Healthwatch Norfolk

Report on NHS Complaints Handling in Norfolk

July 2014
Introduction by Alex Stewart, Chief Executive

Following several reports published in the past 18 months, the handling of NHS complaints is clearly demonstrated as a very important and topical issue. Therefore Healthwatch Norfolk (HWN) identified a need to assess the NHS complaints handling in Norfolk. For the purposes of this report HWN has only focussed on NHS complaints handling but will be reviewing later in the year whether there is a need to carry out a similar piece of work focussing on the handling of complaints about social care provision in Norfolk including those complaints that cross the health and social care boundary.

The purpose of this report is to outline how the complaints handling process works at present, identify good practice and make recommendations for improvements. The report also identifies the ongoing role for HWN in monitoring NHS complaints handling in Norfolk.

Executive Summary

The report is aimed at both the public and NHS complaints managers to illustrate how the complaints handling process currently operates in Norfolk. Information, views and opinions have been sought from commissioners, healthcare providers and the experience of those members of the public who have made a complaint within the last six months have been collected.

The report aims to highlight the process that NHS organisations have in place for:

- Informing people about the complaints process
- Receiving and responding to complaints
- Investigating and evaluating complaints
- Responding to and resolving complaints
- Ensure learning from complaints is embedded throughout the organisation

The report also compares the feedback received from complainants against the above information from NHS organisations. This illustrates where there is disparity between the organisation and the perspective of the person making the complaint.

A number of examples of good practice have been identified for consideration and adoption. HWN believe that sharing and implementation of this good practice will help to improve the experience of those patients who raise some concerns and will help to ensure that a consistent approach to handling complaints is adopted within and across all NHS provider organisations in Norfolk.
Examples of Good Practice

- Easy read version of complaints leaflet (Queen Elizabeth Kings Lynn NHS Foundation Trust, East Anglian Ambulance Service NHS Foundation Trust, Norfolk and Suffolk NHS Foundation Trust, Norfolk Community Health and Care, Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospitals NHS Foundation Trust, Integrated Care24)
- Form sent to complainant at the beginning of the complaint handling process requesting clarification of the complaint and desired outcome (East Coast Community Healthcare)
- Meeting terms of reference form (Queen Elizabeth Kings Lynn NHS Foundation Trust)
- Complaint case studies - What you said and what we did (East Anglian Ambulance Services NHS Trust)
- Guidance document on format of complaint response letters (Queen Elizabeth Kings Lynn)

Recommendations

- All organisations ensure that all information relating to their complaints handling policy is easily accessible to all members of the public and meets the requirements of the appropriate legislation, good practice and guidance issued by the Department of Health and regulatory bodies and there is a consistent approach to complaints handling.

- All organisations to adopt a ‘You said, we did’ approach to publishing the outcome of complaints, lessons learnt and providing evidence that changes have been made. This information to be easily visible and accessible to the public.

- All organisations to ensure that they collate and triangulate patient feedback from a variety of sources and that patients understand they do not have to go through the complaints process in order to provide feedback.

- HWN to ensure that all signposting organisations in Norfolk have up to date information about how to make a complaint.

- All organisations to consider the introduction of six monthly independent audits of complaints handling.

- All organisations to consider reconvening county wide complaints manager forum (to include Social Services in recognition of the further integration of health and social care services). This forum to refresh, publish and implement a shared protocol for complaints handling in Norfolk by all health and social care organisations.
1. Background

Prior to HWN becoming operational from 1 April 2013, the shadow Board identified the issue of complaints handling (based at that time on the outcome of the Mid - Staffordshire NHS Foundation Trust enquiry) as an issue of great concern to the public. Since April 2013, 53.5% of the enquiries received by HWN Norfolk have been about the NHS complaints handling process. As most recently identified through a survey by Healthwatch England, there are more than 75 different types of organisations involved in the health and care complaints system. Healthwatch England chair Anna Bradley said 'the system is incredibly complex and gets in the way of people making complaints about poor care’. A survey commissioned by Healthwatch England last year stated that 54% of people who experienced a problem with health or social care did not report the matter. This is only one report that highlights concerns about the complaints process. Appendix 1 lists other recent reports that have included comments and recommendations about improving NHS complaint handling and which illustrates the national focus on this subject. The Appendix also includes a summary of information available on complaint handling regulations.

1.1 Complaints Framework

In recognition of the complicated scenario, HWN has published a diagram on its website to help patients and their families through the maze of potential organisations and contacts (see Appendix 2).

http://www.healthwatchnorfolk.co.uk/sites/default/files/complaintsinfographic3_2.pdf

The diagram illustrates that some organisations (e.g. the hospitals) handle the complaints themselves whereas the Clinical Commissioning Groups (CCGs), who are responsible for commissioning local healthcare services, have a Service Level Agreement with the Commissioning Support Unit (CSU) to handle the complaints on their behalf. The CSU was established by the Department of Health as part of the implementation of the Health and Social Care Act 2013 as an organisation to provide support services to healthcare commissioners. The CSU is able to review information by individual CCGs and provide monthly reports to the CCGs on the complaints handled on their behalf.

