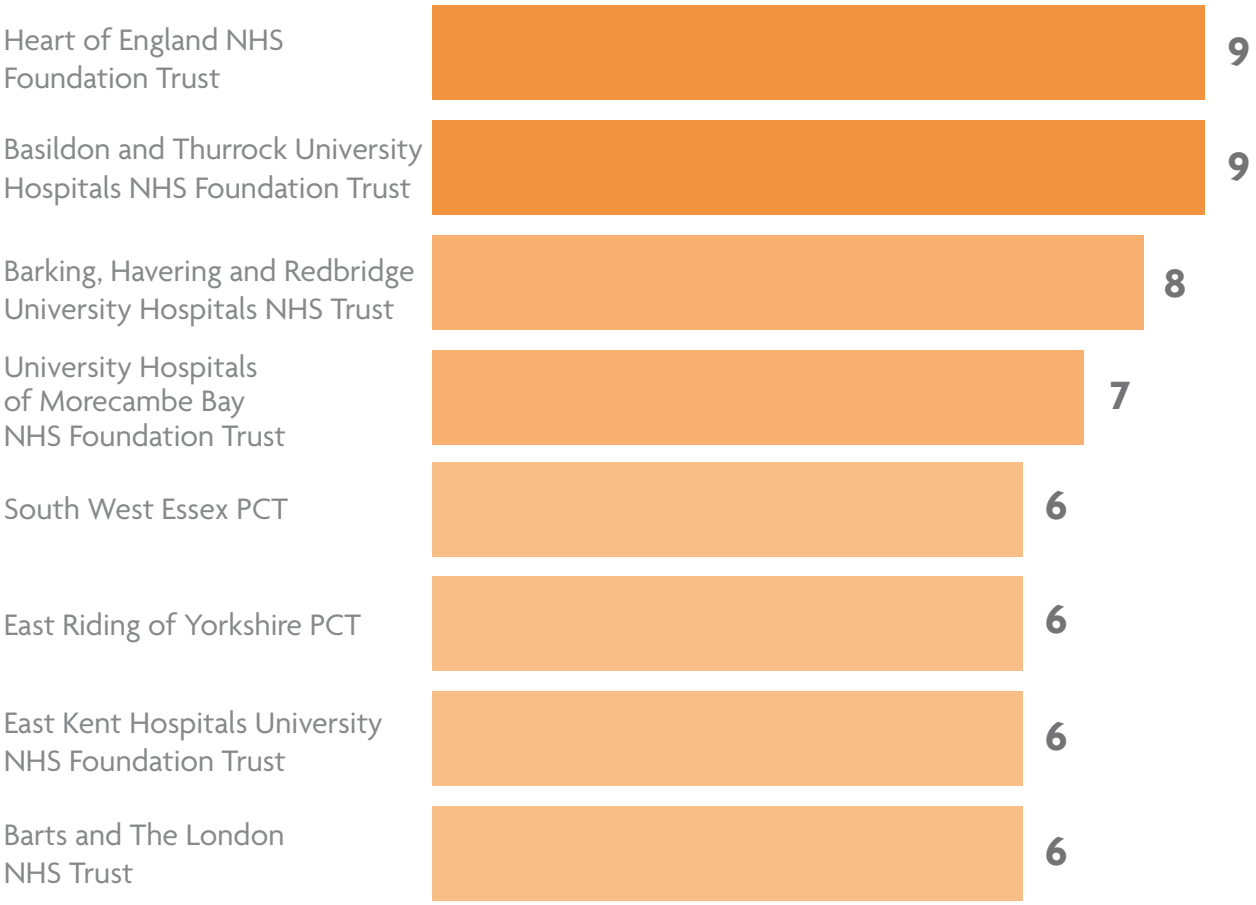


For 14 organisations there were 4 interventions, generating a list of 20 organisations overall.

Volume of complaints can provide an early warning of failures in service delivery, but a high number of complaints does not necessarily mean poor performance. It could mean that information provided by organisations about how to make a complaint is good. Many other factors can affect the volume of complaints, including the size of the organisation and the size and make-up of the population it serves.

