healthwatch


# Shifting the mindset

A closer look at hospital complaints
January 2020

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# Foreword - Sir Robert Francis QC

It is almost seven years since the conclusion of the public inquiry into the serious failings at Mid Staffordshire Foundation Trust.

In the final report of that inquiry, I was clear that improving processes for dealing with complaints should be a priority for the NHS. Ensuring that the learning from complaints is implemented and that the outcomes are shared with the public is essential, and ultimately is key to preventing similar failures in the future.

The conclusions of the inquiry were universally welcomed across the sector and many of the recommendations have been carried out. A series of sector-wide improvement initiatives have brought people, organisations and national bodies together to set out clear expectations for how the complaints system should work.

The data being collected and published about NHS complaints has also seen improvement since the inquiry in 2013. NHS Digital now publishes complaints data on a quarterly basis, breaking things down by theme, provider and service area. This gives a better sense of what sort of problems are arising, and where.

Yet we also know that people still do not always have the confidence to speak up when something goes wrong. *Research* by the Care Quality Commission showed that more than a third of people believe that nothing will change even if they do complain. This means that a significant proportion of people who have concerns about their care may never raise them. This must change.

To us at Healthwatch the solution is clear. Four in five people *have told us* that seeing where other people's complaints have made a difference would encourage them to make their own voice heard in future. The NHS needs to step up efforts to show people what it is doing with their complaints and the direct improvements that happen as a result. This is not just about feeding back to individual complainants but ensuring that all patients understand how their views are leading to change.

Getting this right will require a mix of local action and national leadership. To help drive this forward, we have taken a closer look at what hospitals trusts in England are currently reporting about complaints. What we have found should serve as a reality check to all levels of the system.

Learning from complaints may well be happening but, as a member of the public, it is hard to see. For staff and organisations too, the fact that learning is not being consistently shared means the NHS as a whole cannot systematically learn from when things go wrong.

We know most people who make a complaint don't do it in search of compensation or retribution. People *are motivated* by a desire to make sure health and social care improves for others. So, let us all respond to that in good faith. Let us work together and ensure everyone can see the value in speaking up when care doesn't meet the high standard we have all come to expect from our NHS.

# Introduction

An effective complaints system is a vital part of high-quality health and social care, helping services and individuals learn how to do things better when things don't go according to plan.

For people to speak up about their concerns, they need to be confident the system will act in response. In order to build trust the NHS needs to consistently demonstrate that they are taking people's complaints seriously.

This report investigates how well NHS hospital trusts across England communicate about their work on complaints and whether current efforts are sufficient to build that public trust.

Under the regulations, every hospital is required to collect and report on the number and subject of complaints, how many of them were upheld, and what action was taken as a result. We have looked at all the reports we could access to assess the level of compliance with the current regulations. We have also considered whether current reporting is in line with the spirit of the legislation as well.

This briefing presents our findings and sets out recommendations for improvement in the complaints handling and management system at a national and a local level.

People need to feel confident that their voice will be heard.

**An 83-year-old woman called to share her concerns about the care she had received at her local hospital. She told us that she was not helped to wash for five days and that her discharge from hospital was significantly delayed because no one was available to escort her to a simple pre-discharge check.**

**The caller said: "Everyone was too busy. Nobody had the time to co-ordinate my care. I don't want to complain formally - just to tell someone, so this does not happen to anyone else".**

A personal story shared with Healthwatch Northumberland

# What we did

To find out what hospitals are learning from complaints, we searched the websites of 149 NHS acute trusts in England and looked for substantive reporting on complaints.

Initially, we looked for whether complaints were dealt with in the trusts' general annual reports.

We also searched for stand-alone complaints reports or information on complaints in other trust publications or board papers.

We checked the reports against each of the key elements set out as essential to complaints reporting in the *statutory regulations*.

We also looked for reporting of data on informal complaints and concerns handled by the hospital's Patient Advice and Liaison Service (PALS) team.

We gave each trust a 0-3 rating for the level of transparency they had demonstrated in their reporting and the quality of learning from complaints they had evidenced.