Where a patient wishes to make a complaint about primary care services (GP, dentist, optician and pharmacy) if this is not resolved by the individual service provider then the matter should be dealt with by NHS England (NHSE) as the commissioner of primary care services. NHSE has a central customer contact centre in Redditch from where all complaints are distributed to the NHSE Local Area Team for investigation. NHSE also commission a number of specialist services including prison healthcare. This brief explanation of which organisation deals with different complaint issues illustrates the complexity of the system.
2. Methodology

2.1 Phase 1

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 introduced new legislation for complaints handling in April 2009. The previous 3 tier system was replaced by a 2 tier system - local resolution followed by referral to the Parliamentary and Health Service Ombudsman (PHSO). The previous timescale for handling complaints (25 working days) was replaced by a more flexible, individual approach whereby organisations are expected to discuss an investigation plan, including the proposed timescale, with each complainant.

The PHSO requires that NHS complaints are handled in accordance with their 6 Principles for Remedy:

- Getting it Right
- Being Customer Focussed
- Being Open and Accountable
- Acting Fairly and Proportionately
- Putting Things Right
- Seeking Continuous Improvement

In order to gain information from all organisations that commission and provide NHS healthcare in Norfolk, HWN has engaged with the following organisations.

- Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)
- James Paget University Hospitals NHS Foundation Trust (JPUH)
- Queen Elizabeth Kings Lynn NHS Foundation Trust (QEH)
- Norfolk and Suffolk NHS Foundation Trust (NSFT)
- East Coast Health Community Care (ECCH)
- Norfolk Community Health and Care (NCHC)
- East of England Ambulance Service NHS Trust (EEAST)
- Integrated Care 24 (providers of 111 service in Great Yarmouth and Waveney) (IC24)
- Norwich Clinical Commissioning Group (NCCG)
- South Norfolk Clinical Commissioning Group (SNCCG)
- North Norfolk Clinical Commissioning Group (NNCCG)
- West Norfolk Clinical Commissioning Group (WNCCG)
- Gt Yarmouth and Waveney Clinical Commissioning Group (GYWCCG)
- Anglia Commissioning Support Unit (CSU)
- NHS England Local Area Team (commissioners of specialist services and primary care services) (NHSE)
The purpose of the contact was to gain information about the processes and procedures each organisation has in place for complaints handling. Some of this contact has been by POhWER on behalf of HWN and some contact has been undertaken directly by HWN (Operations Manager). POhWER works in partnership with Age UK Norfolk, Equal Lives and the Norfolk Rural Community Council to provide the current statutory complaints advocacy organisation in Norfolk and works closely with HWN.

A copy of the questionnaire completed by the above organisations is included in Appendix 3. Section 3. of this report details the results from the questionnaires.

In addition, all information available to the general public via the organisations’ websites was reviewed as part of this project.

2.2 Phase 2

The second phase of the project was to ask for feedback directly from complainants detailing their experience of making a complaint. Each provider organisation (and NHS England) randomly selected a number of people who had made a complaint within the past 6 months (and where the complaint had been closed) to receive a questionnaire for completion. A freepost address was made available for return of the questionnaires and there was also the facility to complete the questionnaire online.

A copy of the questionnaire sent to complainants is included in Appendix 4.

Section 4 of this report details the results from the completed questionnaires.

3. Results - Information form NHS providers on complaints handling

We are pleased to note that all organisations have a complaints handling policy in place and that there are several areas of good practice being adopted by all of the organisations.

3.1. Access to information

All organisations have a written complaints policy in place which is consistent with the Department of Health guidance and legislation, although not all organisations publish the full policy on their website. There is an emphasis on patients being able to read the information available but some organisations make it clear that information is available in alternative formats/languages. Some organisations publish a leaflet summarising the main points of their complaints handling policy and all organisations advise that they aim to make the information clearly available in all clinical areas. 7 Trusts currently publish an Easy Read version of a complaints leaflet and we understand some Trusts have involved Learning Disability specialists in producing this information. All Trusts also use their own Patient Advice and Liaison Service (PALS) to provide help and advice to people who wish to make a complaint (via telephone and face to face contact within the hospitals). In addition all organisations include information to complainants about the availability of independent complaints advocacy support and we believe regular contact between organisations and the advocacy support provider in Norfolk (POhWER) was helpful in making sure the information given to complainants about advocacy is up to date. This remains true in the new model of POhWER working with local voluntary organisations to support people in Norfolk.
The information provided in the initial acknowledgement letter to complainants varies and we understand that both NNUH and JPH utilise differing levels of legal expertise at this initial stage of handling complaints. We recommend a consistent approach to how staff handle complaints. In relation to complaints and legal action, all organisations should remember that the 2009 legislation states that written confirmation of a patient seeking legal action does not necessarily preclude the investigation of a complaint continuing.

3.1.1 Recommendations:

- All organisations ensure their full complaints policy is published and make it clear a hard copy is available if requested.
- All organisations ensure that information is available in alternative formats/languages including an easy read version and that these options are made clear.
- All organisations ensure complaint staff are aware that if a patient is seeking legal action this does not necessarily preclude the investigation of a complaint continuing.

3.2 Process

All organisations have confirmed that they include the following information during initial contact with complainants:

- Key stages of complaints handling process and timescales
- Arrangements for complaints spanning more than one organisation
- How consent issues are handled when someone wishes to make a complaint on behalf of a patient
- How medical records can be accessed
- How complaints from under 16’s are managed
- What happens if legal action is taken
- Where to obtain independent complaints advocacy support

Not all organisations make it clear whether they adopt an individual approach to complaint handling in terms of direct contact and discussion/confirmation of an investigation plan. Whilst HWN recognises the resources required in the implementation of an individually tailored approach to complaints handling, we believe that the complaints handling process should clearly indicate to the complainant that there is an option to discuss the process, agree an investigation plan and the complainant’s preferred outcome.

