

Spotlight on complaints



A report on second-stage complaints about the NHS in England

April 2008

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ISBN: 978-1-84562-180-3

Concordat gateway number: 120

Cover image from www.johnbirdsall.co.uk

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Foreword

Complaints present a great opportunity for managers and clinicians in the NHS to understand what should be done to improve the services that they provide.

This is our second report that sets out the Healthcare Commission's work reviewing complaints made by patients or their representatives about NHS services. It covers the 7,500 requests for independent review that we received, and the 10,000 reviews that we completed, between August 2006 and July 2007. It also highlights trends and the lessons that we have learned. Our first report, *Spotlight on complaints*,¹ covered complaints that we received and reviewed between July 2004 and July 2006.

There is much good work being done to deal with complaints in some areas of the NHS. Of the many millions of episodes of treatment carried out across the NHS every year, just 140,000 are the subject of complaints. Only 7,500 of these were referred to us for independent review this year. We have seen an improvement in the way in which trusts are responding to complaints, with us returning fewer complaints to trusts to do more work at a local level: 26% compared with 33% in our first report. We are also seeing more evidence of trusts learning from complaints. For example, trusts have improved their procedures for assessing the risk that complaints represent and have developed better mechanisms for feeding back to their boards information about lessons that have been learned.

However, there is still some way to go before all NHS organisations can confidently say that they have robust local procedures for handling complaints, which lead to improvements in the care of patients in a systematic way. This is

shown by the more than 2,500 cases that we returned this year for further work at a local level, and in the findings of our recent audit of complaints.²

There are also some areas that we highlighted last year where more progress needs to be made. One involves providers apologising to patients and their families when something has gone wrong. In almost one in 10 of the cases referred to us, the person making the complaint was simply seeking an apology, or an acknowledgement that care could have been improved. We are frequently told by the trusts concerned that they had not apologised for fear of admitting legal liability. However, the medical defence organisations and the NHS Litigation Authority have consistently made it clear that apologies can be given to try to resolve matters without admitting liability. We would like to see more organisations and healthcare providers prepared to apologise when errors have been made and it is appropriate to do so.

We feel that more complaints could be resolved at a local level if trusts offered clear, evidence-based explanations and apologies where appropriate, and made good any harm or sense of injustice. But we also emphasise to trusts that good handling of complaints needs to involve more than an apology. It must also demonstrate to patients and to the public that improvements to services are being made as a result of their complaints.

It is vital that the NHS takes account of patients' views if it is to become truly patient-centred.



Listening to, and learning from, complaints is one of the key ways it can do this.

Over the next year, we will be working with NHS organisations to improve measures for handling complaints. We will also help them to prepare for the new system for handling complaints that the Government proposes to introduce in 2009. We agree with the Government that the new regulator of health and social care should not have a role in dealing with individual complaints. Rather, the regulator will have a role in ensuring that trusts meet their obligations. We also feel that it is crucial that there are mechanisms for ensuring that the lessons learned from complaints on a national level are captured and communicated to the NHS. We therefore welcome the Government's proposal that the new regulator, working in conjunction with the Department of Health and the Parliamentary and Health Service Ombudsman, will continue to have an important role in doing so.

In our first report, we described how we received more than double the number of requests for review compared with the previous system for dealing with complaints. This was a real challenge for us – and we have met this challenge. Now, no complainant has to wait for their case to be allocated to one of our investigators; cases are resolved much more quickly, while high standards are maintained; and in the summer of 2007 we met our target of resolving 95% of cases within 12 months. Reviews now take less than three months on average to complete, and we have 50% fewer open cases. We have also improved the quality of our work and our follow-up with organisations to make sure that our recommendations are acted upon.

Over the coming year, we will continue to refine our processes to ensure that we are providing

consistently high levels of service to complainants and NHS organisations that are the subject of a complaint. We will also work with the Department of Health, the Commission for Social Care Inspection, and the Parliamentary and Health Service Ombudsman to support implementation of the Department of Health's proposals to put more emphasis on resolving complaints at a local level as part of the new system for handling complaints. This is what complainants tell us that they want and we welcome it.

Those with concerns about the treatment that they or a relative have received from an NHS trust rightly expect that their complaint will be looked at thoroughly and fairly. They also expect that the NHS will learn from their case and that they will have an assurance that services will be improved.

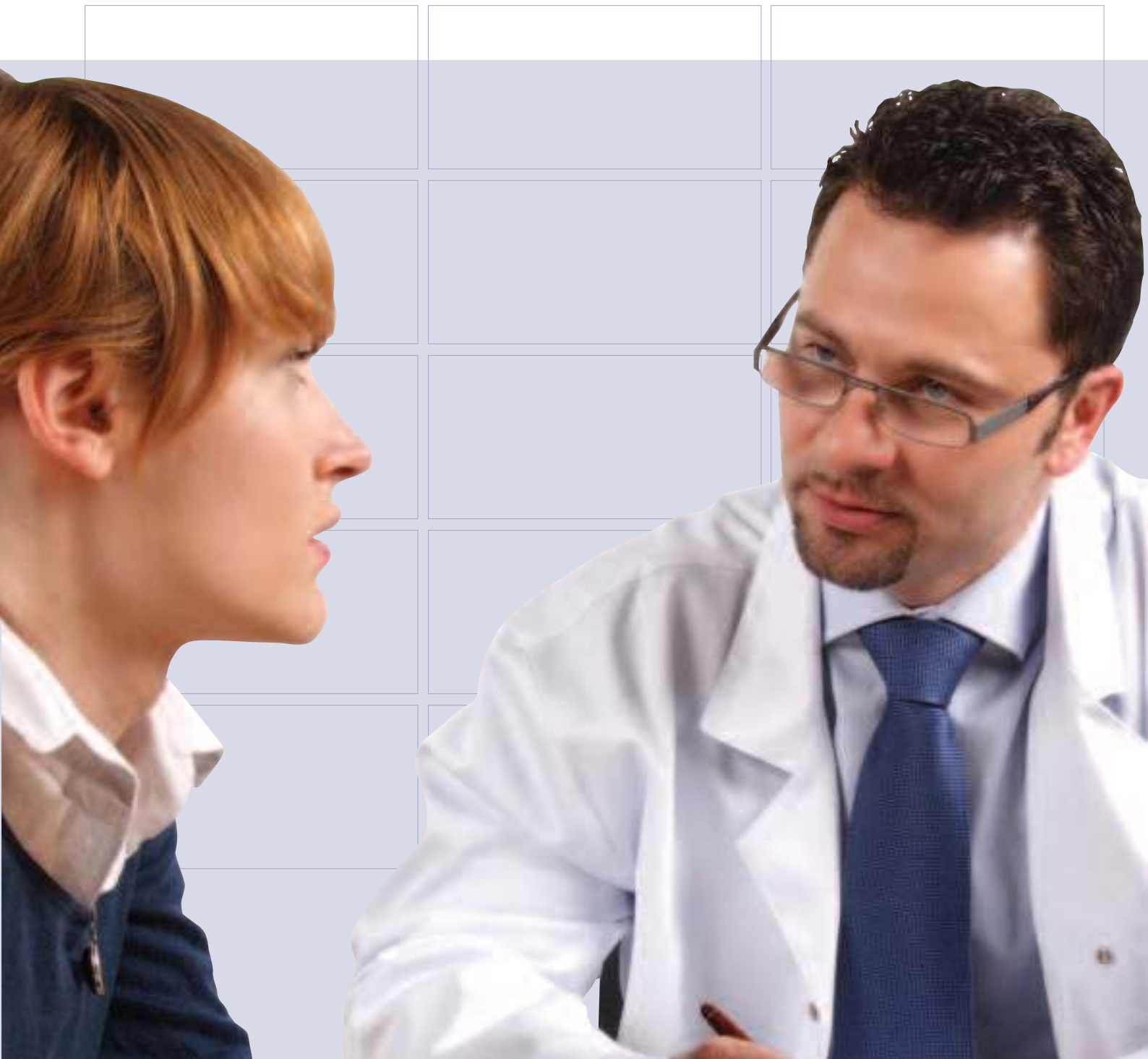
Fairness, robust investigation and assurance that lessons are being learned can be provided at a local level, but in many NHS organisations this will require a significant increase in the capacity and capability of complaints staff, and in the quality of the process for handling complaints. There are significant challenges in providing an impartial investigation and independent clinical advice, as well as in drawing together the lessons from complaints across the health sector at national level. We have already done much good work in reviewing complaints. This work could be built upon to take forward the Government's new arrangements for handling complaints.

Professor Sir Ian Kennedy
Chair

Anna Walker CB
Chief Executive

Summary

The overwhelming majority of NHS patients are satisfied with the care and treatment that they received.³ Many millions of episodes of treatments are provided across the health service each year, yet only 140,000 people make a complaint to their local NHS trust about the care that they or a relative received.



An NHS that aims to make the patient the centre of care must rise to the challenge of responding to more complaints in a sympathetic and flexible way. It must also try to resolve concerns at a local level, without the need for escalation.

If a complaint cannot be resolved at the local level, at present the patient or their representative can ask the Healthcare Commission to independently review the way that the trust investigated and responded to their complaint. This is the 'second stage' of the NHS complaints process that was introduced by the Department of Health in July 2004. The 'third stage' is when the patient or their representative takes their complaint to the Parliamentary and Health Service Ombudsman.

Complaints cover a wide range of issues, but each is important to the person raising it and specific to their circumstances. When complaints are not resolved at the local level, the provider misses an opportunity to strengthen their bond with the people they serve.

As in our last report, the concerns of many patients who have asked us to review their unresolved complaint have centred on the basic elements of healthcare. For example, communication between clinical staff; the attitude of staff; standards of care and safety; and fundamental aspects of nursing care, such as nutrition, and privacy and dignity.