# Key findings

### Local reporting on complaints is inconsistent and inaccessible

- All hospital trusts are reporting to NHS Digital on the numbers of complaints they receive; however, only a minority of trusts report any more meaningful data at a local level.
- Our analysis shows just 1 in 8 hospitals trusts (12%) are demonstrating that they are compliant with the statutory regulations when it comes reporting on complaints.

### Staff are not empowered to communicate with the public on complaints

- All hospitals must produce an annual statutory complaints report but they are only required to make it available to people upon request. Yet we found that hospital complaints staff were often not aware of the reports or who could access them.

### Reporting focuses on counting complaints, not demonstrating learning

- Only 38% of trusts make public any information on the changes they've made in response to complaints.
- Much of this reporting is still only high-level, telling us little detail about what has changed and only stating that "improvements were made".

# How are hospitals reporting on complaints?

All hospitals are required to publish data on the number of complaints they receive via NHS Digital, but for the purposes of this research we wanted to see if trusts are publishing more detail locally.

We searched trust websites for data on how many complaints they had received, the types of complaints and how they learn from them. We checked for this information in all major trust publications.

Here's where we found the evidence:

| Location | Number of trusts reporting | Percentage (n=149) |
|---|---|---|
| **Total reporting on complaints in at least one location** | **126** | **85%** |
| Trust annual report | 104 | 70% |
| Stand-alone complaints report | 24 | 16% |
| Quality account | 10 | 7% |
| Board papers | 3 | 2% |
| Other | 3 | 2% |

Note: Some Trusts reported in more than one location so percentages do not add up to the total.

- Most trusts reported on complaints in their annual reports. However, of the 104 trusts that included information on complaints in their annual reports, 39 included only the total number of complaints received and/or referred to PHSO (Parliamentary and Health Service Ombudsman), with little or no further detail.

  This means that only 65 (44%) trusts included any meaningful information in their annual reports about the types of complaints they received and how they dealt with them.

- Some of the trusts that reported only on the number of complaints in their annual report referenced the existence of additional complaints reporting in other sources, like quarterly patient experience reports or board papers. However, in many cases we were unable to locate these documents.

- The statutory annual complaints reports we found contained the most detailed information about trends and learning from complaints, but the regulations do not require trusts to publish these reports. We were able to locate stand-alone complaints reports for only 16% of trusts.

## How easy was it to access complaints reports on request?

Although trusts are not required to publish their complaints reports, the regulations state that reports should be made available to "any person on request".

To test how easy it is to get hold of these reports, we contacted 15 randomly selected trusts where we had been unable to find the documents on their website.

Where we were able to get through on the phone, staff were often not aware of the existence of an annual complaints report or were unclear about how to locate it. They were also not clear whether the public had a right to access it.

In several cases we were advised to submit a Freedom of Information (FOI) request to access the report. We followed up with an FOI request to one of these trusts, but never received a response. Some hospitals asked us to submit the request in writing, which we did, but did not receive a reply in most cases.

Of the 15 trusts we contacted, only four provided us with the annual complaints report upon request.

### An example of good practice

Maidstone and Tunbridge Wells NHS Trust has a *"complaint outcomes" page* on its website, where a series of detailed case studies explain exactly how the complaints procedure works from a patient perspective and how issues and concerns raised by patients and their families have been resolved.

The trust's *annual complaints report*, which is publicly available, also includes a table with details of every formal complaint closed by the trust over the preceding year with detailed notes about what happened, what went wrong and what was done to resolve the complaint.

## Are trusts complying with complaints regulations?

The way hospitals should report on complaints is set out in the *Local Authority Social Services and National Health Service Complaints (England) Regulations 2009*.

We looked at what hospitals are publishing against five of the key elements of the regulations:

1. the number of complaints received;
2. the number of complaints which are upheld (i.e. accept that something has gone wrong);
3. the number of complaints referred to the PHSO;
4. the subject matter of complaints;
5. where action has been or will be taken to improve services as a consequence.

We excluded a sixth regulation - 'matters of general importance arising from the complaints' -because it was not clear how this should be addressed and none of the reports referenced it directly.