Example of good practice - Form sent to complainant at the beginning of the complaint handling process requesting clarification of the complaint and desired outcome (East Coast Community Healthcare)

In discussions with the organisations it became apparent that there are different approaches to arranging meetings with complainants i.e. when a meeting is offered, who is invited to the meeting, how questions can be posed by the complainants and how meetings are recorded. HWN advocates timely updates on
complaints investigations and clear information being made available about meetings as part of the complaint resolution. The timing of such meetings in the process is crucial and can often help to prevent a lengthy exchange of correspondence which is not resolving the complaint.

**Example of good practice - Meeting Terms of Reference form (Queen Elizabeth Kings Lynn NHS Foundation Trust)**

Although historically all Norfolk NHS (and social care) organisations had signed up to a shared complaint handling protocol for multi organisational issues, it was not clear from the discussions whether this protocol is still in place and operational. HWN recommends the protocol should be reviewed following changes to the health and social care systems since 2013 and adopted by all current health and social care organisations handling complaints in Norfolk. The protocol should make reference to handling complaints which may include organisations outside Norfolk.

All organisations include in their policy how they deal with ‘habitual and repetitive’ complainants albeit the title of this particular group of patients varies between organisations. HWN accept that this group of patients can have a significant impact on resources but the process to handle these sensitively and effectively (from the perspective of both the complainant and the organisation) does need to ensure that no valid complaints are missed.

**3.2.2 Recommendations:**

- All organisations to ensure the initial response to complainants makes it clear there is an option to clarify the complaint (particularly where it is very complex), to discuss the proposed investigation plan and the preferred outcome from the complainants perspective
- All organisations to ensure there is regular update to the complainant particularly where the necessary investigation is lengthy and complex and the offer of a meeting (and details of how the meeting will be conducted) is clearly made
- There is a review of the previous shared protocol for complaints handling in Norfolk and that all current health and social care organisations in Norfolk sign up to and implement this shared protocol

**3.3 Learning from complaints:**

One of the major themes from all the recently published reports on complaints handling and from the perspective of the Parliamentary and Health Service Ombudsman (PHSO) when reviewing the way a complaint has been handled, is that there should be clear evidence that the organisation has learnt from the complaint. See recommendation number 118 from the Francis Report.

‘Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust’s response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.’
All organisations confirmed that there is an identified senior manager (in most cases the Chief Executive) with responsibility for complaints including the escalation of serious complaints, review and signing of individual response letters and a risk assessment of the complaint from the organisation’s perspective. HWN recommends that all organisations should ensure they have a clear process for reviewing and updating the outcomes from complaints and that learning from outcomes is embedded in the organisation, cascading from Board level reports and discussions. As identified in the report published by the Department of Health - Hard Truths, The Journey to putting Patients First, all organisations should ensure that their Board and CEO receive monthly reports on complaints and action plans, including evaluation of the effectiveness, in addition to quarterly reports being published on lessons learnt. HWN would also advocate that such reports need to include qualitative information in addition to statistical information in order to make them more meaningful in terms of trends and patterns of complaint issues. However our review of information available via the internet illustrated that it is not always clear to the public what complaints information has been reviewed and discussed at Board meetings (in an anonymised format to ensure patient identity is protected).

Some organisations have adopted a practice of using patient stories at Board meetings as a very powerful way of reflecting patient experience.

Our research indicates that not all organisation provide information that is easily identifiable on the outcome of complaint handling in terms of a ‘You said, we did’ approach. This would reassure patients and their families that making a complaint is a worthwhile process for both patients and healthcare providers alike.

**Example of good practice - Complaint Case Studies - What you said and what we did (East Anglian Ambulance Services NHS Trust)**

Whilst this report focuses on complaints handling, we would expect all organisations to ensure information is collated and triangulated from all forms of Information on service quality including patient feedback (Patient Advice and Liaison Service enquiries, Friends and Family Test results, informal feedback from front line staff, patient stories, feedback on the patient opinion website - www.patientopinion.org.uk, feedback on NHS Choices website, Serious Incidents Investigations, Coroners Reports and legal claims). By reviewing and collating information from all these sources, the organisation will be better able to highlight trends and patterns and where patients and others have raised cause for concern and a need for improvement. See recommendation number 112 from the Francis Report:

*Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.*

From the information available at the time of writing this report it appears that NHSE has not yet put in place clear processes and procedures for collating information regionally on complaints handling and to carry out audits of complaint handling by CCGs.
3.3.1 Recommendations:

- Ensure that quarterly reports to Boards on complaints handling are easily available to the public
- Adopt a ‘You said, we did’ approach to publishing the outcome of complaints
- NHSE to make clear their process for collating and publishing information on complaints handling
- All organisations to ensure that they make clear to the public that complaints are only part of the process for patient feedback and this includes informal comments, patient surveys, patient opinion, PALS,
4.0 Results - Patients' carers and families' perspective on complaints handling

A total of 450 questionnaires were sent out by the NHS organisations to complainants. To date 74 completed questionnaires have been returned to Healthwatch Norfolk.

