Parliamentary and Health Service Ombudsman

The NHS hospital complaints system

A case for urgent treatment?

Published April 2013

We are the Parliamentary and Health Service Ombudsman

We help resolve complaints about the National Health Service, government departments and other public organisations.

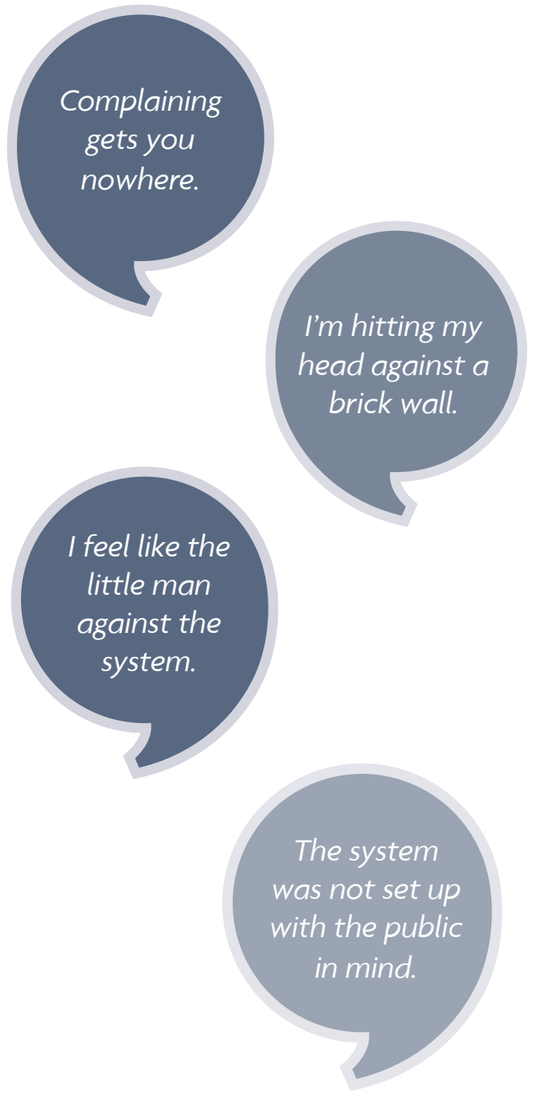
We are the final step in the NHS complaints process. People generally come to us after the NHS has failed to address their concerns.

Our role as an Ombudsman service is to listen to the human stories - to the experiences of individuals and their families. We make judgments on their complaints and help get things put right if they have gone wrong.

We share insights from our casework with others.

We work with others to use what we learn from complaints to help them make public services better and we lead the way to make the complaints system better.

What people say to us about the public services complaints system



Our Principles of Good Complaint Handling

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

These are the principles we use when we investigate a complaint to determine whether it has been handled appropriately.

They should be the starting point for effective complaint handling. You can see more detail at www.ombudsman.org.uk.

Foreword from the Ombudsman

'By tracing a pathway of the patient experience through the complaints system, we can see where things need to be put right - from ward level to board level.'

Dame Julie Mellor, DBE

The NHS provides a great service for thousands of people every day. But sometimes things go wrong. When this happens, how people and organisations deal with it determines whether confidence and trust in the service has been restored.

A good response to concerns and complaints can deliver two things. It can ensure justice for patients and their families. It can also ensure that learning takes place and the quality of service improves so that the same mistakes do not happen again.

The *Francis Report* on the inquiry into the failings in Mid Staffordshire hospitals uncovered shocking standards of basic clinical care and management. But it also highlighted serious failures with the complaints process and the performance of the Trust Board. The report said: *'It* [the Board] *did not listen sufficiently to its patients or its staff or ensure the correction of deficiencies brought to the Trust's attention ...'* .

When it comes to dealing with dissatisfaction and complaints Mid Staffordshire is not an isolated example. We know from our investigations that there are many other hospitals that are failing to respond well to concerns and complaints. Last year (in 2011-12) we saw an increase in complaints where NHS hospitals had failed to acknowledge mistakes or provide an appropriate solution when things go wrong.