Here's what we found:

| Location | Number of Trusts reporting | Percentage (n=149) |
|---|---|---|
| Number of complaints | 111 | 74% |
| Complaints upheld | 35 | 24% |
| Referred to PHSO | 72 | 48% |
| Subjects/themes of complaints | 69 | 46% |
| Action taken to improve services | 56 | 38% |

In total, three in four hospital trusts (74%) reported on the number of complaints. Yet only two fifths (38%) provided any information about the action that they've taken to improve services as a result.

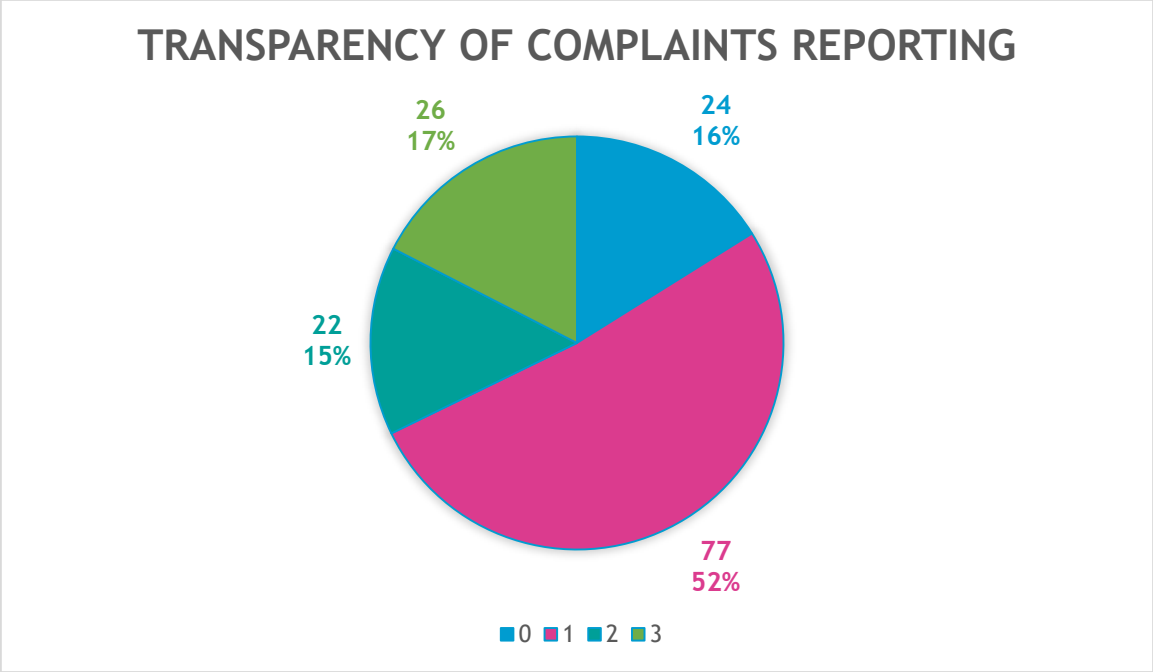
Because the regulations don't require trusts to publish their annual complaints reports, we can't know for sure how many of them are fully compliant with the regulations. However, based on publicly available documents, only 18 hospital trusts (12% of those we were able to review) were fully compliant based on the regulations outlined above.

## How transparent are trusts?

We gave each trust a score from 0 to 3 for the transparency of their reporting on complaints based on the following methodology:

- 0 – No local reporting on complaints located.
- 1 – Includes only total number of complaints or may include basic breakdown of complaints by subject area (e.g. listing top three categories or an un-numbered bar chart) but missing other key data.
- 2 – Includes breakdown of number of complaints by subject area and numbers referred to PHSO, but data is either inaccessible or includes only a limited number of subject categories.
- 3 - Includes full and detailed breakdown of complaints in each category. This covers trusts who have provided additional information like response rates, comparisons with previous years, etc.