<table>
<thead>
<tr>
<th>Name of organisation complained about</th>
<th>Number of completed questionnaires received</th>
</tr>
</thead>
<tbody>
<tr>
<td>JPH</td>
<td>12</td>
</tr>
<tr>
<td>QEH</td>
<td>4</td>
</tr>
<tr>
<td>NNUH</td>
<td>10</td>
</tr>
<tr>
<td>NCHC</td>
<td>7</td>
</tr>
<tr>
<td>NSFT</td>
<td>5</td>
</tr>
<tr>
<td>EEAST</td>
<td>8</td>
</tr>
<tr>
<td>GPs</td>
<td>15</td>
</tr>
<tr>
<td>Dentist</td>
<td>4</td>
</tr>
<tr>
<td>Optician</td>
<td>1</td>
</tr>
<tr>
<td>Un named organisation</td>
<td>8</td>
</tr>
</tbody>
</table>

Of those who provided the information, please see demographic information below:

<table>
<thead>
<tr>
<th>Age 18-29</th>
<th>Age 30-64</th>
<th>Age 65-74</th>
<th>Age 75-84</th>
<th>White British</th>
<th>Other</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>41</td>
<td>17</td>
<td>5</td>
<td>93%</td>
<td>7%</td>
<td>41%</td>
<td>59%</td>
</tr>
</tbody>
</table>

The above figures indicates there is a need to ensure that people from BME communities in Norfolk are aware of and able to access the complaints handling process.

Analysis of the questionnaires indicates that the information provided by the organisations as to how they handle complaints and the experience of those who actually made a complaint is not always the same.

In addition, the analysis illustrated a varied approach by the same organisation to different complainants. This apparent inconsistent approach may have been due to the complainant’s recollection of the process or it may be due to inconsistency in complaints handling by one organisation. It is difficult to conclude whether this is due to the number of different complaint handlers or changes in staff. However what it does indicate is that clear communication is paramount to effective complaints handling.

The points below illustrate the main themes and trends highlighted by patients and their relatives based on the completed questionnaires. HWN acknowledges that to date we have received a limited number of completed questionnaires and that in some cases these questionnaires have been completed sometime after the end of the complaint handling process. Nevertheless we believe that the responses do indicate the need for a clear, timely and consistent approach to complaints handling.

We are aware that many of the NHS organisations routinely conduct customer satisfaction surveys of how their complaints are handled and the organisations concerned confirm they have received some very positive results.

4.1 Accessibility

The majority of respondents (90%) accessed information on the complaints process from the NHS but information was also obtained elsewhere on the internet, from Citizens Advice and from the local MP. 74% of respondents stated that the information available to them about the complaints process was clear.
41% of the respondents confirmed that they were worried that complaining might affect their care or treatment. It is important therefore that all patients, carers and their families are encouraged to provide feedback (positive and negative) in a culture of openness and transparency.

49% of the respondents confirmed that they had been treated with courtesy during the complaints handling process.

70% of respondents said they were able to make their complaint in time (DoH regulations state that complaints must be made within 12 months of the event taking place, although complaint managers have the discretion, if considered appropriate, to waive that restriction in some instances).

4.2 Information and communication

From the responses received (including responses regarding complaints handled by the same organisation), it appears there is significant variation in the information made available to complainants in the first instance.

All organisations confirmed they are aware of the 3-day acknowledgement requirement in the regulations but only 34% of the respondents recalled receiving an acknowledgement within the 3 days. 40% confirmed that the acknowledgement clearly explained the complaints handling process and 31% confirmed that information on help and advocacy available was included although only 2 of the complainants who responded to the questionnaire confirmed that they had used the advocacy services.

As indicated earlier in this report, not all organisations adopt the same approach in involving complainants in an investigation plan and only 28% of the respondents stated that an investigation plan had been agreed. The plan should include details of when progress reports are expected. 20% of respondents stated they did not receive regular contact (we accept that the question does not define ‘regular’ contact).

Respondents had similar experiences in that very few were offered a meeting to discuss their complaint (20%) and 12% had an opportunity to comment on a draft response.

13% of the respondents had requested copies of medical notes as part of the investigation and resolution of their complaint. Whilst we fully accept that this is not necessary in all complaint investigations, giving complainants the opportunity to review their notes together with support to do so can enable them to gain a better understanding of what has happened and why.

We recognise that a detailed investigation plan, a meeting and an opportunity to review a draft response are not appropriate and proportionate in all cases but it is important that consideration of these steps should be included in the initial complaints handling checklist.

4.3 Response letters

In response to the question about whether the final response answered all of their questions, only 27% of complainants said yes.

Some respondents commented on the content of the response to their complaint in terms of lack of apology, insufficient detail and lack of understanding of the original complaint. Please see below some of the direct comments from complainants. Guidance is available from the Department of Health about giving apologies. We accept that complaints handling is very much about perceptions and subjective views but it is important that all responses to complaints are factually correct.
Some comments from complainants about what was missing from the final response they received:

‘A full apology from the doctor concerned’
‘only answered one part of the complaint’
‘complaint grossly misunderstood, fundamentals have never been discussed’
‘they should have read my complaint’

Given that all organisations include in their complaints handling policy the option for complainants to contact the PHSO if they are not happy with the outcome of the complaint, it is surprising that 43% of the respondents stated they had not been advised of this. We would therefore recommend that this information is reiterated at the end of the complaints handling process and sending the information separately may help to ensure the complainant is fully aware of their right to take this action.