This report focuses on these key clinical areas, highlighting the areas of good and poor practice that we have seen both in handling complaints and in delivering services. It also includes information about the common recommendations that we have made to help to resolve complaints and improve services. We

hope that by sharing these trends and recommendations, other NHS trusts can take steps to prevent similar issues arising.

We have seen an improvement in the way that the NHS handled complaints this reporting year. In the first reporting period, we referred 33% of cases back to trusts because their original response was unsatisfactory. This year, this figure fell to 26%.

However, we remain concerned that in over a quarter of the complaints that we were asked to independently review (over 2,500 cases), there was more that the trust could have done to resolve the complaint locally. The findings of our independent reviews show that the NHS has a lot of work to do to improve the way that it handles complaints, both in terms of its responses to individual complaints and the way in which trusts use the lessons that they have learned from them to improve patient services.

Our findings in this report reflect those of our 2007 audit of complaints²: that the standards of handling complaints can vary significantly between providers across England.

The reasons we ask a trust to carry out further work are relatively straightforward, and the things we ask them to do would not have been difficult to do during local resolution of the complaint. For example, the trust may not have interviewed or taken statements from the relevant clinical staff; the letter confirming the outcome of the complaint investigation may have been couched in clinical terms, making it difficult for the complainant to follow; or an apology may not have been offered.

We will continue to work with all NHS trusts to make sure that their procedures for handling

complaints are refined and that they have systems in place so that their boards can use complaints to drive improvements in services.

Central to this is a new national complaints toolkit that we released in March 2008. We drew on our experience of independently reviewing complaints over the past three years when developing this toolkit. We also used the experience of others, including the Parliamentary and Health Service Ombudsman, who work at local and national level across health and social care. The toolkit aims to help to resolve complaints at the local level by addressing many of the common deficiencies in the ways in which complaints are handled. These deficiencies are identified later in this report.

The key findings from our independent reviews of complaints this year are that:

- In 26% of cases (approximately 2,700), we found that more work could be done to resolve matters at the local level. Typically this would have involved offering the complainant:
 - meetings with relevant staff
 - better explanations
 - an apology
 - information about steps taken to prevent a recurrence of the problem
 - simple steps to put things right, such as reimbursing the costs of private treatment needed to remedy an error.
- In almost 20% of cases (approximately 2,000), we upheld the complaint. While we may have acknowledged that the trust provided what they considered to be a full response to the complaint, we found that the response given was not as accurate as it could have been. This was usually because the independent clinical advice that we obtained showed that the care and treatment provided was not in line with the established national standards, and that the trust had not explained this to the patient or their relatives. In such cases, we made recommendations for the trust to improve its services.
- Around 18% of the complaints that we reviewed (approximately 1,900) were not upheld. We found that the trust had given an appropriate response to the complaint, and that the care and treatment met the national standards.
- There was a slight fall in the proportion of cases that were outside our jurisdiction this year: 24% compared with 26% in the period covered by the first report. These were typically cases where the complaint had not yet been made to the trust. This figure suggests that patients and relatives may need to be given more accessible information on how the NHS complaints process works.
- The safety and effectiveness of clinical practice was the issue most commonly raised in complaints (24% of cases). Patients felt that the care and treatment that they had received was not of a sufficiently high standard, and there was actual or potential risk of harm to the patient or others.
- Many of those who contacted us this year (17%) were also concerned about how the trust had handled their complaint. Some people felt that the local investigation was not thorough or objective enough, or that the trust's response was not presented in a way that they could understand.

- The primary care sector, including complaints about GPs and dentists, was the area about which we reviewed the largest number of cases (some 3,700) closely followed by the acute sector (over 3,400 cases).

Around 50% of the complaints that we were asked to independently review raised clinical issues, so we sought advice from our team of advisers. Our key findings on the clinical issues arising from complaints are that:

- In cases involving GP services, 43% of complainants felt that their examination was too brief, with limited discussion about treatment options. A further 23% felt that the GP had failed to diagnose a condition, or delayed diagnosis. Related to this, we reviewed a significant number of complaints about GPs who had not referred patients to specialists soon enough. We often recommended that GP practices should review their referral procedures and that their primary care trust should monitor this.
- Communication issues were prominent in GP cases. Twenty per cent of the GP cases that we reviewed involved concerns about a GP's attitude. Our clinical advisers saw a number of cases when a GP had not told a patient about the common side effects of a treatment. This may be because some GPs assume that patients cannot understand complex information about side effects. Our advisers also found that there were many cases where a GP had failed to engage with the complaint, making it difficult to resolve.
- The most common complaint about dental practices (34%) concerned the standard or quality of clinical treatment. We found that either the dentist had not adequately diagnosed the patient's condition or that they had underestimated the difficulty of the case.
- The issue most frequently raised in complaints about hospital care was also the standard of clinical care (36%). Around 30% of these cases were about the fundamentals of nursing care, such as hygiene, communication, privacy and dignity, and nutrition. We frequently recommended that trusts review their practices in line with *Essence of Care: Patient-focused benchmarking for health care practitioners*.^{*4}
- The complaints about care in A&E departments primarily concerned: communication and record-keeping (particularly a lack of documentation of explanations given to patients' families); poor clinical handover of patients from A&E to other departments in the hospital; and a failure to recognise abnormal initial vital signs in patients, especially the respiratory rate.
- Problems with communication featured prominently in the complaints about maternity services. Our advisers on these cases noted that many complaints were made because mothers felt that staff did not listen to them when they expressed their needs. We also reviewed a small, but significant, number of cases where our advisers were concerned about supervision arrangements, in particular inexperienced midwives managing the care of women with complex medical needs. In such cases, we recommended that trusts review and improve their supervision arrangements.

^{*Essence of Care} is a toolkit designed by the Department of Health to benchmark nursing practice. It covers the major areas of care, including food and nutrition, privacy and dignity, personal and oral hygiene, and record-keeping.

- The most common issue raised in the complaints that we reviewed about mental health services was the poor attitude of staff. Our clinical advisers also highlighted a significant number of complaints concerning local crisis resolution teams. These included service users not knowing whom to contact in times of crisis, poor communication, and poor quality plans for crisis resolution.
 - Around a third of the complaints about ambulance services concerned poor response times. Our clinical advisers found that letters sent to complainants often included highly technical terms and cited the guidance around response times. While the letters helped to resolve the complaint to some extent, more could have been done to empathise with patients and their relatives.
 - Almost 10% of the complaints about the care and treatment provided to children involved safeguarding issues. A specialist group within our complaints team monitors these cases.
 - In the almost 50 complaints that were primarily about palliative care, the most prominent issue was families not being given sufficient or timely information to help them make informed choices about their relative's care.
 - The general standard of healthcare was the most common issue in the 86 complaints that we reviewed about healthcare in state-run prisons. In particular, some prisoners were concerned that they were unable to see a GP when they needed to. We have worked closely with the Prison and Probation Ombudsman to improve the way that complaints are handled in prisons.
 - Around two-thirds of the over 100 cases about continuing care concerned funding issues. We asked trusts to do further work in over half of these cases, usually because funding decisions were not adequately explained to patients and their relatives.
- Issues relating to communication were common throughout all clinical areas. We found that open, clear communication from trusts, and better involvement of patients and relatives in key decisions about clinical care, can often prevent complaints.
- Our findings show that the NHS needs to do a great deal more to improve the way that it handles complaints, but these improvements are not usually complex or expensive to implement.
- Trusts can be more responsive to those they serve on the rare occasions when things go wrong. Being more responsive will also help them to prepare for the Government's proposed reforms to handling complaints, which will focus on trusts resolving concerns locally. We are recommending that trusts do more to improve their procedures for handling complaints by making them:
- accessible to everyone who uses the service
 - easy to use by anyone who wants to make a complaint
 - sympathetic to the complainants
 - focused on resolving matters
 - non-adversarial
 - able to provide a robust examination of the issues raised

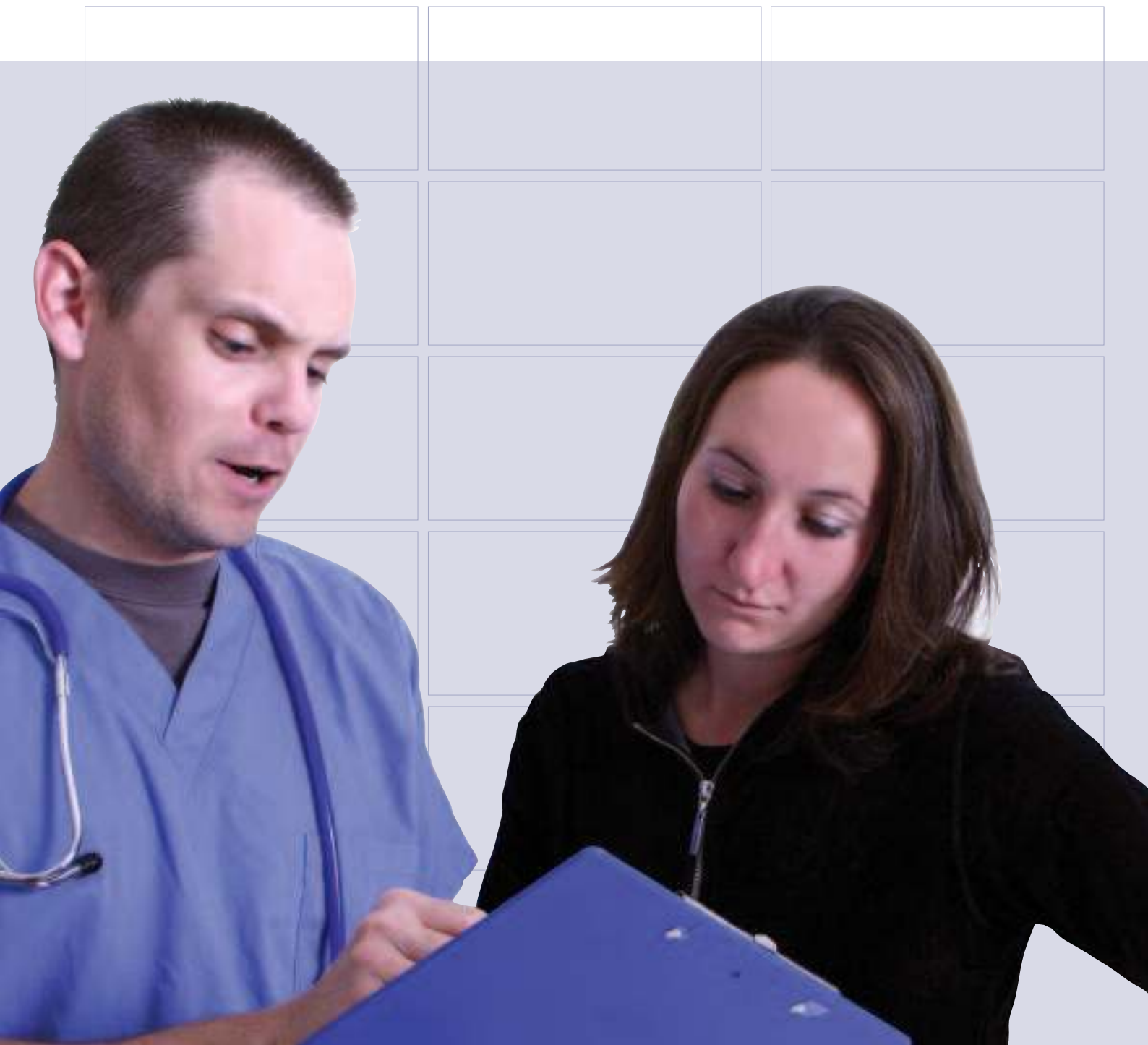
- able to ensure that an appropriate remedy is provided if a problem is found
- linked to each trust's service improvement agenda.