Here's what we found:



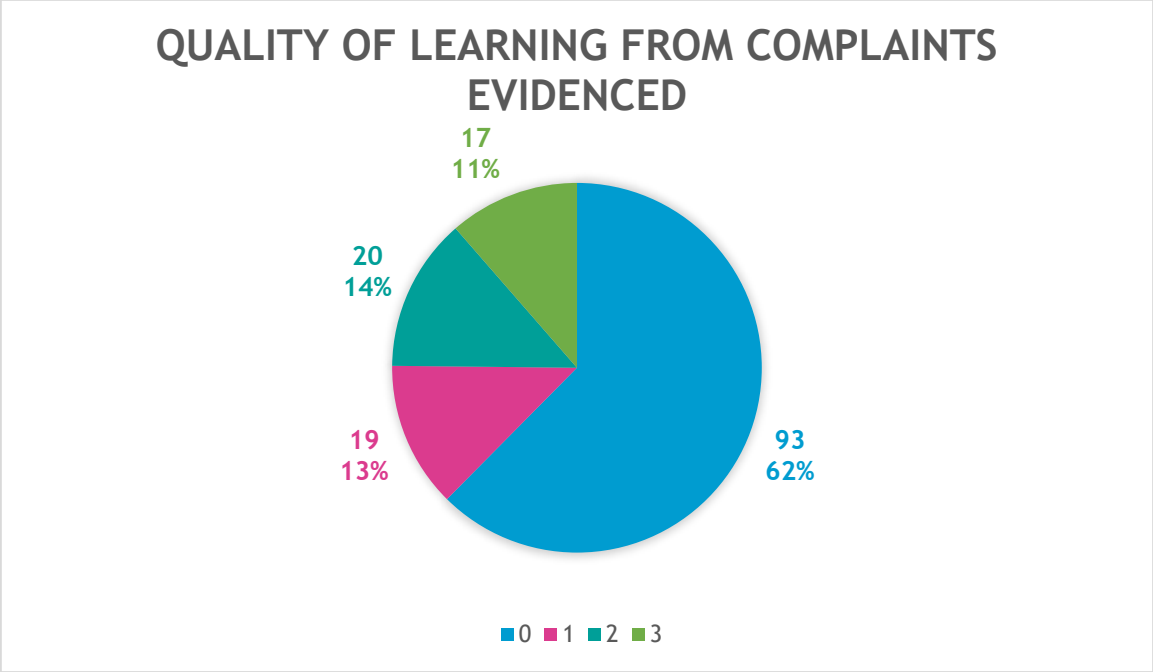

Fewer than two trusts in 10 met our expectation for a high level of transparency in reporting on complaints. Most trusts make only the bare minimum information available.

## How well do trusts set out what they are learning from complaints?

We gave each trust a score from 0 to 3 for the quality of their evidence on how they have improved as a result of complaints, based on the following methodology:

- 0 – No learning from complaints located
- 1 – Includes general statements of improvements made to service areas without reference to the content of complaints or specifics (e.g. "communication systems were improved on the ward").
- 2 – Includes a limited selection of "you said, we did" examples or a breakdown of actions taken by category (e.g. "25 complaints resulted in an audit/review of practice"; "16 complaints resulted in new equipment or infrastructure").
- 3 – Includes comprehensive evaluation of learning across most categories, including discussion of complaint topics, their general significance for the trust, and concrete and specific examples of changes made.

Here's what we found:




Most trusts do not report publicly on learning from complaints. Only 17 (11%) of trusts included detailed and comprehensive examples of learning from complaints in any public document that we were able to locate.

### How well do trusts think they report on learning from complaints?

Earlier this year, we asked hospital trusts a series of questions about their handling of complaints through a Freedom of Information request. In total we had responses from 120 trusts, with 78% telling us that they publish outcomes or learning taken from complaints.

Worryingly, we were only able to find evidence of reporting on learning from complaints for 38% of trusts. This shows that although trusts may believe they are demonstrating learning, this information is not actually accessible to the public.

## Is the language of complaints causing confusion?

The current terminology around complaints is creating inconsistency. In particular, we found trusts reporting on complaints differently depending on:

- Whether or not the trust was found to be at fault or not (upheld v not upheld)
- Whether the complaint was made through a formal or informal route
- Whether the complaint was made by the patient themselves or a third party.

### Does the upheld or not upheld classification work?

Currently, trusts are expected to report on whether each complaint they receive has been upheld or not, i.e. whether sufficient evidence has been found to support the allegation made in the complaint. Yet our findings show that only 1 trust in 4 (24%) is including this

information in its reporting, significantly lower than other elements set out in the regulations. The reason for this is not clear.