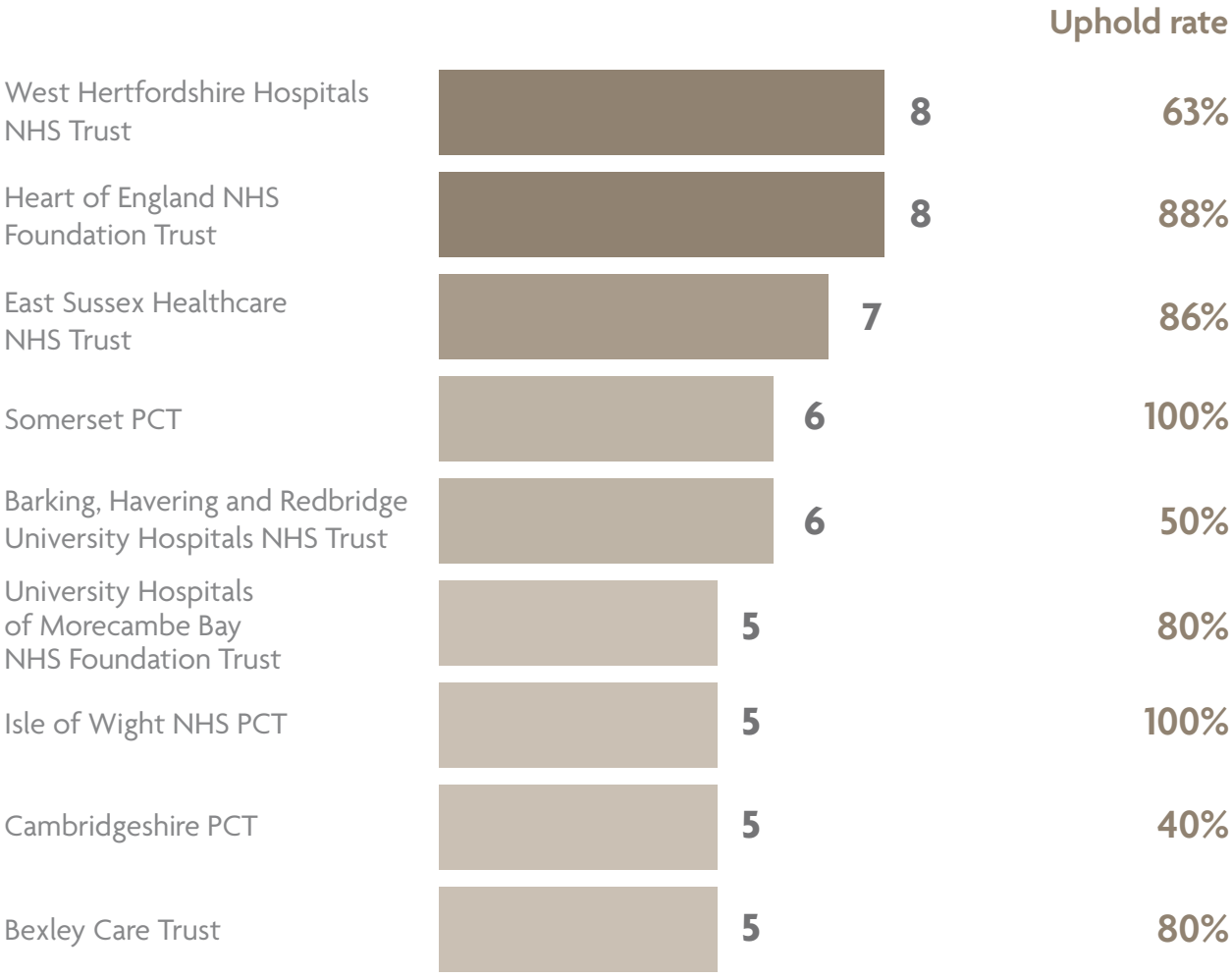
Top health organisations, ranked by complaints accepted for investigation



4 organisations each had 6 complaints accepted for investigation, generating a list of 8 organisations overall.

Volume of complaints can provide an early warning of failures in service delivery, but a high number of complaints does not necessarily mean poor performance. It could mean that information provided by organisations about how to make a complaint is good. Many other factors can affect the volume of complaints, including the size of the organisation and the size and make-up of the population it serves.

Top health organisations, ranked by complaints investigated and reported on



4 organisations had 5 complaints investigated and reported on, generating a list of 9 organisations overall.

Volume of complaints can provide an early warning of failures in service delivery, but a high number of complaints does not necessarily mean poor performance. It could mean that information provided by organisations about how to make a complaint is good. Many other factors can affect the volume of complaints, including the size of the organisation and the size and make-up of the population it serves.

The following table includes statistical information about all NHS organisations in 2011-12.

It includes:

- the number of complaints we received;
- the number of complaints we resolved through interventions;
- the number of complaints we accepted for formal investigation; and
- the number of investigated complaints we reported on, and the percentage of those complaints which were fully upheld, partly upheld, or not upheld.

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

Data for primary care practitioners is included in the figures for primary care trusts.

We record an organisation as an 'unknown body' where someone asks us how to complain about an NHS organisation, but he or she is at such an early stage in the complaints process that they do not know, or are unwilling to give us, the name of the organisation.

Please note that due to a change in the way data is presented, these figures are not directly comparable with those in our 2010-11 report. This is because we now record any complaint about a GP practice against each GP contract within that practice. However, in our analysis of top organisations on pages 54-61 we count these as a single complaint.