We will encourage and support these improvements to make sure that they happen by:

- launching our toolkit on handling complaints, and helping trusts to implement it
- checking that trusts are complying with the standards for handling complaints in *Standards for Better Health*⁵ and if they aren't, taking action through the annual health check
- visiting trusts that are not following recommendations that we have made in our reviews of complaints
- visiting trusts to which we have upheld or referred back a large number of complaints
- improving information about the NHS procedure for handling complaints on our website
- working closely with the Parliamentary and Health Service Ombudsman to make sure that the importance of having good systems for handling complaints is reinforced to trusts.

Common themes

Between August 2006 and July 2007, we completed over 10,000 independent reviews. This section highlights the trends that we saw in these reviews and describes the recommendations that we made to trusts to help them to resolve complaints and drive improvements in their services.



The most common outcome for cases that we independently reviewed this year (26%) was to refer the complaint back to the trust for further work (see figure 1 overleaf). This was also the most common outcome in the previous reporting period (33% of cases). While this reduction is welcomed, because it suggests that complaints are being handled better locally, we still had to refer over a quarter of our cases back to the trust involved because we found that they could have done more to resolve the complaint. This is too great a proportion.

We have frequently asked trusts to do things that should have been considered as part of the local response, such as:

- providing a better explanation of events to the complainant
- showing that they have learned lessons from the complaint
- arranging meetings between the complainant and the staff members involved to discuss the issues raised by the complaint
- responding to all of the issues raised rather than giving selective or partial responses.

We have an ongoing programme of work that addresses these points and supports trusts to better handle complaints locally. This includes us sharing information on the lessons that we have learned from the cases that we have reviewed and from our recent complaints audit, letting trusts know what works well in dealing with complaints, and giving trusts practical information on how to deal with complaints better, including our complaints toolkit.

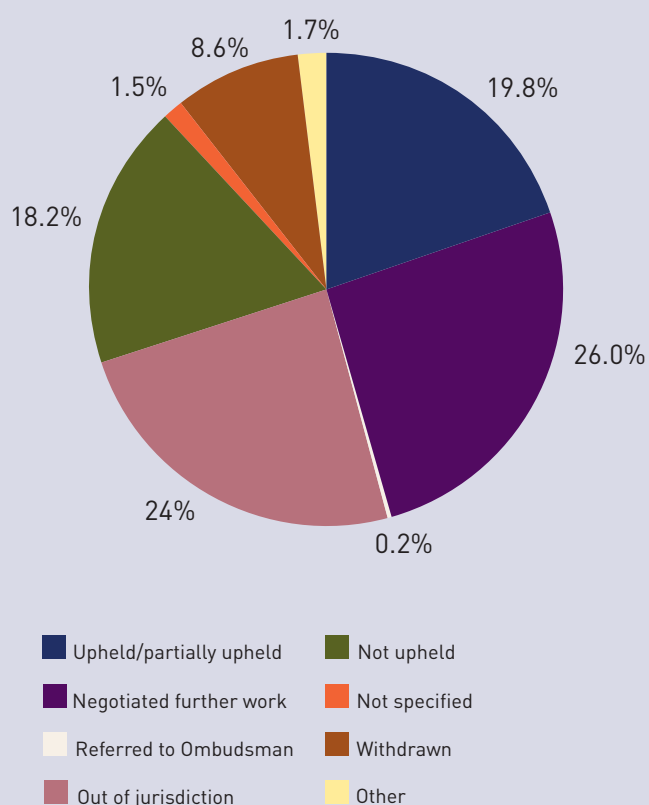
A significant number of cases (24%) fell outside our jurisdiction, usually because the complaint had not been made to the trust or the process of local resolution had not concluded. This is a slight fall on the figure in the previous reporting period (26%), but suggests that people who want to make a complaint need to be given better information about how the system works so that they don't refer their concerns to us prematurely.

Around 20% of the cases that we reviewed were upheld. While we accepted that the trust provided a response to the complaint and there was no further work that could be done to try to resolve matters, we found that the response was not accurate. This was usually because our independent clinical advice showed that the patient's care and treatment was not in line with established national standards, and the trust had not fully explained this to the patient or their relatives. We made recommendations to the trusts concerned so that things could be put right, lessons could be learned, and services could be improved.

We referred a very small number of our cases directly to the Parliamentary and Health Service Ombudsman, because they involved retrospective claims for funding for continuing care, there was only a small pool of available independent clinical advice, or the complainant had a terminal illness. These referrals reflected a protocol agreed between our two organisations. We always obtained consent from the complainant before we made these referrals.

We referred cases to the General Medical Council, the Nursing and Midwifery Council, or other professional regulatory bodies if we suspected that there was misconduct or concerns about the provider's fitness to

Figure 1: Outcomes of independent reviews from August 2006 to July 2007, by resolution type



Out of 10,366 reviews that we completed

practise. Additionally, we suggested that employers refer cases to the National Clinical Assessment Service if there were issues that implied that the staff concerned needed more training.

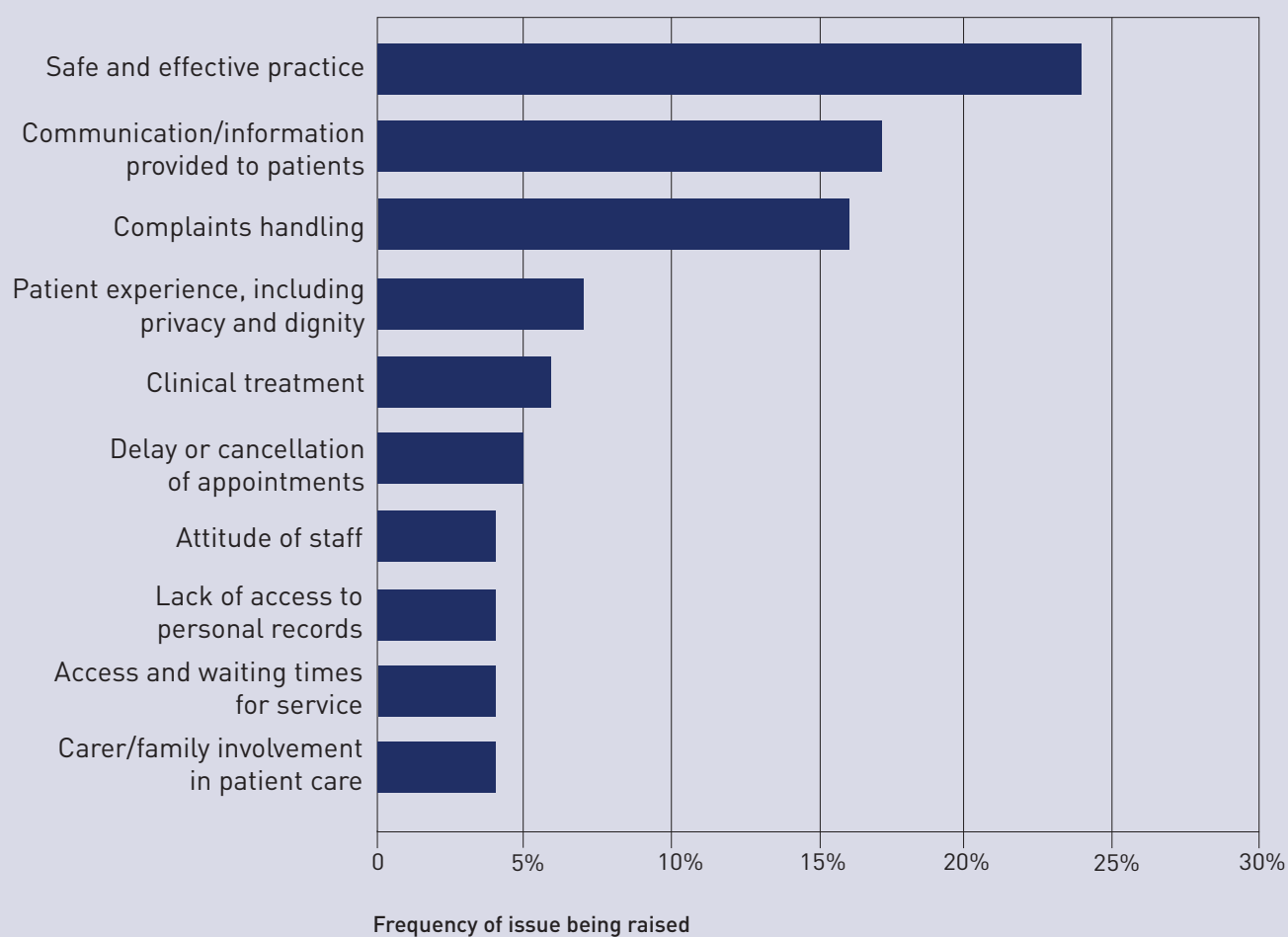
Issues raised in complaints

The issue most frequently raised (24% of cases) by patients or their relatives was about safe and effective practice (see figure 2 opposite). This was usually when patients felt that something had gone wrong with the care and treatment that they received, and there was actual or potential risk of harm to the patient or others.