However, the distinction between 'upheld' and 'not upheld' is not always helpful. Terminology which requires complaints staff to 'rule' on whether mistakes were made can encourage a culture of blame and defensiveness. Even where cases are not upheld there are often still opportunities for learning, and it is important trusts do not leave the patients involved feeling dismissed.

### Should formal and informal complaints be recorded in the same way?

Hospitals use the term 'concerns' to describe informal contacts that have been made with the Patient Advice and Liaison Service which are not escalated to a formal complaint. Our review of trust documents found that fewer than half (43%) of all trusts reported any information on the concerns logged by their PALS teams.

As with formal complaints, a significant proportion of those who reported on PALS concerns published only the total number of concerns raised and did not accompany this with any analysis or reflection on learning. By imposing a distinction between formal complaints and informal concerns there is a possibility that opportunities to learn will be missed.

## Are third party complaints being considered?

We asked hospitals via an FOI request about how they deal with third party complaints. This could include members of the public, people visiting patients or external contractors who have concerns about how patients are being treated or cared for. In total 120 hospital trusts responded.

When asked whether they record complaints made by third parties who don't have the express consent of the patient(s), 69% of trusts said they do, but nearly a third (31%) didn't. This represents only a slight change *from 2014*, when 37% said they did not record these cases.

We also asked whether trusts included third party complaints in official figures as reported to NHS Digital, and found that only 65% of trusts do, while 35% do not.

Jane tells us how she felt more people would speak up if they believed their complaint would be taken seriously.

**When waiting in A&E with her mother, Jane witnessed an elderly man being discharged around midnight, who subsequently continued to wander in and out of reception, looking vulnerable and confused. After watching him walk into the middle of the road, Jane and another bystander decided to pay for him to get a taxi after being concerned for his safety. She felt the hospital had a responsibility to offer him support – and they didn't.**

**Despite feeling that a patient had been treated poorly, she worried it was "not her business" to make a complaint which might affect hospital staff negatively.**

**Reflecting on her experience, Jane said: "I'm ashamed I didn't make a fuss then and there. I didn't contact PALS because I didn't trust that they would take my complaint seriously.**

**"In my experience, most people who complain are trying to stop something similar happening to others. The opposite seems to be assumed, so if you have concerns and try to raise them, you'll be asked whether it's a close relative you're concerned about, and if it isn't, you can't complain.**

**"We need a complaints system which ensures individual cases contribute to addressing systemic issues. Healthwatch does some of this work, but it should be embedded at every level."**

A personal story shared by Jane with Healthwatch Northamptonshire

## A closer look at who complains

National data on hospital complaints tells us little about who complains. Currently, age is the only individual characteristic included in the NHS Digital data collection, and this is only reported in broad age brackets which are not comparable (18-25, 26-55, 56-64).

When we looked at local complaints reporting, we expected to find more detail. We did locate detailed demographic data in some of the stand-alone statutory reports but very few trusts overall published information about who is raising complaints.

As a minimum, we would have expected hospitals to be collecting demographic data based on the protected characteristics as set out under the Equalities Act 2010. This data is vital for monitoring equality of opportunity in speaking up about concerns.

## What reporting tells us about the complaints culture

In their annual reports and quality accounts, many trusts treated a lower number of complaints as an indicator of success and improvement. Trusts with relatively low numbers of complaints often highlighted this as evidence of high-quality care.

Indeed, many trusts which set priorities for improvement in their quality accounts use 'reduction in the number of complaints' as an indicator for improving patient experience.

But a higher number of complaints does not necessarily mean that quality of care is worsening. It could mean that people are more informed about how to complain and more confident that speaking up will make a difference.