Around 10% of all formal complaints about the health service come to us to be resolved. The scope and breadth of our work gives us a unique perspective on what is wrong with the complaints process within the health service and how best to put things right. There are serious flaws at each stage of the journey that patients, their families and carers experience as they try and achieve a response to their complaints.

This report brings together lessons learnt from the thousands of cases that have been brought to us over the past five years by individuals who were unhappy with the way their complaints were handled by the NHS. It offers our perspective on what is wrong with the complaints system. We know the process can be overly bureaucratic and impersonal, clashing with the needs of the unwell patient who simply wants to be heard, understood and have things put right simply and quickly.
By tracing a pathway of the patient experience through the complaints system, we can see where things need to be put right - from ward level to board level.

Dame Julie Mellor, DBE
Health Service Ombudsman
April 2013

The patient experience journey

'If the doctors had listened to our concerns and noted all the symptoms we had told them of, this may have given him a chance of survival.' Parents whose son with severe learning disabilities died after complications following the removal of a tumour.

'I feel like the little man against the system.' Potential complainant.

One woman was advised to complain in writing about concerns that her mother was not being washed or helped to go to the toilet in hospital. She was told her complaint would be acknowledged within 28 days. *'My mum could have died in that amount of time,'* she said.

'I am not happy with the response I received from the Trust ... Out of the 34 questions I sent them, many were either not fully answered or completely ignored.' Letter to us.

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

'She did not feel reassured that the Trust had valued her complaint as a learning opportunity. Instead, it was defensive and unwilling to take responsibility for the issues she raised.' Letter to us from an advocate, on behalf of a patient.

Putting things right

When things go wrong on the ward, immediate listening, responding and action to put things right by staff at all levels can prevent formal complaints.

Access

If matters cannot be put right straight away, it can be difficult for patients to find out how or where to complain.

Process

The formal complaints process can be long-winded and bureaucratic.

Response

Patients often feel they do not receive clear or adequate explanations in response to their complaints.

Last year, complaints to us about inadequate responses to complaints rose by 13%.

Leadership

NHS Boards which do not look regularly at complaints miss important feedback on the quality of service they provide.

Learning

Patients often tell us they do not want anyone else to suffer the same experience, but 64% do not believe complaining will make a difference.

NHS organisations need to learn from complaints and take action to prevent mistakes being repeated.

Signposting

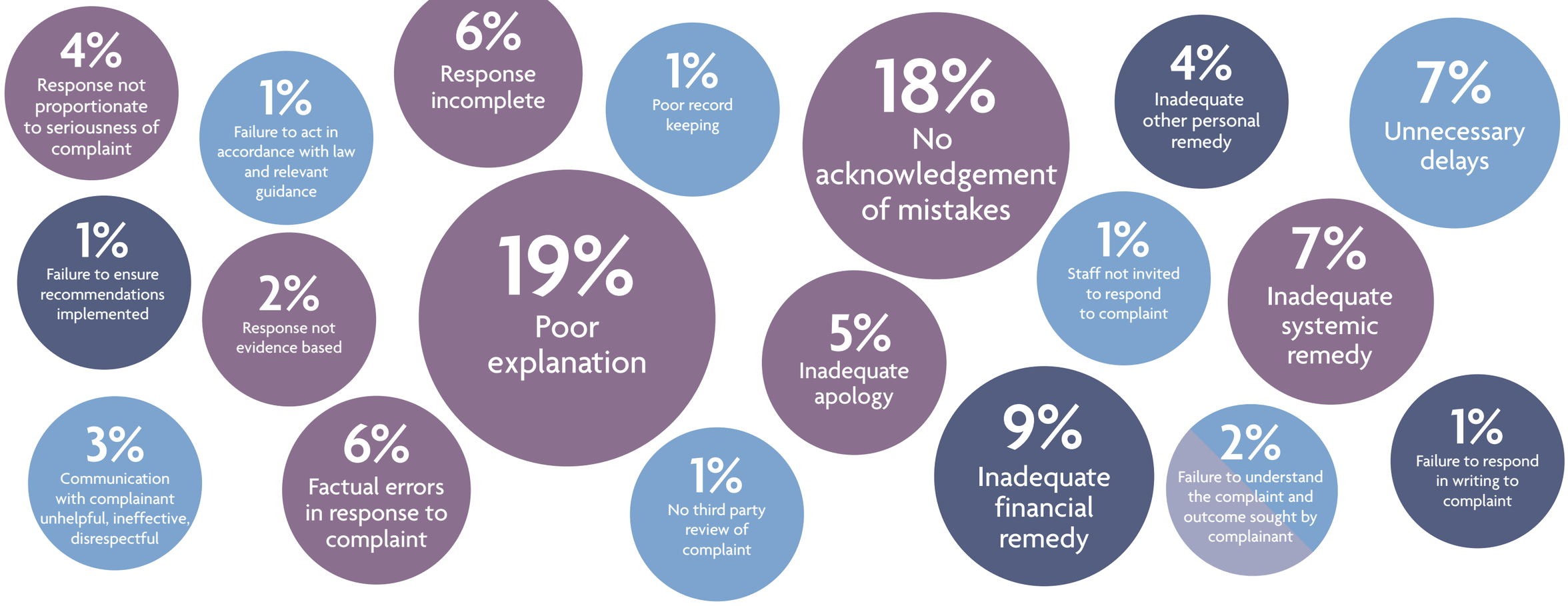
45% of people who want to make a complaint about public services are not told about the Ombudsman.