Statistical information about NHS organisations 2011-12

	Complaints received	Complaints resolved through intervention
2gether NHS Foundation Trust	12	0
5 Boroughs Partnership NHS Foundation Trust	27	0
Aintree University Hospitals NHS Foundation Trust	35	1
Airedale NHS Foundation Trust	11	0
Alder Hey Children's NHS Foundation Trust	8	0
Ashford and St Peter's Hospitals NHS Foundation Trust	22	0
Ashton, Leigh and Wigan PCT	19	0
Avon and Wiltshire Mental Health Partnership NHS Trust	38	0
Barking and Dagenham PCT	15	1
Barking, Havering and Redbridge University Hospitals NHS Trust	145	9
Barnet and Chase Farm Hospitals NHS Trust	58	3
Barnet PCT	60	1
Barnet, Enfield and Haringey Mental Health NHS Trust	47	0
Barnsley Hospital NHS Foundation Trust	34	3
Barnsley PCT	16	3
Barts and The London NHS Trust	108	5
Basildon and Thurrock University Hospitals NHS Foundation Trust	75	2
Bassetlaw PCT	10	0
Bath and North East Somerset PCT	21	3
Bedford Hospital NHS Trust	22	0
Bedfordshire PCT	49	7
Berkshire East PCT	27	0
Berkshire Healthcare NHS Foundation Trust	14	1
Berkshire West PCT	50	0
Bexley Care Trust	30	2

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	0	-	-	-
1	1	0%	100%	0%
1	0	-	-	-
2	0	-	-	-
0	0	-	-	-
1	0	-	-	-
2	3	100%	0%	0%
1	1	100%	0%	0%
1	0	-	-	-
8	6	17%	33%	50%
2	2	100%	0%	0%
1	0	-	-	-
0	0	-	-	-
2	0	-	-	-
0	0	-	-	-
6	2	100%	0%	0%
9	2	100%	0%	0%
0	1	0%	0%	100%
0	0	-	-	-
1	2	100%	0%	0%
0	1	100%	0%	0%
0	1	0%	0%	100%
0	0	-	-	-
1	1	100%	0%	0%
2	5	80%	0%	20%

	Complaints received	Complaints resolved through intervention
Birmingham and Solihull Mental Health NHS Foundation Trust	24	0
Birmingham Children's Hospital NHS Foundation Trust	6	0
Birmingham Community Healthcare NHS Trust	10	1
Birmingham East and North PCT	34	1
Birmingham Women's NHS Foundation Trust	11	1
Black Country Partnership NHS Foundation Trust	17	1
Blackburn with Darwen Teaching Care Trust Plus	9	1
Blackpool PCT	30	0
Blackpool Teaching Hospitals NHS Foundation Trust	63	4
Bolton NHS Foundation Trust	16	0
Bolton PCT	15	0
Bournemouth and Poole Teaching PCT	36	2
Bradford and Airedale Teaching PCT	59	1
Bradford District Care Trust	22	0
Bradford Teaching Hospitals NHS Foundation Trust	45	0
Brent Teaching PCT	44	1
Bridgewater Community Healthcare NHS Trust	3	0
Brighton and Hove City PCT	25	2
Brighton and Sussex University Hospitals NHS Trust	87	4
Bristol PCT	55	0
Bromley PCT	16	0
Buckinghamshire Healthcare NHS Trust	36	1
Buckinghamshire PCT	51	4
Burton Hospitals NHS Foundation Trust	23	1
Bury PCT	12	0
Calderdale and Huddersfield NHS Foundation Trust	41	4
Calderdale PCT	21	0
Cambridge University Hospitals NHS Foundation Trust	38	2
Cambridgeshire and Peterborough NHS Foundation Trust	24	0

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
2	2	0%	50%	50%
0	1	0%	100%	0%
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
5	1	100%	0%	0%
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
1	1	0%	0%	100%
2	0	-	-	-
0	1	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
0	1	100%	0%	0%
0	0	-	-	-
0	2	0%	100%	0%
3	1	100%	0%	0%
0	1	100%	0%	0%
1	1	0%	0%	100%
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	1	100%	0%	0%

	Complaints received	Complaints resolved through intervention
Cambridgeshire Community Services NHS Trust	7	0
Cambridgeshire PCT	35	0
Camden and Islington NHS Foundation Trust	28	1
Camden PCT	39	0
Central and Eastern Cheshire PCT	42	1
Central and North West London NHS Foundation Trust	65	2
Central Lancashire PCT	56	1
Central London Community Healthcare NHS Trust	13	0
Central Manchester University Hospitals NHS Foundation Trust	71	3
Chelsea and Westminster Hospital NHS Foundation Trust	48	0
Cheshire and Wirral Partnership NHS Foundation Trust	11	0
Chesterfield Royal Hospital NHS Foundation Trust	30	1
City and Hackney Teaching PCT	26	1
City Hospitals Sunderland NHS Foundation Trust	42	2
Clatterbridge Centre For Oncology NHS Foundation Trust	1	0
Colchester Hospital University NHS Foundation Trust	60	3
Cornwall and Isles Of Scilly PCT	60	1
Cornwall Partnership NHS Foundation Trust	10	0
Countess Of Chester Hospital NHS Foundation Trust	11	0
County Durham and Darlington NHS Foundation Trust	68	7
County Durham PCT	22	0
Coventry and Warwickshire Partnership NHS Trust	31	1
Coventry Teaching PCT	39	1
Croydon Health Services NHS Trust	37	1
Croydon PCT	21	0
Cumbria Partnership NHS Foundation Trust	12	1
Cumbria Teaching PCT	51	2
Darlington PCT	15	0
Dartford and Gravesham NHS Trust	28	1