Positive examples of trusts emphasising a welcoming approach to complaints:

- **Blackpool Teaching Hospitals stated in their *patient experience report:* "Whilst reduction of complaints is not necessarily an indicator of improvement, the severity of complaints received has lessened in the last 12 months".**
- **Northern Devon Healthcare Trust also stated in their *annual report:* "The combined complaints and PALS activity is a positive reflection on how patients and service users feel able to provide feedback on their experiences, which the Trust welcomes and encourages."**
- **Taunton and Somerset NHS Foundation Trust emphasised openness to complaints in their *annual report:* "The Trust takes concerns and complaints seriously. They are an important opportunity for the Trust to learn and improve. Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where complaints are welcomed and learnt from."**
- **Wrightington, Wigan and Leigh NHS Foundation Trust states in its *annual report:* "We welcome complaints to learn and reflect on how we work and to make the appropriate improvements. Whilst we provide an apology to our complainants, the following outlines actions taken, and lessons learned from a sample of complaints received."**

## Learning from complaints

Though the quality of evidence on learning from complaints varied, we found positive examples of demonstrating learning which are highlighted below.

- **In its *annual report*, Calderdale and Huddersfield NHS Foundation Trust provides examples of learning from complaints which state the specific complaint made, the hospital's findings about why the mistake was made and a detailed explanation of what changes have been made and the improvements they will make as a result.**

  **When describing learning from complaints, it goes beyond generalities. For example, instead of stating that, for instance, "communications to patients were revised and improved", it is specific about the improvement by saying "the standard letter template will be revised to inform patients that only one escort**

can stay in the room with the patient during the procedure and signs erected in the room informing patients of the one escort policy".

- In a section of its *complaints report* dealing with complaints made about staff behaviour, University College London Hospitals NHS Foundation Trust includes a section setting out factors which contributed to people making a complaint, e.g. "staff not introducing themselves or wearing a visible ID badge", "lack of rooms for private discussion in some areas". This type of analysis goes beyond the individual complaints made and identifies actions that can be taken proactively to avoid complaints being made in the future.
- Moorfields Eye Hospital NHS Foundation Trust has a patient-facing *page on its website* which sets out issues people have commonly complained about, and directs people to a 'you said, we did' page for each issue which sets out changes made recently and the trust's overall approach to improvement. Although these pages are an example of good practice, they need to be updated regularly – Moorfields has not updated them since 2017.

## How Healthwatch is helping

Many local Healthwatch have worked with their local NHS hospital trust to review how well the complaints system is working for patients and supported them to improve.

Healthwatch East Sussex provides one example of partnership working:

In September 2015, East Sussex Healthcare NHS Trust (ESHT) was placed in special measures following two Care Quality Commission (CQC) inspections with overall ratings of inadequate. The CQC inspection reports highlighted poor support for people who wanted to raise concerns and problems with the complaints handling process.

The trust and Healthwatch East Sussex agreed to work collaboratively on a series of projects aimed at strengthening ESHT's patient and public engagement and promoting a culture of openness and transparency aimed at demonstrating improvement. One of three key strands of this work was focused on the complaints system.

Healthwatch East Sussex supported specially recruited and trained volunteers who reviewed a random selection of complaints received by the trusts to scrutinise the process, and conducted a series of interviews with people who had been through the complaints process.

The trust then made a series of improvements to their complaints processes in direct response to the recommendations of the Healthwatch review. The complaints team began contacting all complainants over the phone to discuss the issues they wanted to raise and offer them the option of early resolution. Multidisciplinary processes were improved to speed up response times and inform clinical staff of issues raised through complaints to encourage a preventative approach.

The trust also committed to developing a Complaints Action Plan to follow up on the findings of the review and develop longer-term improvement goals.

Read their project report *here*.

# Recommendations

To give people confidence that speaking up makes a difference, we need a shift in mindset across NHS hospitals when dealing with complaints. Feedback from patients should be seen as an opportunity to learn and demonstrate improvement rather than an adversarial process to be managed and minimised.

This is not just about ensuring patients feel listened to. Building public confidence in the complaints system is the only way to encourage people to speak up and share concerns. This is a vital part of spotting potential patient safety issues before they develop and will ultimately help reduce avoidable harm and the need for the legal claims that come with such incidents.

The problems we have identified with the current complaints system are not new, but to date there has simply been insufficient action. Throughout the development of this report we have therefore been engaging with stakeholders to develop a series of recommendations that would help improve the quality and transparency in learning from complaints. Some of these will require local action and others require national leadership.