What people complain about

Reasons for complaints about NHS hospital complaint handling in 2012-13*

Leadership and learning are essential throughout the patient journey

- Putting things right
- Access
- Process
- Response



* Figures from April 2012 - February 2013

Failures in access and process

Making it easier to make a complaint

'I might have pursued it further if a complaint form had been offered, or if I had been given advice of the "how to and who to complain to" variety ... Some of the reception staff are very brusque and fail to make eye contact. It is as if it is such an everyday occurrence that it is not worth their while bothering to explain or take it further.'

What a person with cognitive impairment told us in one of our surveys.

Our case files contain many examples of failures in the way hospitals handle complaints.

The first task for anyone wishing to complain is to try and get the problem sorted out within the hospital. All NHS hospitals must have systems for complaint handling, but in practice we find many staff are unaware of this or do not follow procedures. In one of our cases, for instance, a complainant was told '*there is no complaints department*'. Many of the people who come to us to resolve issues with hospitals have been frustrated, exasperated and drained by the whole complaints process.

Inadequate complaint handling systems mean missed opportunities to learn from mistakes and make public services better. We see a link between those hospitals most complained to us about and those that have been in the spotlight for governance or service concerns.

Poor hospital complaint handling can be an indicator of more substantial problems.

These are the failings in access and process:

- Not listening to patients or responding when things go wrong on the ward.
- Not attempting to put things right when mistakes occur.
- Patients not being told how to complain.
- Staff either not knowing about the complaints procedures or, if they do, failing to follow them properly.
- Staff failing to share information openly with patients and relatives.
- Poor communication between hospitals and other providers of health and social care.
- Patients and their families treated insensitively and without compassion.

Mother kept waiting for apology

Mrs V was admitted to the maternity unit at a hospital in north London. During labour she was given intravenous antibiotics in her arm incorrectly (the drug had been insufficiently diluted by the midwife) which made her arm red, swollen and painful. Although the midwife took remedial action, the symptoms lasted for six weeks.

Mrs V complained to the Trust saying that she had suffered unnecessary stress during a crucial part of her labour. Although the Trust agreed to review their drug policy, Mrs V asked for a meeting to discuss the matter, which took 39 weeks to arrange. In her view they had taken an unacceptable length of time to produce an unconvincing conclusion with no evidence of the lessons learnt.

Our investigation showed that the Trust's response provided inaccurate information and that staff had not complied with the drug administration policy. We found that the doctor had not followed procedures, the facts had not been clearly established and wider system problems had not been identified.

Following our recommendation, the Trust reinvestigated the incident and formulated an action plan to prevent a similar incident happening again.

Failures in communication and responsiveness

Making sure that patients are told what is happening

'Not consulting my father or I was both disempowering and insensitive ... The deeper the investigation went the more discrepancies became apparent. I was concerned that other elderly people might encounter similar experiences and would like to prevent more serious outcomes for those who do not have relatives to advocate on their behalves.'