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	0	-	-	-
3	5	0%	40%	60%
0	0	-	-	-
2	0	-	-	-
2	3	67%	33%	0%
0	1	0%	100%	0%
0	2	50%	0%	50%
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
1	1	100%	0%	0%
2	2	50%	0%	50%
0	0	-	-	-
1	0	-	-	-
0	0	-	-	-
2	1	100%	0%	0%
3	0	-	-	-
0	0	-	-	-
0	1	0%	100%	0%
2	4	50%	50%	0%
2	0	-	-	-
2	0	-	-	-
0	0	-	-	-
0	2	100%	0%	0%
0	0	-	-	-
0	1	100%	0%	0%
0	0	-	-	-
1	2	0%	50%	50%
0	0	-	-	-

	Complaints received	Complaints resolved through intervention
Derby City PCT	32	0
Derby Hospitals NHS Foundation Trust	39	0
Derbyshire Community Health Services NHS Trust	11	2
Derbyshire County PCT	65	4
Derbyshire Healthcare NHS Foundation Trust	22	0
Devon Partnership NHS Trust	26	0
Devon PCT	72	1
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	43	1
Doncaster PCT	17	2
Dorset County Hospital NHS Foundation Trust	37	1
Dorset Healthcare University NHS Foundation Trust	21	0
Dorset PCT	43	3
Dudley and Walsall Mental Health Partnership NHS Trust	11	0
Dudley PCT	35	1
Ealing Hospital NHS Trust	40	1
Ealing PCT	36	0
East and North Hertfordshire NHS Trust	104	2
East Cheshire NHS Trust	10	0
East Kent Hospitals University NHS Foundation Trust	90	2
East Lancashire Hospitals NHS Trust	44	2
East Lancashire Teaching PCT	26	0
East London NHS Foundation Trust	25	1
East Midlands Ambulance Service NHS Trust	24	0
East Midlands Strategic Health Authority	22	1
East of England Ambulance Service NHS Trust	27	0
East of England Strategic Health Authority	16	0
East Riding Of Yorkshire PCT	57	0
East Sussex Downs and Weald PCT	44	1
East Sussex Healthcare NHS Trust	31	1

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	2	100%	0%	0%
2	1	100%	0%	0%
0	0	-	-	-
0	1	100%	0%	0%
3	1	0%	0%	100%
1	0	-	-	-
10	1	0%	0%	100%
1	3	0%	0%	100%
0	0	-	-	-
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
1	2	50%	0%	50%
0	0	-	-	-
0	0	-	-	-
3	3	100%	0%	0%
0	1	100%	0%	0%
6	3	33%	33%	33%
2	1	0%	100%	0%
4	1	100%	0%	0%
0	0	-	-	-
1	0	-	-	-
1	1	0%	0%	100%
2	0	-	-	-
0	0	-	-	-
6	2	100%	0%	0%
1	2	0%	0%	100%
3	7	86%	0%	14%

	Complaints received	Complaints resolved through intervention
Eastern and Coastal Kent PCT	97	1
Enfield PCT	37	1
Epsom and St Helier University Hospitals NHS Trust	51	2
Frimley Park Hospital NHS Foundation Trust	28	0
Gateshead Health NHS Foundation Trust	11	1
Gateshead PCT	12	0
George Eliot Hospital NHS Trust	17	0
Gloucestershire Hospitals NHS Foundation Trust	64	2
Gloucestershire PCT	46	2
Great Ormond Street Hospital For Children NHS Foundation Trust	25	1
Great Western Ambulance Service NHS Trust	26	1
Great Western Hospitals NHS Foundation Trust	32	0
Great Yarmouth and Waveney PCT	34	0
Greater Manchester West Mental Health NHS Foundation Trust	18	2
Greenwich Teaching PCT	37	0
Guy's and St Thomas' NHS Foundation Trust	123	3
Halton and St Helens PCT	16	0
Hammersmith and Fulham PCT	23	0
Hampshire Hospitals NHS Foundation Trust	30	1
Hampshire PCT	94	2
Haringey Teaching PCT	36	2
Harrogate and District NHS Foundation Trust	21	0
Harrow PCT	12	0
Hartlepool PCT	7	0
Hastings and Rother PCT	32	1
Havering PCT	43	1
Healthcare Commission	1	0
Heart of Birmingham Teaching PCT	39	1
Heart of England NHS Foundation Trust	124	7

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
3	1	100%	0%	0%
0	0	-	-	-
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	1	0%	100%	0%
1	0	-	-	-
2	1	100%	0%	0%
0	1	100%	0%	0%
0	1	0%	0%	100%
0	1	100%	0%	0%
0	0	-	-	-
1	1	100%	0%	0%
6	6	0%	100%	0%
1	1	0%	100%	0%
0	1	100%	0%	0%
1	0	-	-	-
0	0	-	-	-
2	1	0%	100%	0%
0	2	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
5	1	100%	0%	0%
0	2	100%	0%	0%
0	1	0%	100%	0%
9	8	63%	25%	13%