4.4. Recommendations

- HWN to ensure that all signposting organisations in Norfolk have up to date information about how to make a complaint
- All organisations to ensure that complaints handling training is mandatory for all staff dealing with complaints to ensure consistent approach
- All organisations to manage the complainants expectations effectively through agreement of an investigation plan (including timescales and methodology for regular contact)
- All organisations to implement a check list to be used by all complaints handlers
- All organisations to ensure that information is clearly provided at the end of the complaints handling process detailing the complainant’s right to contact the PHSO.

4.5 Actions as a result of complaints

Whilst 32% of the respondents confirmed that the organisation agreed to make changes as a result of the complaint, only 22% of those complainants were aware that changes had been made.

HWN accept that not all organisations use the terminology as to whether the complaint has been ‘upheld’ or not. We also accept that it is not always appropriate or possible to take any action as a result of a complaint but in accordance with the PHSO Principles for Remedy an offer to ‘put things right’ should always be considered. We reiterate the importance of ‘you said, we did’ being promoted by all organisations.

5. Direct quotes from complainants

Several of the questionnaires contained some positive feedback on the process:

‘They were very helpful and kept me informed all the way through’
‘I think they were very helpful and kept me informed all the way through’
‘I had a positive outcome, it was a shame I had to complain to get my son the treatment he needed’
The quotations below are taken directly from the questionnaires and illustrate the level of dissatisfaction and frustration experienced by patients and their families who have made a complaint:

‘The letter I received got details of my complaint totally wrong’

‘I felt the complaints process was ‘set up’ to achieve the outcome desired by the hospital’

‘The NHS needs to have an independent complaints process rather than one that has working relationships with services that you are complaining about’

‘a long winded process in order to deter’

‘process was atrocious, more understanding should be shown’

‘it seems very one-sided and not completely independent’

‘still awaiting a formalised response to a letter sent two months ago’

‘I was confused by the buck passing between 999 and 111’

‘Feels as if it was all swept under the carpet, pointless in complaining’

‘It took over a year, was a mess’

6. Generic comments

From both discussions with the commissioner and provider organisations, and the feedback from complainants, it appears there are some inconsistencies in approach to complaint handling between and within organisations. HWN believes that a robust, consistent approach would be of benefit to all involved in dealing with complaints (patients, commissioners and providers). However we also appreciate that several organisations raised the potential issue of increased regulation and widening remit of complaints teams that will possibly impact on resources available to manage complaints effectively. We would therefore recommend that the previous county wide complaints manager forum is reconvened as a shared resource. This forum could be used as an opportunity to share good practice, discuss multi organisational complaints and provide scope for training e.g. conflict resolution, root cause analysis, investigation techniques. Currently there is no formal training qualification for NHS complaints handlers.

In seeking to address claims that there is insufficient independence to the complaints investigations, we strongly recommend the introduction of a regular external audit of complaints handling. HWN would be willing to discuss a potential role for our volunteers in completing such audits with the co-operation of commissioners and providers. We also recognise that access to such information would need to meet the legislation around patient confidentiality.

6.1 Recommendations:

- Reconvene county wide complaints manager forum (to include Social Services)
- Consider the introduction of six monthly independent audit of complaints handling
7. Conclusion

We are pleased to find that all NHS healthcare organisations have a complaints handling process in place and engaged with HW Norfolk in discussing those processes. We are aware from discussions with many of the organisations involved that the potential issue of the increased regulation and widening remit of complaints teams will possibly impact on resources available to manage complaints effectively. We therefore hope that this report provides information and recommendations which will help all involved to achieve a high quality, consistent level of complaints handling across Norfolk.

Whilst we accept that some of the recommendations in this report will impact on the resources currently available within the complaints handling teams, we believe that much can be done to improve the processes by sharing good practice. By the implementation of a robust checklist of information to be exchanged between complainant and complaint handler at the beginning of the process, this should reduce subsequent protracted and difficult exchanges. As a final comment, HWN believe that by clearly publishing what improvements and changes are made as a result of complaints, all involved are more likely to view the complaints handling process as positive and worthwhile.

In the words of Cabinet Office Minister, Oliver Letwin, about complaints:
Instead of viewing them as a “danger,” complaints should be seen as a vital “mine” of information
Appendix 1

Listed below are recent regulations and reports published about NHS complaints handling:

**Regulations**

Complaints Regulations local authority social services and National Health Service complaints (England) regulations 20009

Listening, responding and improving - A guide to better customer care (Code of Practice - Department of Health - February 2009)

The Health and Social Care Act 2012

The NHS Constitution

Care Quality Commission Essential Standards outcome 17

**Identifying Good Practice**

Hard Truths. The Journey to Putting Patients First published by Department of Health - (government response to the mid-Staffordshire NHS Foundation Trust Public Enquiry) January 2014


The Health Committee Sixth Report on Complaints and Litigation August 2013

The Francis Report: One Year On (published February 2014 published by The Nuffield Trust)

A Review of the NHS Hospital Complaints System -Putting Patients Back in the Picture - Rt Hon Ann Clwyd MP and Prof Tricia Hart October 2013


October 2013

House of Commons Health Committee - After Francis, making a difference - published in September 2013

Designing Good Together - transforming hospital complaints handling published by PHSO August 2013


Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report – by Prof Sir Bruce Keogh KBE – July 2013

The NHS Governance of Complaints Handling published by PHSO June 2013

The NHS Hospital Complaints System published by PHSO April 2013
Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry - Executive Summary (published in February 2013)

Parliamentary and Health Service Ombudsman - Principles of Good Complaint Handling (published 2009)
Diagram produced by Healthwatch Norfolk illustrating the complexity of which organisation to contact if you wish to make a complaint. The version of the diagram on our website will help people to locate the correct contact details to make a complaint.
Appendix 3

Copy of questionnaire sent to NHS commissioners and providers in Norfolk for completion and discussion with either POhWER or directly with Healthwatch Norfolk.