Daughter of an elderly man who complained about his treatment in hospital.

Failings in communication and inadequate responses are two of the most common causes of complaints - a recurring theme in a large number of our cases. It should be so simple just to apologise when things go wrong. The NHS Litigation Authority clearly states that '*Saying sorry is not an admission of liability and it is the right thing to do*'. Yet so often this does not happen. In some cases, people are provided with information which turns out to be incorrect, or occasionally are even lied to.

But there are also failings in basic humanity - one of the most disturbing findings from the *Francis Report*. The lack of basic care and compassion by medical and care staff is something that we have highlighted in our reports.

We are concerned about the examples we see, time and time again, of careless communication, insincere apologies, lack of courtesy and unclear explanations. In one case a hospital responded to a grieving relative by writing: '*Death is rarely an ideal situation for anyone ...*' .

These are the failings in communication and responsiveness:

- Failure to deal with patients and families with compassion and sensitivity.
- Not keeping relatives and friends informed about what is happening.
- Providing complainants with inaccurate or incomplete information.
- Not admitting when mistakes have been made and not attempting to put things right.
- Failure to convey apologies in the appropriate language with sincerity and tact.
- In a few cases, blatant attempts to cover up mistakes or falsify records.

Misleading information given to the parents of a stillborn baby

Mr and Mrs D, the parents of a stillborn baby, complained to a hospital about the failures in maternity care. Their concern was that Mrs D should have been treated as a high-risk pregnancy because of her age (she was 36), high body mass index, history of depression and epilepsy.

When they complained to the hospital Mr and Mrs D were dismayed with the response they received. The hospital admitted it had identified a number of shortcomings in Mrs D's care, but was unable to say whether the baby would have survived. Although it paid the couple £30,000 in an out-of-court settlement, it made no defence with regard to breach of duty or causation and failed to provide accurate information about what happened. Mr and Mrs D were not happy with the response.

So the couple approached us. Our report found that guidelines for women with risk factors were not in practice, guidelines for women with epilepsy were not in circulation, and electronic foetal monitoring was not performed as it should have been. We found that the hospital trust had made inaccurate and '*highly misleading*' statements to Mr and Mrs D, failed to provide accurate evidence-based explanations and did not acknowledge their mistakes or apologise for them. We ensured that the hospital acknowledged and apologised for its failings and put together a plan and timescale to put things right.

Mrs D said that when she learnt the Ombudsman's verdict:

'*I collapsed in a heap. I broke down in tears. This was the first time that the evidence provided to all regulators and organisations had been interpreted correctly. To think any couple could go through what we went through makes me shudder.*'

Failures in leadership and learning

Making sure that hospital boards learn from their mistakes

'I was disgusted that a dying man was left in a chair for almost a month, with no one ever trying to make him comfortable in bed, no one relieving his pain adequately, checking for pressure sores or ensuring he ate or drank ... When I first started the complaints procedure I felt the hospital completely ignored me.'

Daughter who complained about treatment of her elderly father in an NHS hospital.

Failures to provide basic care and communicate effectively with patients and their families can flag up systemic problems in hospitals, as we have seen in the Mid Staffordshire hospitals.

If the necessary changes are to happen, this needs to start with the board. Not all hospital boards are taking complaints seriously enough and some adopt a defensive response when confronted with service failures. Sometimes board members are not given useful or adequate information about complaints and failings in patient care. Simply providing bare statistics is not good enough, although these are important in monitoring trends. A patient-centred NHS means that boards need to learn from the experience of patients and then take action to make improvements in services.

For us, questions are raised about leadership and learning at trusts rated 'red' by Monitor for governance and about whom we receive and uphold a high proportion of cases. Our analysis of complaints for each trust can be seen in our *Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England*, and trust governance ratings are available on Monitor's website.

An alleged assault - the result of a flawed investigation

A woman with a borderline personality disorder, known as Ms J, was attending a therapy session at a mental health trust in the west of England. When she became distressed and went into a nearby room to lie down on the floor, a clinician called in two security guards to remove her. One of them allegedly kicked her.