	Complaints received	Complaints resolved through intervention
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	68	1
Herefordshire PCT	18	0
Hertfordshire Community NHS Trust	12	1
Hertfordshire Partnership NHS Foundation Trust	35	0
Hertfordshire PCT	77	0
Heywood, Middleton and Rochdale PCT	22	0
Hillingdon PCT	35	1
Hinchingbrooke Health Care NHS Trust	5	0
Homerton University Hospital NHS Foundation Trust	36	1
Hounslow and Richmond Community Healthcare NHS Trust	2	0
Hounslow PCT	32	0
Hull and East Yorkshire Hospitals NHS Trust	66	3
Hull PCT	39	0
Humber NHS Foundation Trust	15	0
Imperial College Healthcare NHS Trust	83	2
Ipswich Hospital NHS Trust	37	0
Isle of Wight NHS PCT	46	1
Islington PCT	32	0
James Paget University Hospitals NHS Foundation Trust	18	0
Kensington and Chelsea PCT	21	0
Kent and Medway NHS and Social Care Partnership Trust	45	3
Kent Community Health NHS Trust	11	0
Kettering General Hospital NHS Foundation Trust	29	0
King's College Hospital NHS Foundation Trust	65	2
Kingston Hospital NHS Trust	30	1
Kingston PCT	15	0
Kirklees PCT	27	0
Knowsley PCT	6	0
Lambeth PCT	46	0

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
2	1	100%	0%	0%
2	0	-	-	-
0	0	-	-	-
1	1	0%	0%	100%
0	3	67%	0%	33%
1	2	0%	0%	100%
3	1	0%	100%	0%
0	1	100%	0%	0%
1	2	50%	50%	0%
0	0	-	-	-
1	1	100%	0%	0%
2	2	50%	0%	50%
0	1	100%	0%	0%
0	0	-	-	-
0	3	33%	33%	33%
1	0	-	-	-
2	5	60%	40%	0%
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	1	0%	100%	0%
0	0	-	-	-
2	2	50%	50%	0%
0	2	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
1	0	-	-	-
0	0	-	-	-
0	1	100%	0%	0%

	Complaints received	Complaints resolved through intervention
Lancashire Care NHS Foundation Trust	56	2
Lancashire Teaching Hospitals NHS Foundation Trust	58	2
Leeds and York Partnership NHS Foundation Trust	17	0
Leeds Community Healthcare NHS Trust	5	0
Leeds PCT	89	8
Leeds Teaching Hospitals NHS Trust	108	3
Leicester City PCT	35	4
Leicestershire County and Rutland PCT	59	1
Leicestershire Partnership NHS Trust	40	0
Lewisham PCT	20	0
Lincolnshire Community Health Services NHS Trust	5	0
Lincolnshire Partnership NHS Foundation Trust	13	0
Lincolnshire Teaching PCT	36	3
Liverpool Community Health NHS Trust	2	0
Liverpool PCT	36	0
Liverpool Women's NHS Foundation Trust	11	1
London Ambulance Service NHS Trust	64	0
London Strategic Health Authority	16	0
Luton and Dunstable Hospital NHS Foundation Trust	29	1
Luton PCT	14	0
Maidstone and Tunbridge Wells NHS Trust	50	0
Manchester Mental Health and Social Care Trust	21	0
Manchester PCT	69	2
Medway NHS Foundation Trust	45	0
Medway PCT	40	1
Mersey Care NHS Trust	24	2
Mid Cheshire Hospitals NHS Foundation Trust	25	1
Mid Essex Hospital Services NHS Trust	82	5
Mid Essex PCT	39	0

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
1	2	50%	50%	0%
1	3	33%	33%	33%
1	1	0%	0%	100%
0	0	-	-	-
7	2	0%	0%	100%
5	3	67%	0%	33%
0	3	67%	0%	33%
0	3	67%	0%	33%
1	1	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
0	1	0%	0%	100%
1	1	0%	0%	100%
0	0	-	-	-
0	0	-	-	-
1	1	100%	0%	0%
2	1	100%	0%	0%
0	0	-	-	-
1	0	-	-	-
1	4	100%	0%	0%
2	1	100%	0%	0%
0	0	-	-	-
2	4	50%	0%	50%
1	0	-	-	-
0	0	-	-	-
1	0	-	-	-
2	1	0%	100%	0%
4	2	0%	0%	100%
0	0	-	-	-

	Complaints received	Complaints resolved through intervention
Mid Staffordshire NHS Foundation Trust	50	4
Mid Yorkshire Hospitals NHS Trust	51	2
Middlesbrough PCT	6	2
Milton Keynes Hospital NHS Foundation Trust	37	1
Milton Keynes PCT	49	4
Moorfields Eye Hospital NHS Foundation Trust	37	1
National Institute for Health and Clinical Excellence	3	0
National Patient Safety Agency	3	0
Newcastle PCT	9	2
Newham PCT	30	0
Newham University Hospital NHS Trust	40	0
NHS Blood and Transplant	5	0
NHS Business Services Authority	33	2
NHS Direct	21	0
NHS Institute for Innovation and Improvement	1	0
NHS Litigation Authority	4	0
Norfolk and Norwich University Hospitals NHS Foundation Trust	40	2
Norfolk and Suffolk NHS Foundation Trust	37	0
Norfolk Community Health and Care NHS Trust	10	0
Norfolk PCT	56	1
North Bristol NHS Trust	61	0
North Cumbria University Hospitals NHS Trust	27	0
North East Ambulance Service NHS Foundation Trust	11	0
North East Essex PCT	46	3
North East Lincolnshire Care Trust Plus	17	0
North East London NHS Foundation Trust	30	0
North East Strategic Health Authority	5	0
North Essex Partnership NHS Foundation Trust	20	0
North Lancashire Teaching PCT	49	1