A large number of complainants (17%) were concerned about the way that trusts communicated with them, and with the lack of information they received about their treatment. We received many complaints about clinicians giving patients information that was either not sufficient or too complex for them to understand. The patients could therefore not make informed choices about their treatment.

Related to this, in 16% of cases, complainants raised the provider's complaints handling as an issue. Usually this was because they felt that the investigation was not sufficiently thorough or objective, and that the response to the complaint did not adequately address all of their concerns.

Figure 2: Top 10 issues raised in complaints that we independently reviewed from August 2006 to July 2007



Types of services that complaints were about

This year we received complaints about the full range of NHS organisations (see figure 3). The highest proportion of the cases we completed in the year related to the primary care sector, including GP practices and dental practices, (about 38% of cases), but complaints about the acute sector (around 35% of cases) were also very common. The proportion of complaints about foundation trusts increased significantly compared to last year (from 8% to 18%). This principally reflects the rise in the number of trusts gaining foundation status since the last report.

There was a common pattern to the issues raised in complaints that we received from different regions of England. The way in which complaints were handled, communication, and concerns about safety featured highly (see figure 4).

Figure 3: Reviews completed, by NHS provider

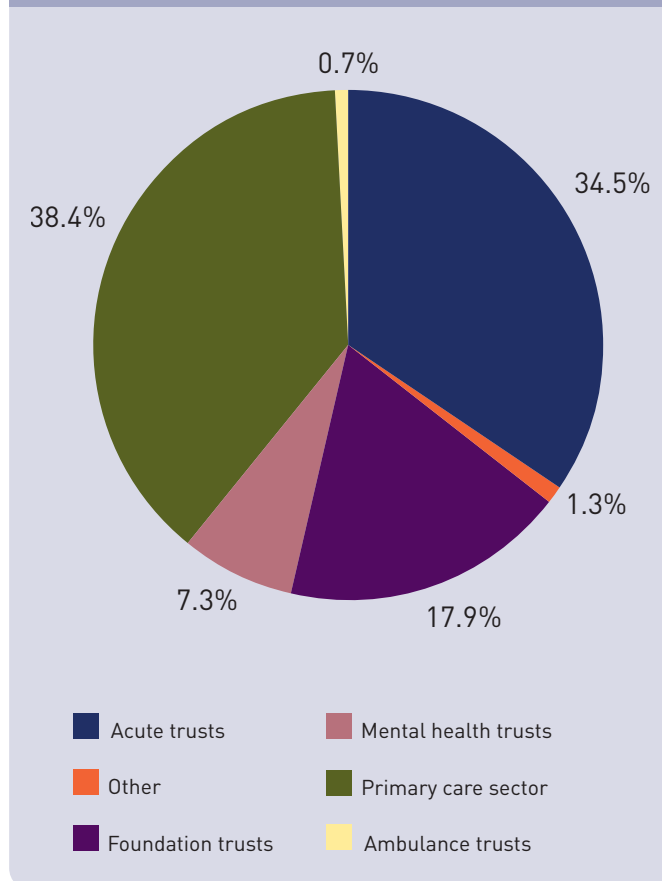
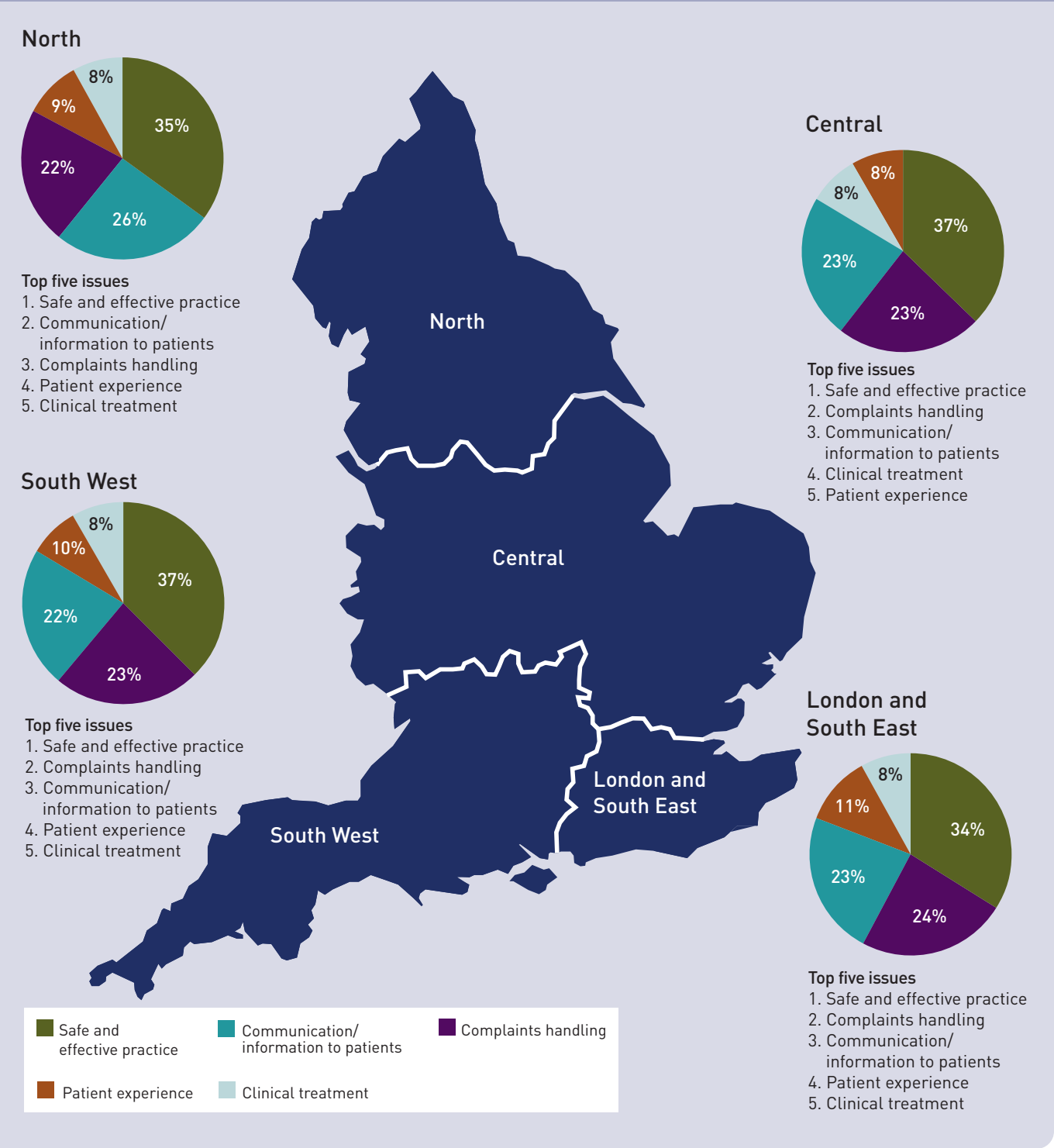


Figure 4: Breakdown of independent reviews carried out, by Healthcare Commission region



We reviewed complaints about almost every NHS trust this year. Table 1 lists the trusts that we referred the lowest proportion of cases back to for further work. In most cases, we were satisfied with the work that the trust had already done to resolve the complaint. Table 2 lists the trusts where we have identified that we referred most complaints back to for further work. These trusts had a significantly higher number of cases referred back to them than the national average.

We congratulate the trusts shown in table 1 for their consistently high standard of responses to complaints that we independently reviewed. We will work with the trusts in table 2 to assess their arrangements for responding to complaints against the requirements of the core standards and statutory guidance.

Table 1: Trusts with the lowest percentage of cases referred back for further local work

Central and North West London Mental Health NHS Trust	12%
Hampshire Partnership NHS Trust	13%
Northamptonshire Healthcare NHS Trust	14%
Barts and the London NHS Trust	16%

Table 2: Trusts with the highest percentage of cases referred back for further local work*

Pennine Acute Hospitals NHS Trust	51%
Mayday Healthcare NHS Trust	51%
North Cumbria Acute Hospitals NHS Trust	44%
Leicestershire Partnership NHS Trust	41%

*Trusts that have had 10 or more independent reviews and not including primary care trusts

Clinical themes

Around 50% of the complaints that we independently reviewed this reporting year raised clinical issues and required clinical advice from our team of advisers. This section highlights the main trends that our advisers found and what recommendations we made to trusts to help them to improve their patient care.



In each clinical area, there were unique lessons to be learned about the care and treatment of patients, but a common lesson was to improve communication. Our advisers identified many cases where poor communication from clinicians – mainly not giving patients and their relatives a clear explanation about treatment – led to a complaint being made.

The analysis in this section is taken from our case management system, a representative sample of 500 case files, and feedback that we received from our independent clinical advisers on trends and issues in the cases they have reviewed in the year.

Primary care

This year, we reviewed a wide range of complaints about primary care services, including complaints made against GPs, dentists, and services directly provided by primary care trusts (PCTs).