Healthwatch Norfolk

Complaints handling survey
Questionnaire for NHS organisations

Organisation Name: 

Name, title and contact details for person responding to the questionnaire:

Date and place of interview:

Name of interviewer:

1  Governance:

Policy
a) Please may I have a copy of your complaints policy?
b) Where is this policy available?
   i. Website
   ii. Leaflet on display in all patient areas
   iii. Community locations
   iv. Staff intranet
   v. Elsewhere

c) Is the policy available in easy read and or other languages?
Yes? No?

d) How and when is the policy updated?

Leadership and resources

a) Who has overall executive lead responsibility for complaints handling procedures?

b) What does this responsibility entail?
c) What is the Board’s role in relation to complaints?

…………………………………………………………………………………………………………

………………

d) Does the Board receive an annual complaints report?
Yes? No?

…………………………………………………………………………………………………………

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e) Does the Board receive any other reports relating to complaints
Yes? No?

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f) Who manages complaints handling on a day to day basis?

…………………………………………………………………………………………………………

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g) How many staff are there in the complaints department?

…………………………………………………………………………………………………………

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h) Is the department fully staffed?
Yes? No?

…………………………………………………………………………………………………………

………………

i) Is staff turnover high or are staffing levels relatively stable?

…………………………………………………………………………………………………………

………………

j) Do you feel that the department is adequately staffed?
Yes? No?

…………………………………………………………………………………………………………

………………

k) What training do complaints handling staff receive in complaints handling?

…………………………………………………………………………………………………………

………………

l) What training do complaints handling staff receive in reaching out to and working with ‘hard to reach’ groups?

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m) What supporting resources are available for staff – e.g. interpreters?

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………………

n) How is staff compliance with policy monitored?

…………………………………………………………………………………………………………

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o) What action is taken to address performance issues?

…………………………………………………………………………………………………………

………………
p) Is there any training about handling complaints for other staff groups

Any other issues?

(a) Is there anything else you would like to comment on with regard to the issues in this section:
   i. any changes that you think could improve the governance arrangements?
   ii. any blockages to the arrangements working effectively?

........................................
2 Access

Publicity and information

a) What information is available to potential complainants about your complaints process?

b) Where is this available? Please tick as many answers as apply
   i. Website
   ii. Leaflet on display in all patient areas
   iii. Community locations (please note where)
   iv. Staff intranet
   v. Elsewhere (please note where)

c) How do people with communication issues get to know about the complaints process?

d) What happens if a person currently receiving care/treatment wishes to complain? (i.e. will staff be able to guide them to PALS or the complaints process?)

e) How do you test the effectiveness of your publicity arrangements?

f) What information about sources of advocacy or other independent advice is made available to complainants?

g) How do you work with advocacy or other independent organisations?

h) Do you have examples of how you encourage wider feedback including complaints?

Any other issues?

a) Is there anything else you would like to comment on with regard to the topics in this section:
   i. any changes that you think could improve the access?
   ii. any blockages to the arrangements working effectively?
3 Effective processes
Meeting key deadlines and standards
a) What arrangements are in place for making complainants aware of
   i. The NHS constitution.
      ...........................................................................................................
      ................................................................
   ii. The key stages and deadlines in the complaints process.
      ...........................................................................................................
      ................................................................
   iii. Handling arrangements for cases that span more than one organisation.
      ...........................................................................................................
      ................................................................
   iv. How third party complaints, including on behalf of people who lack capacity, are handled.
      ...........................................................................................................
      ................................................................
   v. How cases involving children and young people are handled.
      ...........................................................................................................
      ...............................................................
   vi. Obtaining consent.
      ...........................................................................................................
      ...............................................................
   vii. Releasing records.
      ...........................................................................................................
      ...............................................................
   viii. Working with an advocate or other independent source of advice.
      ...........................................................................................................
      ...............................................................

b) What happens if complainants say they also wish to pursue legal action or may wish to do so?
   ...........................................................................................................
   ................................................................

c) How do you distinguish between concerns and complaints?
   ...........................................................................................................
   ...............................................................

Managing investigations
a) How are high risk cases identified and escalated?
   ...........................................................................................................
   ...............................................................

b) In high risk cases is there a requirement to have a senior person manage the investigation and to obtain independent advice?
   ...........................................................................................................
   ...............................................................

What guidance is in place to guide the investigations process?
Do all staff involved in the investigations process receive investigations training?
Is there an internal committee established to review complaint investigations?