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
3	1	100%	0%	0%
1	2	100%	0%	0%
0	0	-	-	-
2	1	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	1	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
1	1	100%	0%	0%
1	0	-	-	-
0	0	-	-	-
0	1	0%	0%	100%
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	1	100%	0%	0%
0	0	-	-	-
2	1	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
1	3	67%	0%	33%

	Complaints received	Complaints resolved through intervention
North Lincolnshire PCT	11	3
North Middlesex University Hospital NHS Trust	51	1
North Somerset PCT	31	1
North Staffordshire Combined Healthcare NHS Trust	9	1
North Staffordshire PCT	21	0
North Tees and Hartlepool NHS Foundation Trust	31	4
North Tyneside PCT	26	0
North West Ambulance Service NHS Trust	27	1
North West London Hospitals NHS Trust	77	1
North West Strategic Health Authority	15	0
North Yorkshire and York PCT	72	2
Northampton General Hospital NHS Trust	43	1
Northamptonshire Healthcare NHS Foundation Trust	22	0
Northamptonshire Teaching PCT	56	2
Northern Devon Healthcare NHS Trust	23	1
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	37	0
Northumberland Care Trust	22	2
Northumberland, Tyne and Wear NHS Foundation Trust	32	0
Northumbria Healthcare NHS Foundation Trust	39	1
Nottingham City PCT	40	3
Nottingham University Hospitals NHS Trust	51	0
Nottinghamshire County Teaching PCT	50	0
Nottinghamshire Healthcare NHS Trust	57	1
Oldham PCT	25	0
Oxford Health NHS Foundation Trust	36	2
Oxford University Hospitals NHS Trust	61	0
Oxfordshire Learning Disability NHS Trust	3	0
Oxfordshire PCT	51	1
Oxleas NHS Foundation Trust	27	1

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
3	1	0%	100%	0%
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
2	2	50%	0%	50%
2	2	50%	50%	0%
0	1	100%	0%	0%
1	0	-	-	-
3	0	-	-	-
1	0	-	-	-
0	4	50%	25%	25%
0	1	100%	0%	0%
0	0	-	-	-
1	0	-	-	-
0	2	0%	50%	50%
2	2	100%	0%	0%
0	0	-	-	-
0	3	0%	33%	67%
2	1	100%	0%	0%
0	2	100%	0%	0%
1	1	100%	0%	0%
0	0	-	-	-
1	1	100%	0%	0%
1	0	-	-	-
1	0	-	-	-
2	2	100%	0%	0%
0	1	0%	0%	100%
0	0	-	-	-
0	0	-	-	-

	Complaints received	Complaints resolved through intervention
Papworth Hospital NHS Foundation Trust	9	0
Pennine Acute Hospitals NHS Trust	81	3
Pennine Care NHS Foundation Trust	37	0
Peterborough and Stamford Hospitals NHS Foundation Trust	31	1
Peterborough PCT	13	2
Plymouth Hospitals NHS Trust	61	3
Plymouth Teaching PCT	27	0
Poole Hospital NHS Foundation Trust	24	2
Portsmouth City Teaching PCT	22	2
Portsmouth Hospitals NHS Trust	58	0
Queen Victoria Hospital NHS Foundation Trust	6	0
Redbridge PCT	47	3
Redcar and Cleveland PCT	8	0
Richmond and Twickenham PCT	11	0
Rotherham PCT	13	0
Rotherham, Doncaster and South Humber NHS Foundation Trust	19	0
Royal Berkshire NHS Foundation Trust	36	1
Royal Brompton and Harefield NHS Foundation Trust	14	0
Royal Cornwall Hospitals NHS Trust	40	0
Royal Devon and Exeter NHS Foundation Trust	50	2
Royal Free Hampstead NHS Trust	95	4
Royal Liverpool and Broadgreen University Hospitals NHS Trust	63	1
Royal National Orthopaedic Hospital NHS Trust	21	0
Royal Surrey County Hospital NHS Foundation Trust	29	0
Royal United Hospital Bath NHS Trust	43	2
Salford PCT	30	0
Salford Royal NHS Foundation Trust	28	0
Salisbury NHS Foundation Trust	22	1
Sandwell and West Birmingham Hospitals NHS Trust	68	2

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	0	-	-	-
3	4	50%	0%	50%
0	2	50%	50%	0%
2	1	100%	0%	0%
1	0	-	-	-
0	2	0%	100%	0%
2	1	100%	0%	0%
0	0	-	-	-
1	0	-	-	-
3	1	100%	0%	0%
0	0	-	-	-
1	1	100%	0%	0%
1	1	100%	0%	0%
0	0	-	-	-
0	1	100%	0%	0%
2	0	-	-	-
0	1	100%	0%	0%
0	0	-	-	-
1	1	100%	0%	0%
1	2	50%	0%	50%
2	2	100%	0%	0%
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
3	1	100%	0%	0%
0	1	100%	0%	0%
0	1	0%	100%	0%
0	0	-	-	-
0	1	0%	100%	0%