GP services

The most common type of complaint (43%) about GPs concerned clinical treatment. Many patients who requested an independent review of their complaint were concerned about GPs who gave a poor quality examination. They told us that their examination was extremely brief, with limited discussion of treatment options.

The significant number of complaints (23%) that we received about a GP's failure or delay to diagnose a condition may be linked to these poor quality examinations. These complaints were usually about the diagnosis of cancer and many complainants told us that the GP had

Top five issues in complaints about GP services

1. Clinical treatment
2. Diagnosis – failure/delay
3. Attitude of doctor or practice staff
4. Handling of complaints
5. Removal from practice list

Top five recommendations in complaints about GP services

1. Improve systems for handling complaints
2. Make an apology
3. Review referral procedures
4. Improve record-keeping
5. Review removal from practice list

missed signs that may have led to an earlier diagnosis.

Related to this, we also reviewed a large number of complaints about GPs not referring patients to specialists soon enough. In most cases, our clinical advisers found that GPs had acted appropriately and in line with relevant clinical guidance, such as the General Medical Council's *Good Medical Practice*.⁶ However, we often recommended that practices review their referral procedures and that their local PCT should monitor this. Many PCTs have their own referral pathways and the performance of individual doctors can be measured against these, often using the GP appraisal system.

Around 20% of complaints about GPs raised

concerns about their poor attitude to patients. This included rudeness, not listening to patients, and an unwelcoming environment at surgeries. A number of complainants were also concerned about the poor attitude and behaviour of practice managers and receptionists.

Our clinical advisers told us that a common problem they saw was that some GPs assumed patients could not cope with detailed information about the potential side effects of a treatment, so avoided giving them this information. Our advisers noted many cases when the GP had not told the patient about common side effects. The General Medical Council's guidance on appropriate prescribing sets the standard to which doctors should work.

Our advisers also saw many cases when the GP failed to engage with the complaint. They found that complaints were usually resolved more quickly and at the local level if GPs engaged positively with them in the early stages, to prevent the views of the complainant and GP becoming entrenched. The most common recommendation that we made to GPs this year was for them to improve their procedures for handling complaints. This includes making patients aware of the practice's complaints policy and offering meetings between patients and staff to try to resolve complaints in a less adversarial manner.

Dental services

The most common complaint (34%) about dental practices that we received concerned clinical treatment. Our dental advisers found that these complaints were frequently made after a treatment failed, or where problems

"I would like to express our gratitude for the help you gave us with my late father's case. My whole family was grateful for the speedy, professional way this issue was brought to the best conclusion that we could have hoped for. Dr X of X Health Centre admitted 'slip ups' had been made, and that a new code of practice will be put in place to ensure no other family will have to experience such events. Thanks to you and your team."

Feedback following our review of a complaint about a GP

Top five issues in complaints about dentists

1. Clinical treatment
2. Communication with patients
3. Costs
4. Removal from practice list
5. Availability of NHS dentists

Top five recommendations in complaints about dentists

1. Improve communication
2. Improve systems for handling complaints
3. Improve record-keeping
4. Improve clinical procedures
5. Make an apology

with the treatment led a patient to seek a second opinion that revealed specific concerns about their care. In many of these cases, our dental advisers concluded that either the dentist had failed to make an adequate diagnosis of the patient's condition or that they had underestimated the difficulty of the case and attempted to provide care that might have seemed reasonable, but was beyond their level of experience and technical ability. Our advisers often recommended that dentists review their practice to make sure that it meets the General Dental Council's *Standards for dental professionals*.⁷

Reflecting on the complaints that we reviewed this year, our dental advisers found that the vast majority of cases where dentists underestimated the difficulty of the case involved relatively inexperienced dentists. They concluded that this could have been because less experienced dentists may:

- take more risks and carry out more ambitious treatments
- be more easily influenced by patients who have unrealistic expectations of the care that might be available
- not understand some of the risks that they are taking with the care and treatment that they provide.

Our advisers recognise that these are difficult and complex situations. In their view, the best way to learn from some of the errors that they have seen is to make sure that all dentists, particularly recently qualified ones, are encouraged to develop their clinical skills.

If there were questions raised about standards of treatment, our advisers recommended that the local PCT referred the dentist to the Practitioner Advice and Support Scheme for a wider assessment of their practice. They also suggested that shortfalls in clinical performance be addressed through a supportive local professional network.

Hospital care

Over a third of the complaints that we reviewed this year were about hospital care. The three sub-sectors where the most cases originated this year were nursing care, A&E care, and maternity services.

Most people (36%) who asked us to review their complaint about a hospital were concerned about the clinical care and treatment that was provided.

Top five issues in complaints about hospital care

1. Clinical treatment
2. Compliance with *Essence of Care*⁴
3. Communication
4. Diagnosis
5. Handling of complaints

Top five recommendations in complaints about hospital care

1. Improve communication
2. Improve record-keeping
3. Improve staff training
4. Review compliance with *Essence of Care*
5. Improve clinical procedures

Nursing care

Many complaints about hospitals (around 30%) were about *Essence of Care* issues in nursing. Patients complained that some of the fundamental elements of nursing care – nutrition, privacy and dignity, and communication – were not delivered to an acceptable standard. Where our nursing advisers told us that things could have been done better, we recommended that trusts review their compliance with the benchmarks in *Essence of Care*.

Communication

When complainants raised concerns about communication in hospitals, our nursing advisers found the following frequently occurring issues:

- call bells not being provided or being left out of reach of patients, particularly elderly patients
- a lack of communication and involvement with relatives and carers about care and treatment plans
- nurses being “abrupt” or “sharp” when speaking to a patient, making the patient feel like they were a nuisance.

Our advisers have also highlighted these improvements:

- greater involvement and communication between carers and link workers when caring for patients who may have special needs. For example, staff liaising with community learning disability services when patients with a learning disability were admitted, and making an early referral to mental health workers for patients who may have mental health problems

- using the *Essence of Care* toolkit to review and improve current practice.

Privacy and dignity

Many complainants felt that their privacy and dignity, or that of a relative, was not maintained while they were in hospital. Our nursing advisers reviewed many complaints that involved:

- patients being left in soiled bedding and clothing
- personal hygiene needs not being met, in particular patients not being given regular baths or showers, hair care, nail care or oral hygiene
- clothing being inappropriate or inadequate – for example, gowns or nightdresses not maintaining patients’ modesty
- bedside curtains or room doors being opened when the patient was receiving intimate care, or staff entering without knocking or waiting for permission to enter.

However, our advisers also noted that trusts made a number positive improvements in the past year, including:

- using more signs to designate toilet and bathroom facilities for single sex use
- introducing signs that can be pinned to bedside curtains, and using fastenings to keep curtains closed to improve privacy
- a trend towards the return of single sex wards, although problems remain in assessment units and facilities that care for ‘day cases’ (patients who are not expected to stay in hospital overnight)

- staff being given training and attending induction programmes on the *National Service Framework for Older People*⁸ and meeting the needs of the older person.

Nutrition

Sometimes concerns about nutrition were the primary complaint, but usually they were a contributing factor to complaints made about other aspects of care. For example, complainants were often concerned that a relative could not get better because of the poor nutritional support that they were offered. Common issues that our nursing advisers saw this year included:

- a lack of choice or variety of meals
- inedible food being served – for example, solid food being given to a patient who could only take liquids, or cold or unpalatable food being served
- meals being poorly presented
- food not being available outside specific meal times
- nursing staff not helping patients to eat
- a lack of aids to help patients eat. For example, specially designed cutlery for arthritic patients, or special cups and beakers to help patients to drink
- food and drinks being placed out of reach, particularly of elderly people.

Our nursing advisers told us that the reason for these problems was often that a full nursing assessment was not carried out (or recorded)

during the patient's admission and that no risk-assessment tools were used to determine the risks posed to the patient or the level of care that they needed.

Our advisers reviewed a large number of cases where trusts did not follow NICE guidelines on nutrition. However, they also saw an increase in the use of the *Essence of Care* toolkit to review nutritional care and implement improvements in practice. Some positive changes included trusts:

- developing local nutritional policies and using risk-assessment tools and guidelines
- using a red tray or red dot to identify patients who need help at mealtimes
- encouraging relatives and carers to help patients at mealtimes if they wish to
- introducing 'protected mealtimes'.

Case study – Complaint about nursing care

N, an 86-year-old lady, was admitted to hospital through A&E. She had a history of chest infection and confusion, and had suffered a number of falls at home. N was transferred to a medical ward. Within 24 hours, N had fallen twice during the night. On the following morning, she fell again and fractured her femur.

N's daughter made a complaint to the trust about her mother's care and treatment. The trust said that it was satisfied that the care and treatment provided was appropriate. N's daughter was not happy with the trust's response, so asked us to independently review her complaint.

We found that the staff on the medical ward had failed to read all of N's admission history and gave care solely for her chest infection. They had also failed to undertake a moving and handling assessment and a falls risk assessment, and their notes described the patient as independently mobile. We concluded that the trust's record-keeping in relation to the falls was poor, and no forms were completed or could be found. On reviewing the nursing records, our nursing adviser noted a lack of time, dates and signatures on some of the evaluation sheets, illegible entries, and a lack of detail of the care planned and delivered.

We upheld the complaint and the trust accepted that poor documentation made it impossible to assure the complainant that N had received an appropriate standard of care. The trust apologised to N's daughter for the poor care and implemented an improvement programme. This included an audit of nursing documentation, training for staff in record-keeping and risk assessment, and a review of nursing standards using the benchmarks in *Essence of Care*.

A&E care

Our advisers on care in A&E departments told us that for many patients and relatives, the care given in this department "sets the scene" for the rest of their stay in hospital. If things go wrong in A&E, it will often affect a patient's perception of their entire stay.