Please could you describe how each of the following occurs:

i. Clarifying the issues that the person wishes to complain about

ii. Clarifying expectations and desired outcomes with the complainant

iii. Explaining about complaints from third parties

iv. Explaining about complaints from children and young people.

v. Obtaining consent

vi. Informing people of advocacy or other independent advice

vii. Finding out about and agreeing any communications support the complainant may need

viii. Agreeing a plan with the complainant

ix. Co-ordinating with other agencies if required

x. Holding meetings and preparing for them

xi. Keeping in touch

xii. Identifying and escalating high risk cases

xiii. Scoping the investigation

xiv. Deciding who will manage the investigation
xv. Clarifying what standards the complainant should have expected to experience

………………………………………………………………………………………………………………

xvi. Obtaining independent advice

………………………………………………………………………………………………………………

xvii. Maintaining records

………………………………………………………………………………………………………………

xviii. Preparing a draft report

………………………………………………………………………………………………………………

xix. Checking the report against the complaint and the client’s expectations

………………………………………………………………………………………………………………

xx. How much information is provided to complainants about action taken in relation to staff

………………………………………………………………………………………………………………

xxi. Making a decision about upholding/not upholding the complaint.

………………………………………………………………………………………………………………

xxii. Sharing with relevant parties in draft format

………………………………………………………………………………………………………………

xxiii. Options for resolving issues if there appears to be a strong conflict of views

………………………………………………………………………………………………………………

Remedy

a) What remedies are available?

………………………………………………………………………………………………………………

b) Who decides the remedy?

………………………………………………………………………………………………………………

c) What information is made available to complainants about next steps if they remain dissatisfied?

………………………………………………………………………………………………………………

Any other comment

a) Is there any further comment you would wish to make:
   i. any changes that you think could improve the complaints investigation process?
   ii. any blockages to the arrangements working effectively?

………………………………………………………………………………………………………………

………………………………………………………………………………………………………………
4 Making Connections

a) What arrangements are made for handling complaints that might also involve other processes such as the regulators or the criminal justice system?

b) Do you have any systems for picking up complaints other than through the complaints process (e.g. through untoward incident processes or informal comments that sound as though they might relate to a serious matter)? If so, please could you describe these?

Any other comment

b) Is there any further comment you would wish to make:
   iii. any changes that you think could improve co-ordination of systems?
   iv. any blockages to the arrangements working effectively?
5 Monitoring and evaluating the complaints process
a) Are systems in place for:
   i. Monitoring complaints handling performance against key standards?
      ……………………………………………………………………………………………………..
   ii. Sampling and reviewing the quality of reports to complainants?
       ……………………………………………………………………………………………………..
   iii. Obtaining complainant feedback?
        ……………………………………………………………………………………………………..
   iv. Reviewing the handling of high risk cases?
        ……………………………………………………………………………………………………..
   v. Reviewing cases that were submitted to PHSO?
       ……………………………………………………………………………………………………..
   vi. Checking that agreed actions have been delivered?
        ……………………………………………………………………………………………………..
   vii. What action is taken in light of the above feedback?
        ……………………………………………………………………………………………………..

Any other comment
a) Is there any further comment you would wish to make:
   v. any changes that you think could improve the monitoring and evaluation process?
   vi. any blockages to the arrangements working effectively?
      ……………………………………………………………………………………………………..
      ……………………………………………………………………………………………………..
      ……………………………………………………………………………………………………..
      ……………………………………………………………………………………………………..
6 Learning and Improvement
a) What systems are in place for analysing complaints and identifying trends, themes or action arising from single, high risk cases?
..............................................................................................................................................................................
........................................................................
b) What evidence is there of change resulting from complaints?
..............................................................................................................................................................................
........................................................................
c) Are the public made aware of the impact of learning from complaints?
..............................................................................................................................................................................
........................................................................
d) How does the organisation know that learning is embedded?
..............................................................................................................................................................................
........................................................................

Any other comment
a) is there any further comment you would wish to make:
   i  any changes that you think could improve the learning process
   ii  any blockages to the arrangements working effectively?
..............................................................................................................................................................................
........................................................................
..............................................................................................................................................................................
........................................................................
## Appendix 4

Copy of questionnaire sent by the organisation who received the complaint to randomly selected complainants who had made a complaint (now closed) within the past 6 months.

### Questionnaire about the NHS Complaints Process

#### A  Brief details

1. Which organisation(s) did you complain about?
   - …………………………………………………………………………………………………………
   - …………………………………………………………………………………………………………
   - …………………………………………………………………………………………………………

2. Was your complaint about:
   - Your own experience?
   - Someone else’s experience?
   Please tick whichever applies to you.

3. Was your complaint
   - Upheld?
   - Not upheld?
   - Partly upheld?
   Please tick whichever applies to you.

#### B  About the complaints process

4. How did you find out about the complaints process?
   Please tick whichever applies to you

   a. NHS Trust Website
   b. NHS Choices Website
   c. Other website (Please tell us which one)
       …………………………………………………………………………………………………………

   d. Leaflet (please tell us where you found the leaflet)
       …………………………………………………………………………………………………………

   e. NHS staff
   f. Some other way (please tell us where)
       …………………………………………………………………………………………………………

5. Was the information you found about the complaints process clear to you?
   Yes?  No?

6. If you said no, what could have been better?
   …………………………………………………………………………………………………………

7. Did you find out about complaints process soon enough?
   Yes?  No?

#### C  How your complaint was handled

8. How did you contact the organisation you wanted to complain about:
   Please tick whichever applies to you
a. By telephone?
b. By letter?
c. By email?
d. By another method? If so, please tell us how you contacted the organisation?
   ........................................................................................................................................
   ................................................................