	Complaints received	Complaints resolved through intervention
Sandwell PCT	28	1
Scarborough and North East Yorkshire Healthcare NHS Trust	42	0
Sefton PCT	22	2
Sheffield Children's NHS Foundation Trust	9	0
Sheffield Health and Social Care NHS Foundation Trust	18	0
Sheffield PCT	44	0
Sheffield Teaching Hospitals NHS Foundation Trust	65	0
Sherwood Forest Hospitals NHS Foundation Trust	41	1
Shrewsbury and Telford Hospital NHS Trust	44	0
Shropshire Community Health NHS Trust	3	0
Shropshire County PCT	19	0
Solent NHS Trust	35	1
Solihull Care Trust	3	0
Solihull PCT	25	3
Somerset Partnership NHS Foundation Trust	19	3
Somerset PCT	48	1
South Birmingham PCT	40	1
South Central Ambulance Service NHS Foundation Trust	8	0
South Central Strategic Health Authority	27	0
South Devon Healthcare NHS Foundation Trust	23	0
South East Coast Ambulance Service NHS Foundation Trust	17	1
South East Coast Strategic Health Authority	17	0
South East Essex PCT	37	0
South Essex Partnership University NHS Foundation Trust	28	1
South Gloucestershire PCT	41	1
South London and Maudsley NHS Foundation Trust	59	1
South London Healthcare NHS Trust	105	4
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	25	1
South Staffordshire PCT	47	2

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	0	-	-	-
0	2	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
2	0	-	-	-
2	1	100%	0%	0%
2	2	100%	0%	0%
0	1	100%	0%	0%
0	0	-	-	-
0	1	0%	0%	100%
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	1	100%	0%	0%
0	6	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
0	1	0%	100%	0%
2	1	0%	0%	100%
1	1	0%	0%	100%
0	0	-	-	-
0	1	100%	0%	0%
1	0	-	-	-
5	0	-	-	-
0	1	0%	0%	100%
3	4	100%	0%	0%
0	0	-	-	-
2	0	-	-	-

	Complaints received	Complaints resolved through intervention
South Tees Hospitals NHS Foundation Trust	35	0
South Tyneside NHS Foundation Trust	23	0
South Tyneside PCT	15	0
South Warwickshire NHS Foundation Trust	13	1
South West Essex PCT	61	4
South West London and St George's Mental Health NHS Trust	42	2
South West Strategic Health Authority	30	0
South West Yorkshire Partnership NHS Foundation Trust	24	0
South Western Ambulance Service NHS Foundation Trust	7	1
Southampton City PCT	26	0
Southend University Hospital NHS Foundation Trust	35	0
Southern Health NHS Foundation Trust	26	0
Southport and Ormskirk Hospital NHS Trust	48	0
Southwark PCT	37	0
St George's Healthcare NHS Trust	70	0
St Helens and Knowsley Hospitals NHS Trust	47	1
Staffordshire & Stoke on Trent Partnership NHS Trust	9	1
Stockport NHS Foundation Trust	35	1
Stockport PCT	42	0
Stockton-on-Tees Teaching PCT	10	0
Stoke-on-Trent PCT	35	1
Suffolk PCT	58	2
Sunderland Teaching PCT	27	1
Surrey and Borders Partnership NHS Foundation Trust	25	0
Surrey and Sussex Healthcare NHS Trust	20	0
Surrey PCT	94	3
Sussex Community NHS Trust	15	0
Sussex Partnership NHS Foundation Trust	52	2
Sutton and Merton PCT	38	1

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
2	1	0%	100%	0%
2	0	-	-	-
0	0	-	-	-
0	0	-	-	-
6	5	100%	0%	0%
0	0	-	-	-
0	1	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
1	1	0%	100%	0%
2	2	50%	50%	0%
0	1	100%	0%	0%
5	2	50%	50%	0%
2	2	100%	0%	0%
0	3	33%	33%	33%
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
1	4	100%	0%	0%
0	0	-	-	-
0	0	-	-	-
6	0	-	-	-
1	2	0%	50%	50%
1	0	-	-	-
1	0	-	-	-
2	2	100%	0%	0%
1	0	-	-	-
1	0	-	-	-
0	2	50%	50%	0%