We received a large number of complaints about communication in A&E. It is difficult to comment on this issue because what has been discussed with relatives and carers is often not documented. Our advisers have frequently recommended that clinicians write down the explanations they gave to patients' families and the context for the explanation.

Our advisers noted some instances of poor

clinical handover of patients between teams. This included a lack of written plans that detail current and ongoing issues in a patient's care. These plans should follow the patient when they are transferred between care, but our advisers saw a number of cases where this did not happen.

Another issue that frequently occurred in complaints about A&E was the failure of staff to recognise or act upon abnormal vital signs, especially in respiratory rates. Patients sometimes arrive in A&E with vital signs that are initially abnormal, but that then improve.

These patients may be sent home because no obvious cause is found for the initial abnormal vital signs. However, many later return to A&E because the underlying problem has worsened. Our advisers found that this was particularly common in elderly patients, who often arrived with vague or non-specific symptoms, and in patients who were in the early stages of sepsis.

Using tools to assess risks to patients is an effective way of detecting early warnings of such problems. The timely use of antibiotics early in the patient's care could also help in these situations. We have told trusts that they should make sure their systems for assessing patients are reviewed in line with NICE guidance.⁹

Our advisers found that pain relief was a widespread issue in complaints about A&E. Many patients were concerned about the lack, or insufficient use, of timely pain relief. A trust's failure to give appropriate antibiotics and problems with their management of warfarin were also common complaints. We have frequently recommended that trusts review their approach to pain relief against the standards set by the College of Emergency Medicine and the British Association of Medicine.

As in many of the other clinical areas, poor documentation was a recurring issue in complaints about A&E. This was particularly the case when A&E doctors examined the neurological and musculoskeletal systems of patients. However, our advisers welcomed the increasingly widespread use of generic and condition-specific patient care proformas, such as those issued by the Informatics Unit at the Royal College of Physicians. These help to improve record-keeping in line with guidance issued by the General Medical Council and the Royal College of Physicians.

“Many thanks for your support and your research. It is so good to have someone who listens to me at last.”

Feedback from a complainant following our review of their complaint about hospital care

Maternity services

Communication issues also featured in many of the complaints about maternity services that we received this year. Our advisers reviewed many cases when mothers felt that clinical staff did not listen to them when they expressed their needs.

Our advisers also noted a large number of examples of poor practice, such as:

- women being left alone in labour, without access to pain relief
- a lack of support and encouragement for women during various phases of labour
- midwives being too busy to give good quality care during the birth of the baby, and in the immediate periods before and after
- midwives having poor attitudes and communication skills
- poor record-keeping
- a lack of team work and of consistent advice based on evidence.

This year, we made a number of recommendations to trusts to improve their services and address these concerns.

- We recommended that one trust should make sure an appropriate escalation plan was in place to cover maternity services in the community during peaks in activity. This would enable women in its care to receive the quality of antenatal support from midwives indicated in the *National Service Framework for children, young people and maternity services*¹⁰ and *Maternity matters: choice, access and continuity of care in a safe service*.¹¹
- We recommended that another trust should invite the complainant to be part of the local maternity service users group, or labour ward forum, so she could help to resolve some of the communication issues that her complaint raised.
- We also recommended that a trust facilitated a workshop on communication and attitude for staff involved with care delivery, and that this workshop should involve representatives from the Patient Advisory Liaison Service.

We have frequently reminded trusts that the national service framework¹⁰ places a great deal of importance on communication. It urges midwifery leaders to address communication issues by: “having the time to talk, engage and build a relationship with women and their partners to understand and help meet their needs throughout pregnancy.”

Supervision was another issue that frequently occurred in complaints about midwifery services. Many incidents involving midwifery care and practice were dealt with under the general framework for the statutory supervision of midwives. Our advisers noted a small but significant number of complaints that related to the competence of midwives. Many of them involved inexperienced midwives being

left to manage the care of women with very complex medical needs.

One example of poor practice was when a student midwife was left alone to care for a woman thought to be in the latent phase of labour. The woman was actually in active labour and problems went unrecognised because of the student’s lack of experience and supervision. This could have had a seriously detrimental effect not only on the patient and her family, but also on the student. Our recommendation was that the trust should make sure that the student had the time and opportunity to reflect on her care for the complainant with her named supervisor of midwives. The student should also discuss with her supervisor things that she could have done to improve the patient’s perception of her care.

However, there were some very good examples where trusts have used the general framework for the statutory supervision of midwives appropriately and effectively. These included:

- using a supervisor from another trust to review a patient’s care and treatment, so that an independent report could be drawn up
- developing organisational and multidisciplinary learning to address issues such as the management of haemorrhage
- reviewing existing protocols and guidelines to bring them in line with current evidence, and informing all staff of any changes.

Case study – Complaint about maternity services

Mrs D was in the 38th week of pregnancy. She became unwell and was admitted to the maternity unit at a large NHS trust with contractions and a spontaneous rupture of her amniotic membranes. Following the birth, Mrs D began to bleed and had a postpartum haemorrhage. She was transferred to theatre for further investigation into the cause of the haemorrhage, but suffered a cardiac arrest in the corridor outside the theatre and died later.

Mrs D's husband made a complaint to the trust about her care and treatment. The trust's response was that the care and treatment was of a high standard and that all procedures had been correctly followed.

Unsatisfied with this response, Mr D asked us to independently review his complaint. We obtained clinical advice from a consultant obstetrician and concluded that there had been a number of deficiencies in the care and treatment given to Mrs D, including poor record-keeping and inadequate supervisory arrangements.

We recommended that the trust should:

- make sure that midwifery and medical staff fully and accurately record their involvement in a patient's care, in accordance with guidance from the Nursing and Midwifery Council
- arrange for the midwives involved in Mrs D's care to have a supervision interview with their named supervisor of midwives to review their practice, and arrange for them to attend a skills workshop on managing postpartum haemorrhage
- review its guidelines for the management of postpartum haemorrhage and massive obstetric haemorrhage
- formally acknowledge that there were deficiencies in the care given to Mrs D
- apologise to Mr D for these failings and for the misleading explanation it gave him in its response to his complaint.

The trust accepted our recommendations and commissioned an independent report into its maternity services. The report highlighted a culture of bullying among staff, and resulted in a referral being made to our investigations team, which found some further concerns about patient safety. We have continued to closely monitor the trust's maternity unit since we reviewed this complaint, and the trust has put in place an action plan to drive improvements in this area.

“I was fortunate that you were involved, that you were persistent, *au fait* with regulations and processes, and paid attention to detail. Thank you very much for all of your assistance.”

Feedback from a patient following our review of their complaint about maternity care

Mental health services

A significant number of complaints about mental health services were about crisis resolution teams. Our advisers noted that the following issues occurred regularly:

- service users not knowing whom to contact in times of crisis
- poor (or absence of) crisis and contingency plans for service users who were subject to the Care Programme Approach (CPA)¹²
- poor communication between staff, service users and their families, particularly about what the crisis service was for and how to access it out of hours – for example, no telephone number being provided
- service users having different expectations about what a crisis team can do compared with what service the trust delivers
- inadequate assessments being done over the telephone, resulting in poor clinical conclusions
- staff having a poor attitude. Some service users felt that they were often referred back

to their GP the next day, or if they were an existing service user, they were told to discuss their issues with their care coordinator

- complainants feeling that the crisis team was reluctant to assess them at home
- a lack of a clear care pathway into and out of the service.

Many complaints about mental health services involved the CPA. The CPA states that service users should expect an assessment of their health and social care needs, a care coordinator to be assigned to them, a care plan to be drawn up for them, and to receive a regular review of their needs. Our clinical advisers found the most common themes in these complaints were:

- no evidence of a crisis plan* in the care plan
- the care plan not reflecting the assessed needs of the patient
- the patient not being involved in the formulation of their care plan
- the patient not being given a copy of their care plan
- crisis plans not being detailed enough or not being adequately understood by the patient
- a lack of detailed care planning and risk assessments
- carers not being supported adequately or offered assessments

*A crisis plan is an explicit plan of action to be implemented in a crisis or in a developing crisis situation. The plan should include early warning signs of relapse, previous strategies that were successful in managing crisis situations, and out-of-hours contact details. This information should be clearly stated on a specific section of the care plan and should be easily accessible out of normal working hours.

Case study – Complaint about mental health services

D, a 17-year-old girl, was admitted to hospital with a severe infection. She remained in hospital for almost two months. D's parents made a complaint to the trust about her care and treatment. They believed that she was discriminated against due to her learning disabilities and that she was given sub-standard care because staff felt that she did not have a good quality of life.

We upheld the complaint made by D's parents. We found that the trust had failed to consult externally based professionals who knew D to make sure that it gave her the most appropriate care. The trust had also failed to appropriately consult with D's parents, and did not appear to want their input into her care. We concluded that the quality of nursing care was poor, that some medications were not administered properly, and that the trust's investigation of the complaint was inadequate.

To resolve this complaint and improve patient care, we recommended that the trust should:

- provide a clear statement of how it planned to improve staff knowledge and understanding of the complex needs of people with learning disabilities
- develop an action plan with clear outcomes, and share this plan with the complainant. The trust should involve local expert providers and Mencap to help to facilitate this work, and should identify an individual within its staff to champion this cause
- the trust's clinical governance committee should review the case to establish what lessons could be learned. The trust should advise the complainant of the outcome of this review
- the director of nursing should oversee a review of the trust's administration of medicines policy to make sure that nursing staff follow it
- provide a detailed explanation of why additional staffing was not provided and what action it would take in future if it was faced with a similar situation
- the director of nursing should contact their fellow director of nursing at the neighbouring specialist service for people with learning disabilities to discuss how to improve the experience of people with learning disabilities during acute hospital admissions
- confirm that changes have been made to its procedure for handling complaints to make sure that the NHS complaints regulations are followed.

The trust accepted our recommendations. The complainants telephoned us to say how pleased they were with the quality of our review and the recommendations that we made for improvement.