9 From memory, did someone contact you within three days of receiving your complaint?
   Yes? No?

10 From memory, did the person who contacted you do the following:
   Please tick whichever applies to you

   i. Introduce himself/herself?
      Yes? No?
   ii. Give you the name of the person who you could contact about your complaint?
      Yes? No?
   iii. Make sure he/she understood your complaint?
      Yes? No?
   iv. Check how best to communicate with you?
      Yes? No?
   v. Explain about independent sources of advice and advocacy?
      Yes? No?
   vi. Check that you had given consent for the complaint to be investigated?
      Yes? No?
   vii. Ask you what outcome you hoped for?
      Yes? No?
   viii. Explain the complaints process to you?
      Yes? No?
   ix. Give you the chance to ask questions?
      Yes? No?
   x. Answer your questions clearly?
      Yes? No?
   xi. Agree a plan with you?
      Yes? No?

11 Did you receive a letter confirming the plan?
   Yes? No?

12 Did your named contact keep in touch with you regularly?
   Yes? No?

13 Did you request a copy of your notes?
   Yes? No?
   If yes,
   a. Were the notes provided quickly?
      Yes? No?
   b. Was it easy to read and understand the notes?
      Yes? No?
   c. Were you offered any help to understand the notes?
      Yes? No?
   d. Were you charged for a copy of your notes?
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes?</th>
<th>No?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you invited to any meetings to discuss your complaint?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes?  No?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. was the purpose of the meeting explained to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes?  No?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Were you able to bring anyone with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes?  No?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Did you feel at ease in the meeting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes?  No?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Did the meeting help you understand what had happened?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes?  No?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Please tell us what could have made the meeting better?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Were you given a draft response to comment on before receiving the final response?</td>
<td>Yes?</td>
<td>No</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Did you feel that the final response answered your questions clearly?</td>
<td>Yes?</td>
<td>No</td>
</tr>
<tr>
<td>If no, please tell us what could have made it better?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Did the organisation agree to make changes?</td>
<td>Yes?</td>
<td>No</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>If so, do you know if those changes have been made?</td>
<td>Yes?</td>
<td>No</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Were you advised that you could complain to the ombudsman if you were not satisfied with the outcome of your complaint?</td>
<td>Yes?</td>
<td>No</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Overall, did you feel you were treated with courtesy throughout the process?</td>
<td>Yes?</td>
<td>No</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Were you worried that complaining might affect your care/treatment</td>
<td>Yes?</td>
<td>No</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Please tell us below if there are any other comments you would like to make about the complaints process</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
D The Ombudsman
If you did not take your complaint to the Ombudsman, please go to section E

23 If you took your complaint to the Ombudsman, did they:
   a. Uphold your complaint?
   b. Respond to your complaint within xxxx days?
   c. Check with you that they understood your complaint properly?
   d. Give you a named contact?
   e. Keep in touch with you?
   f. Did they check out their response with you before it was finalised?
   g. Was their response clear?
   h. Did they make recommendations?
   i. Have they checked that these were actioned?

24 What would have made things better?

E If you used an advocate or other independent support:
If you did not contact an advocate or other independent support, please go to section F

1 Which organisation provided you with support?

2 How did you find out about the support?

3 Did you find out soon enough?

4 What information was provided to help you decide about independent support?

5 Was it clear?
   Yes? No?
   If no, what would have made it better?

6 How did you contact the independent organisation or advocate?

7 Did the organisation or advocate explain clearly what they could and could not do?
   Yes? No?

8 Did the organisation discuss any communication needs with you?
   Yes? No?

9 Did the organisation agree a plan with you?
   Yes? No?

10 Did the organisation keep in touch with you regularly?
   Yes? No?
11 Did the organisation /your advocate help you to understand the complaints process?
   Yes? No?

12 Did the organisation/your advocate help you to find out information?
   Yes? No?

13 Did the organisation or your advocate provide someone to attend meetings with you?
   Yes? No?
   If yes, did you feel they well prepared?
   Yes? No?
   If no, what would have made things better?

14 What overall did the external organisation/advocate do well?
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………

15 What overall could the external organisation/ your advocate have done better?
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………

16 Would you use an advocate again?
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………

About you

Healthwatch Norfolk would like to be sure that the NHS complaints system works fairly for everyone. To help us do this we would be very grateful if you would complete the following details.

1 Are you
   Male
   Female
   Trans-gender

2 Do you have a disability? If so, please would you give brief details:
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………

3 Are you
   Under 18
   18 – 29
   30 -64
   65 – 74
   75 – 84
   85+

4 Would you describe yourself as:

   WHITE
   White British
   White Irish
   White – Eastern European
   White other

   MIXED
   Mixed white and black Caribbean
   Mixed white and black African
Mixed white and Asian
Other mixed background

ASIAN or ASIAN BRITISH
Indian
Pakistani
Bangladeshi
Any other Asian Background

BLACK or BLACK BRITISH
Caribbean
African
Any other black background

OTHER ETHNIC CATEGORIES
Chinese
Other

Thank you very much for completing the questionnaire. Please return the questionnaire to Healthwatch Norfolk as follows:

Freepost RTEZ-YTHH-LTBT
Healthwatch Norfolk
28 Queens Road
Hethersett
Norfolk
NR9 3DB