## Improving transparency

1. **All hospital trusts should publish regular complaints reports and ensure these contain details on learning and improvement taken as a result. This could be guaranteed by:**
    - The Department of Health and Social Care updating Regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations to require hospitals to publish complaints reports

- NHS England and Improvement requiring CCGs to monitor compliance with complaints regulations and intervene in local processes where necessary

2. **To improve public confidence in the complaints system, trusts should work to communicate learning from complaints with the public in more accessible ways,** e.g. through leaflets or physical 'you said, we did' display boards in the hospital.

3. **All trusts should collect demographic data, including information on all protected characteristics, as part of their complaints processes. This could be achieved by:**

   - The Department of Health and Social Care updating Regulation 17 of the Local Authority Social Services and National Health Service Complaints (England) Regulations to require collection of demographic information
   - NHS Digital requiring demographic data submission as part of the national dataset on NHS complaints.

   This would help facilitate local and national understanding of the equalities impact of complaints systems.

## Developing and supporting hospital staff/boards

4. **More should be done to empower complaints managers and staff (including communications teams) in hospitals to be proactive in demonstrating learning from complaints and transparency in reporting.**

   The implementation of a national complaints standards framework, such as the one currently being developed by the PHSO, is a positive step. This should be linked to local training to ensure staff understand the expectations set out in the framework. This could be supported through new professional accreditations for complaints managers.

   Good practice on complaints handling should also be included in wider staff training initiatives such as the universal patient safety syllabus.

5. **The national NHS Complaints Managers Forum, which has previously existed as a voluntary group, should be formally resourced and supported by NHSE/I.**

6. **NHS England/Improvement should work with trust boards to embed the Good Governance Institute's guidance on transparency around complaints.** This should be linked to consideration of how trusts can embed the 'Just and Learning Culture Charter' developed by NHS Resolution in their report *Being Fair*.

## A system-wide approach

7. **A single organisation should be empowered to act as a national complaints standards authority**, and tasked with developing national good practice, training and monitoring on reporting and learning from complaints. This function could be

performed by an existing national organisation - like the PHSO - with an expanded remit, or by a new body with the powers and responsibilities to provide leadership on complaints handling and reporting.

A standard method of reporting on learning from complaints should be developed and implemented across the NHS, not just hospitals, as part of this work. This should be aligned with the ambition set out in the NHS Patient Safety Strategy to develop a shared taxonomy for incidents, complaints and claims.

8. **While arrangements for a national complaints standards authority are being developed, the Department of Health and Social Care should consider commissioning an independent body to conduct a holistic review of the complaints system.**

9. **National organisations like NHSE/I and PHSO should lead by example in publishing detailed thematic analysis and learning from their own complaints processes.**

10. **National oversight of the complaints system should be linked to regional and local learning.** Thematic analysis of learning from complaints and concerns (including incidents and claims) should be conducted at ICS (Integrated Care System) level to enable proactive change across trusts and learning from local trends.

# About us

Healthwatch is the independent champion for people who use health and social care services. We exist to ensure that people are at the heart of care.

We listen to what people like about services, and what could be improved, and we share their views with those with the power to make change happen. We also help people find the information they need about services in their area.

We have the power to ensure that people's voices are heard by the government and those running services. As well as seeking the public's views ourselves, we also encourage services to involve people in decisions that affect them. Our sole purpose is to help make care better for people.

## Role of local Healthwatch

There is a local Healthwatch in every area of England. They provide information and advice about publicly-funded health and care services. They also go out and speak to local people about what they think of local care and share what people like and what could be improved with those running services.

They share feedback with us at Healthwatch England so that we can spot patterns in people's experiences and ensure that people's voices are heard on a national level.

# How to get in touch with Healthwatch

Healthwatch England
National Customer Service Centre,
Citygate, Gallowgate, Newcastle upon Tyne
NE1 4PA

Telephone - 03000 683 000 – between the hours of 08:30 – 17:30 Monday to Friday
Email – *enquiries@healthwatch.co.uk* / *policy@healthwatch.co.uk*
Twitter - *@HealthwatchE*
Facebook - *@HealthwatchE*

Making a complaint to Healthwatch England
You can find out about our complaints process *here*

If you want to find your local Healthwatch you can find them *online*.