- a lack of evidence that patients were included in decisions about their care and treatment – for example, the patient and carer not signing the plans.

However, our clinical advisers also noted many examples of good practice within mental health services, including:

- clear crisis and relapse plans that were easy to understand and that were signed by the service user. Such plans included statutory and non-statutory contact numbers and help lines
- consultant psychiatry ‘emergency clinics’ having an open referral system for service users known to community mental health teams
- evidence of detailed crisis and care plans from some trusts that were using electronic CPA systems
- 24-hour cover being provided by crisis teams
- good communication tools being shared between crisis teams and community mental health teams – for example, shared care planning, shared telephone logs, and integrated electronic records.

Ambulance services

Around a third of these cases concerned complaints made about ambulance response times.

Our advisers found that the majority of cases within this sector were linked to a complaint about a trust. For example, a patient or relative often complained about the care and treatment at a trust at the same time as they expressed concerns about an ambulance transfer. Most of the complaints involved the A&E service rather than the patient transport service.

Our advisers found that the standards of record-keeping in ambulance services were sometimes inadequate. In some cases, we needed to review accompanying hospital records to establish what care the ambulance crew provided because their records were not satisfactory.

Our advisers noted that in response to a complaint, some ambulance trusts set out the Department of Health’s guidelines and targets on ambulance response times, and explained to the complainant that they had met these. This resolved the complaint to some extent. However, we often recommended that ambulance trusts should take a more rounded view of the complainant’s concerns, and express sympathy that the person making a 999 call will have experienced considerable distress.

Case study – Complaint about a child’s care and treatment in A&E

B, a 19-month-old girl, was taken to A&E by her parents with a scald injury. The injury required three follow-up visits at 48-hour intervals so that her dressings could be changed. B was then referred to a specialist burns unit where upon admission she was given morphine and a skin graft. B’s parents made a complaint about their daughter’s clinical treatment. In particular, they were concerned about what they saw as inadequate pain relief during dressing changes.

The trust stated that pain relief was not required at dressing changes because the time it would take for analgesia to become effective would be as distressing for the child as the time it would take to change the dressing. Its response to the complaint simply repeated the sequence of events rather than properly addressed the concerns that B’s parents had raised.

Our independent review of the case found that:

- the initial assessment of B’s wound was inadequate
- the pain relief was inadequate
- follow-up visits were poorly recorded and the notes were often illegible
- the trust had not provided evidence of any guidelines for the management of burns in children, either as an existing policy or one under development.

We therefore upheld the complaint and recommended that the trust should:

- work with the local burns unit to develop guidelines for the management of burns in children
- record burns on specific burns charts
- make the recognition and alleviation of pain a priority when treating ill and injured children. This process should start at triage, be monitored during the child’s time in A&E, and finish with ensuring adequate analgesia. If appropriate, it should also continue beyond discharge, in accordance with the British Association for Emergency Medicine’s *Guideline for the Management of Pain in Children*.¹³

Services for children

In carrying out all of our statutory duties, including the review of second-stage NHS complaints, we are required to pay particular attention to the need to safeguard and promote the rights and welfare of children, and the effectiveness of measures taken to do so.

We have a dedicated children's complaints group within our complaints team. This group monitors complaints involving children to make sure that if there is a serious service failure involving the care of a child, or there are unrecognised and/or ongoing child protection concerns, appropriate referrals are made to other agencies or to other groups within the Healthcare Commission. The children's complaints group reports to our Children's Strategy Group and to our Safeguarding Children Board.

This year, we received over 500 complaints about the care and treatment provided to children. Around 10% of these concerned the safeguarding of a child or a vulnerable person.

Complaints that involved the care and treatment provided to children were most commonly made about the primary care sector (39%), closely followed by the acute sector (32%).

The issue most frequently raised was about the way in which the trust handled the complaint (19%). The next most common complaints related to concerns about communication (16%) and diagnosis (10%).

Palliative care

We reviewed almost 50 complaints that were primarily about palliative care this year. The most frequently occurring issue in these complaints was that the family had perceived the physical deterioration of their relative, but that the healthcare team had not kept them informed, given them choices, or supported them to make decisions about the patient's care.

Our clinical advisers on palliative care found that poor communication between and within teams, specialisms, and different transfer areas was another area of concern that occurred too frequently in complaints.

In a significant number of cases, our advisers found that this poor communication limited a patient's sense of empowerment and their ability to make an informed decision about their care. Often the decision to move the focus from patient 'cure' to patient 'care' was also not clearly communicated. As a result, needless and painful interventions took place, diminishing the patient's quality of life. Our advisers told us that referrals to specialist palliative care teams were sometimes made too late, or not at all.

Poor support for basic comfort, family and patient privacy, and spiritual, cultural and psychological needs were all common issues in complaints about palliative care. Our advisers felt that a basic lack of communication led to many of these problems. Clinical teams often did not convey the seriousness of an illness to patients or their relatives, who need this information to make decisions. An early referral to palliative care means that greater emphasis can be placed on making a patient comfortable, and their spiritual and psychological needs can be attended to.

Our clinical advisers noted that not all trusts had adopted the *Care of the dying: A Pathway to Excellence*,¹⁴ the Preferred Place of Care Plan,¹⁵ and the Gold Standards Framework.¹⁶ So, while there were a number of areas of good practice in palliative care, we also made recommendations that trusts put these frameworks into place.

Prison healthcare

We received 86 requests to independently review complaints about healthcare in state-run prisons this year.

Recognising the challenges faced by prisoners who want to make a complaint, we proactively involve the Independent Complaints Advocacy Service when we review these complaints. We referred over half (47) of the complaints that we received this year to the Independent Complaints Advocacy Service and our experience shows that many prisoners will ask them for their support to make a complaint.

About half of the complaints that we received were ineligible for independent review, usually because the complaint had not yet been made at the local level. As only 25% of all of the requests that we receive are ineligible, this suggests that there may be some uncertainty in prisons about the correct procedure for making a complaint about prison healthcare.

Establishing whether a complaint is eligible for review can be difficult. Often the prisoner will complain about matters that concern both healthcare and the prison service. The prisoner may also no longer be in the prison that they are complaining about, so the information we need to determine eligibility may be located in different prisons and trusts.

The most common issue in these complaints was the general standard of healthcare. For example, prisoners being unable to see a GP when they needed to; the poor attitude of staff, particularly nursing staff; and nurses controlling access to GPs. Prisoners also tend to be regularly moved around the prison estate, so can receive a type of service at one prison that is not available at another prison. This causes issues about medication – for example, a particular medication may be prescribed in one prison, but not in another.

We found that the informal prison complaints process was sometimes used for complaints about healthcare. This process involves the prisoner completing a 'Comp1' form and a member of the healthcare team writing a response on the back of the form. The prisoner was often not advised of the correct procedure to follow to make a complaint about their healthcare.

During the year, we worked with the Prison and Probation Ombudsman to consider better ways to handle complaints that involves healthcare and prison issues. We have seen a genuine willingness from prison healthcare teams and PCTs to resolve complaints about prison healthcare, and to improve their procedures for handling complaints.

Continuing healthcare

The term 'NHS continuing healthcare' means fully funded care for people who do not need care in an NHS acute hospital, but still need a high degree of ongoing healthcare. Continuing healthcare funding is intended to cover the entire costs of care, including all medical care, nursing care, personal care, living costs and accommodation costs.

Case study – Complaint about prison healthcare

A, a prisoner, was admitted to hospital with 23% burns from a fire in his cell. He died as a result of his injuries. A's family made a complaint to the trust about his care and treatment.

The trust investigated the complaint and concluded that there was no further action to be taken. A's family were not happy with this response, so asked us to independently review their complaint.

Our review found several failings in the way that the trust managed A's care and treatment:

- it had not carried out toxicology screening on A when he was admitted to hospital
- it had inappropriately prevented A's mother from taking photographs of him
- it did not take a full medical history of A
- its protocols for the admission of prisoners to hospital were inadequate.

We upheld the complaint and recommended that the trust should:

- urgently review its protocols for the admission of prisoners, and work with the police and prison services to do so
- acknowledge that it would have been good medical practice to carry out toxicology screening and apologise that it did not
- review its procedures for dealing with burns patients, especially if there is doubt about the cause of the injuries
- review its policy regarding photography, particularly in special situations – for example, medico-legal cases or if a patient is unconscious.

This year, we reviewed over 100 complaints about continuing healthcare. Two-thirds of these related to funding issues.

Our approach to reviewing complaints about continuing healthcare is to review the procedures that the trust follows when it makes a decision on whether or not to grant funding. We do this to make sure that their procedures are in line with established Department of Health guidance. We then make recommendations to strategic health authorities (SHAs) and PCTs based on our findings.

We have regular contact with SHAs, PCTs and complainants, and have developed a proactive approach to reviewing complaints about continuing healthcare. This has enabled us to negotiate the resolution of cases with PCTs and SHAs as quickly as possible and identify if either the PCT or SHA needs to take any further action. All parties welcome this approach.

We also give the Department of Health feedback about any concerns or trends that we notice in these complaints.

We follow a basic list of steps (below) when we review complaints about continuing healthcare. It is very closely based on the *National Framework for NHS continuing healthcare and NHS funded nursing care in England: a consultation*.¹⁷ It also takes account of the Health Service Ombudsman's approach to reviewing retrospective continuing care cases.

- The PCT should have gathered all available and appropriate evidence, including information from the GP, the hospital (such as nursing, medical, and mental health records, and records of any other therapies), community nursing services, care homes, social services, and the patient and their relatives.