	Complaints received	Complaints resolved through intervention
Swindon PCT	31	3
Tameside and Glossop PCT	27	0
Tameside Hospital NHS Foundation Trust	38	0
Taunton and Somerset NHS Foundation Trust	15	1
Tavistock and Portman NHS Foundation Trust	4	0
Tees, Esk and Wear Valleys NHS Foundation Trust	18	0
Telford and Wrekin PCT	18	2
The Christie NHS Foundation Trust	6	0
The Dudley Group NHS Foundation Trust	58	1
The Hillingdon Hospitals NHS Foundation Trust	52	0
The Lewisham Healthcare NHS Trust	40	0
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	56	2
The Princess Alexandra Hospital NHS Trust	52	2
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	18	0
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	4	0
The Rotherham NHS Foundation Trust	11	0
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	41	1
The Royal Marsden NHS Foundation Trust	13	0
The Royal Orthopaedic Hospital NHS Foundation Trust	16	0
The Royal Wolverhampton Hospitals NHS Trust	79	2
The Walton Centre NHS Foundation Trust	8	1
The Whittington Hospital NHS Trust	31	2
Torbay Care Trust	31	1
Tower Hamlets PCT	33	0
Trafford Healthcare NHS Trust	7	0
Trafford PCT	11	0
United Lincolnshire Hospitals NHS Trust	97	2
University College London Hospitals NHS Foundation Trust	108	2

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
2	1	0%	0%	100%
0	0	-	-	-
2	4	100%	0%	0%
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	1	100%	0%	0%
0	0	-	-	-
2	1	0%	0%	100%
0	2	50%	50%	0%
1	1	100%	0%	0%
2	0	-	-	-
1	0	-	-	-
1	0	-	-	-
0	0	-	-	-
1	0	-	-	-
1	2	50%	0%	50%
0	1	100%	0%	0%
0	0	-	-	-
1	2	50%	50%	0%
0	1	100%	0%	0%
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	1	0%	0%	100%
0	4	50%	50%	0%
1	3	67%	0%	33%
0	0	-	-	-

	Complaints received	Complaints resolved through intervention
University Hospital of North Staffordshire NHS Trust	58	2
University Hospital of South Manchester NHS Foundation Trust	23	0
University Hospital Southampton NHS Foundation Trust	51	0
University Hospitals Birmingham NHS Foundation Trust	75	1
University Hospitals Bristol NHS Foundation Trust	63	2
University Hospitals Coventry and Warwickshire NHS Trust	61	4
University Hospitals of Leicester NHS Trust	79	3
University Hospitals of Morecambe Bay NHS Foundation Trust	71	1
Unknown	1,939	0
Wakefield District PCT	21	0
Walsall Healthcare NHS Trust	17	0
Walsall Teaching PCT	8	1
Waltham Forest PCT	40	2
Wandsworth PCT	31	2
Warrington and Halton Hospitals NHS Foundation Trust	35	1
Warrington PCT	14	3
Warwickshire PCT	38	0
West Essex PCT	23	0
West Hertfordshire Hospitals NHS Trust	64	0
West Kent PCT	43	0
West London Mental Health NHS Trust	38	0
West Middlesex University Hospital NHS Trust	31	0
West Midlands Ambulance Service NHS Trust	23	0
West Midlands Strategic Health Authority	18	0
West Suffolk NHS Foundation Trust	17	0
West Sussex PCT	84	4
Western Cheshire PCT	18	1
Western Sussex Hospitals NHS Trust	44	1
Westminster PCT	41	0

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
5	2	0%	100%	0%
1	1	100%	0%	0%
2	2	50%	0%	50%
3	1	0%	100%	0%
2	1	0%	100%	0%
1	2	50%	50%	0%
3	4	25%	50%	25%
7	5	80%	0%	20%
0	0	-	-	-
3	3	100%	0%	0%
0	0	-	-	-
0	1	0%	100%	0%
0	0	-	-	-
0	2	50%	0%	50%
1	2	0%	50%	50%
1	0	-	-	-
2	0	-	-	-
0	0	-	-	-
3	8	50%	13%	38%
3	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
1	1	100%	0%	0%
0	0	-	-	-
1	3	67%	33%	0%
2	1	100%	0%	0%

	Complaints received	Complaints resolved through intervention
Weston Area Health NHS Trust	40	0
Whipps Cross University Hospital NHS Trust	54	1
Wiltshire PCT	56	0
Wirral Community NHS Trust	1	0
Wirral PCT	17	0
Wirral University Teaching Hospital NHS Foundation Trust	29	1
Wolverhampton City PCT	17	0
Worcestershire Acute Hospitals NHS Trust	51	0
Worcestershire Health and Care NHS Trust	17	0
Worcestershire Mental Health Partnership NHS Trust	10	0
Worcestershire PCT	49	3
Wrightington, Wigan and Leigh NHS Foundation Trust	31	1
Wye Valley NHS Trust	26	0
Yeovil District Hospital NHS Foundation Trust	6	0
York Teaching Hospitals NHS Foundation Trust	48	2
Yorkshire Ambulance Service NHS Trust	19	2
Yorkshire and The Humber Strategic Health Authority	5	0
Grand Total	**16,337**	**399**

Complaints accepted for investigation	Investigated complaints reported on %	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
3	1	0%	100%	0%
1	1	100%	0%	0%
1	3	67%	0%	33%
0	0	-	-	-
0	0	-	-	-
3	1	100%	0%	0%
0	2	100%	0%	0%
3	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
1	0	-	-	-
2	0	-	-	-
0	0	-	-	-
1	0	-	-	-
0	0	-	-	-
0	0	-	-	-
400	**375**	**60%**	**19%**	**21%**

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