The Trust took nearly a year to respond formally when Ms J complained. Our investigation uncovered serious flaws in their investigation. The Trust had not taken statements from all the key witnesses, nor sought advice about the wisdom of calling in security guards.

Ms J said: *'It was bad enough being kicked by a security guard. It has now all been made even worse by a very unsatisfactory complaints process.'* Following our recommendations, the Trust apologised to Ms J for the distress caused, paid her compensation, agreed that their executive board would consider our investigation report and agreed to commission an independent review into their complaint handling function.

From ward level to board level

'A poor complaints system has a negative impact on the patients and others who seek to use it. Inadequate responses cause distress and may exacerbate bereavement.'

From the final report of the Mid Staffordshire NHS Foundation Trust Inquiry (6 February 2013), chaired by Robert Francis QC.

What needs to change

Improvements are neeeded in governance, records, accountability, standards and practice.

Governance

If complaints are to have an impact, this needs to be led at board level. Hospital boards need to understand what good practice looks like and identify the levers that will drive good practice into the organisational culture. They also need to appreciate the perspectives of staff, patients and their families. The questions boards should be asking are not simply about the number of complaints. They should be considering the subject matter of complaints and listening to patients' stories. They should be checking the necessary actions are taken to resolve issues. The leadership role of chief executives should include overseeing complaints, ensuring the quality of responses and being open and honest about learning from mistakes.

Records

Keeping accurate records is essential in order to learn from the volume and nature of complaints and people's experiences of complaining. Records will enable benchmarking against other organisations. If this happens then governors, staff and patients can be told what has changed and improvements can be monitored.

Accountability

Accountability for complaints must run from ward level to board level. There should be clarity around who is responsible for listening and putting things right from ward to board level. Trusts should make their complaint handling an integral part of how they report progress to patients, their carers and families, governors, commissioners and regulators. Only by making complaints everyone's business can we make progress.

Standards

We have set out our Principles of Good Complaint Handling (page 3). They include being customer focused, being open and accountable, acting fairly and proportionately, seeking continuous improvement and, above all, putting things right. When a complaint comes to us, these principles are the criteria we use to assess whether something has gone wrong. They should be just the starting point for any complaints process. Setting clear expectations of complaint handling across the organisation and measuring performance against them is essential.

Practice

Dealing with issues as they arise is best for the patient and the hospital. There are areas of practice where our analysis of complaints points to room for improvement. Hospitals need to ensure staff at all levels have the skills to listen to patients, learn from them and put things right. They need the confidence and humility to say 'sorry' in a meaningful way and nurture a culture of openness at all levels. This needs to extend from reception and administrative staff, to doctors and nurses, to chief executives and non-executive directors. Accreditation for complaint handlers could help drive up the quality of practice.

What we are changing

From April 2013 we are increasing the number of cases we investigate and sharing the learning from these cases widely, with government, health professionals, regulators and the general public. This change of approach is a result of listening to Parliament, the public and NHS organisations. It is part of the new strategy we agreed in 2012 to achieve more impact for more people. We want to ensure that people feel confident that there is an independent Ombudsman service available to them if they are not satisfied with the response to their complaint at a local level.

Our agenda for change

We will work with the NHS and other organisations to share the insight our cases give us to help improve the hospital complaints system. We are undertaking research to find out more about the governance of complaint handling in the NHS. We are also working with a range of partners, NHS staff and patients to research what good practice looks like for NHS hospital complaints. We are sharing the results of this as part of our work and using what we learn from complaints to lead the way to make the complaints system better. This will be fed into the Clwyd and Hart review of NHS hospital complaint handling. Our ultimate goal is to make good practice commonplace.

References

The report of the Mid Staffordshire NHS Foundation Trust Inquiry, chaired by Robert Francis QC (2013)

Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman 2009)

Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England (Parliamentary and Health Service Ombudsman 2011-12 and 2010-11)

Care and compassion? Report of the Health Ombudsman on ten investigations into NHS care of older people (Parliamentary and Health Service Ombudsman 2011)

Six Lives: the provision of public services to people with learning disabilities (Parliamentary and Health Service Ombudsman 2009)

Remedy in the NHS (Parliamentary and Health Service Ombudsman 2008)

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