- The PCT should have assessed the patient's healthcare needs at the relevant point in time, and the patient should be reassessed at appropriate intervals.
- The patient, or their relatives, should be involved as much as possible and given opportunities to input information at all stages.
- All deliberations at review panels should be fully and accurately documented.
- All attempts to gather information should be fully auditable, even if that information was ultimately unavailable.
- There should be clear and easy-to-understand letters sent to the patient or their relatives. The letters should explain the rationale behind the panel's decision on whether or not the patient is eligible for continuing healthcare, based on their overall health needs.
- The panel should consider whether a patient is eligible for continuing care, and any rationale for the decision should be fully documented and auditable, prior to any consideration for Registered Nursing Care Contributions (money paid by the NHS for the nursing care component of a patients' continuing care package).
- The panel deliberations and the decision letter should be consistent.
- The patient should be offered a SHA panel review.
- If the SHA panel chair declines a SHA panel, the chair should send the patient, or their relatives, a letter that fully explains why "the patient falls well outside the eligibility

criteria” or why “the case is very clearly not appropriate for the panel to consider”, as stated in the Department of Health’s document HCS2001/015: LAC (2001)18, paragraph 7. The chair should have taken relevant advice to enable them to make this decision, and this advice should be recorded in the patient’s file.

- If the SHA panel chair decides to hold a SHA panel:
 - the panel must comprise one PCT member, one local authority member, and one appointed lay chairman, as per the Department of Health’s *The Continuing Care (National Health Service Responsibilities) Directions 2004*
 - the SHA should have gathered all available and appropriate evidence, including information from the GP, the hospital (such as nursing, medical, and mental health records, and records of any other therapies), community nursing services, care homes, social services, and the patient and their relatives
 - the panel must have obtained independent clinical advice where appropriate
 - all deliberations at review panels should be fully and accurately documented

- patients, or their relatives, should be sent clear and easy-to-understand letters that explain the rationale behind the panel’s decision on whether or not the patient is eligible for continuing healthcare, based on their overall health needs. The letter should also explain what the next stage of the appeals process is.

In over half (57%) of the complaints about continuing healthcare that we were asked to review, we either upheld the complaint or asked the trust to do further work to resolve it.

Improving our independent review service

In the first reporting period, we received a very large number of requests for an independent review, largely due to increased public confidence in our independent review service. This section discusses the improvements that we made to our service to manage these requests.



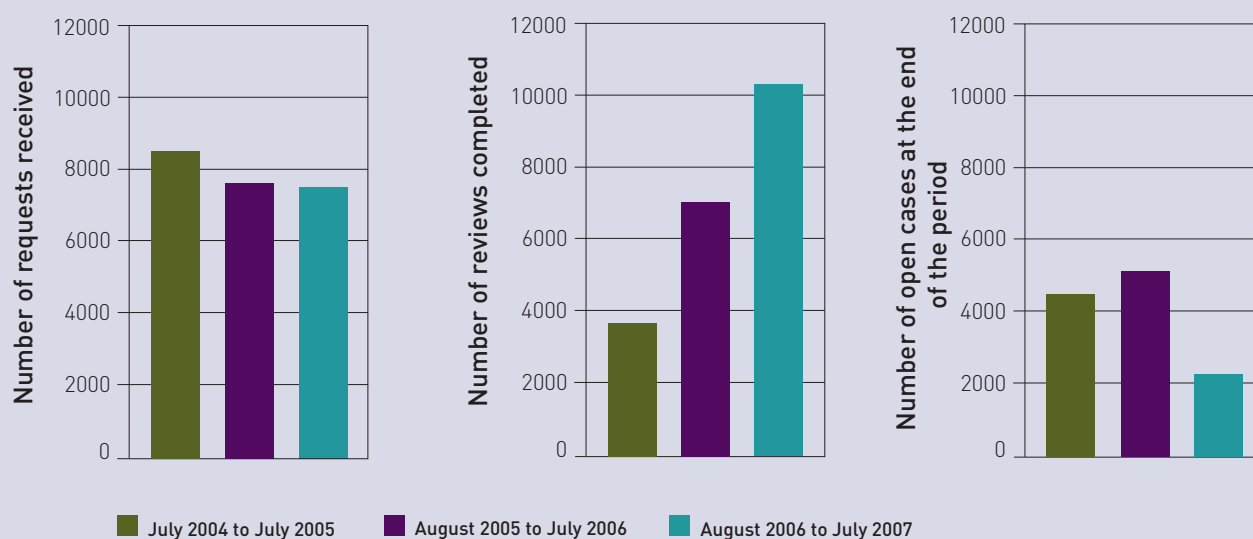
Many patients, and staff who had complaints made against them, had to wait longer than we would have liked for their cases to be resolved because we received so many requests to independently review a complaint. Therefore, we re-evaluated our processes for reviewing a complaint and implemented a number of changes (see appendix), including:

- increasing the number of staff that handle cases
- increasing the number and type of clinical advisers that we use
- streamlining our process to make it more efficient.

These changes have led to significant performance improvements. As a result:

- at the start of August 2006, we had 5,180 open cases. At the end of July 2007, we had just 2,298 open cases – a reduction of over 50%
- we closed 10,950 cases in the first two years, and 10,366 cases this year. People are now waiting far less time for their case to be considered.

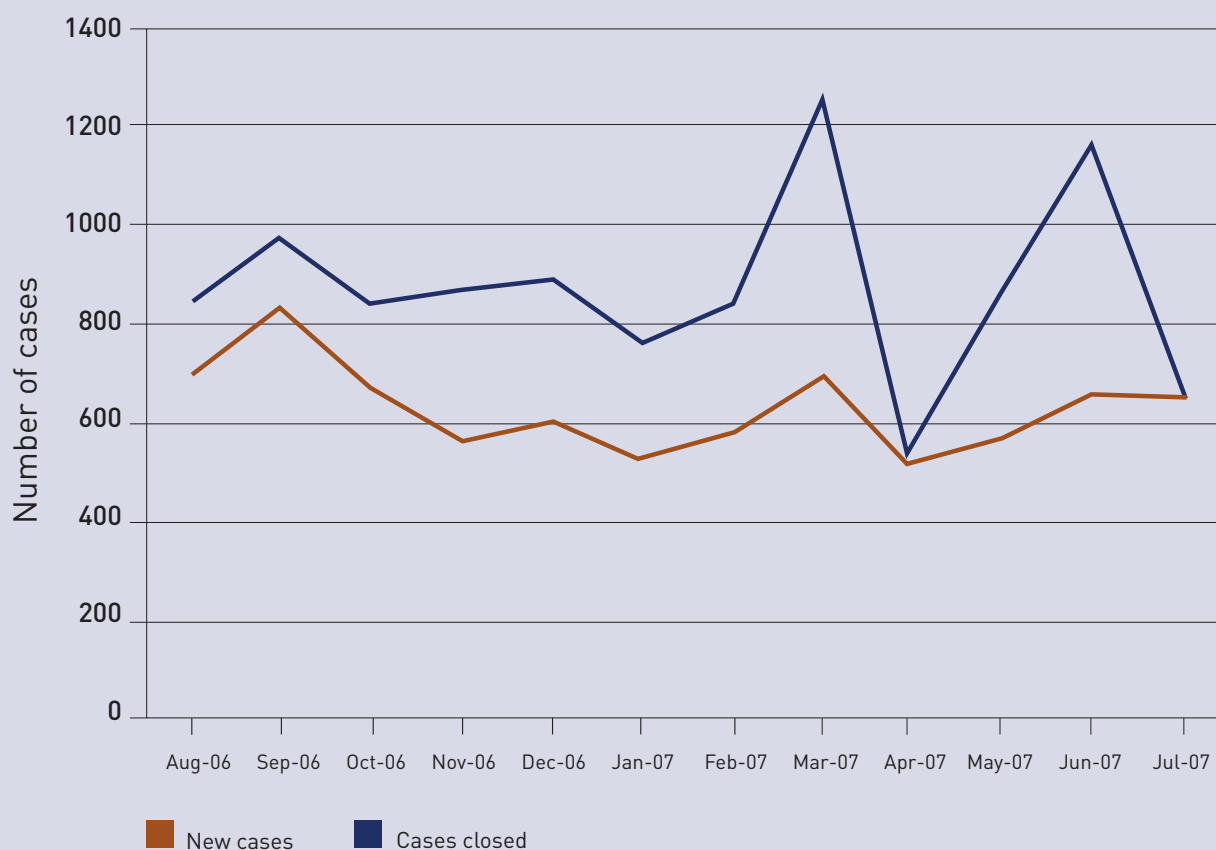
Figure 5: Complaints team output, comparison of first two years with August 2006 to July 2007



The demand for reviews was relatively constant this year, at around 650 requests per month. Our challenge was to shorten the time it takes to review a case and reduce the number of cases that take more than 12 months to close. People who ask us to review their case have often waited some months to get a response from the trust involved, and we don't want to extend this wait. It is also unpleasant for NHS staff who have had a complaint made against them having to wait for resolution, and the opportunity to learn from events reduces over time. It is therefore in everyone's best interest for the review to be completed as quickly as possible.

While the number of new cases that we were asked to independently review was relatively stable, the number of completed cases increased dramatically. From August 2005 to July 2006, the number of case closures per month steadily increased to 800. This year, there was even more improvement, with on average 863 cases closed per month. Over the course of the year, 10,366 cases were closed, 2,887 more than had been opened. Fewer open cases means that we can use our resources more efficiently to resolve complaints more quickly.

Figure 6: Number of cases opened or closed in a month, from August 2006 to July 2007



This year we reduced the average time it takes to close a case to just below five months – seven weeks less than in the previous reporting period. We did this by addressing the profile of open cases and using a more effective process to review new cases. As at March 2008, the average time for us to resolve cases is now less than three months.

We aim to consistently reduce the average time it takes to close a case, while maintaining our focus on quality. Making a complaint can be highly distressing for the patient and for the individual or trust being complained about. Therefore, it is better for both parties if a complaint can be resolved as quickly as possible.

We have not only improved our efficiency, but we have also developed the way in which we learn from complaints and feed our learning back to the NHS to improve patient care.

We use the information that we gather from our independent reviews of complaints (in particular, the recommendations that we make to trusts) in our annual health check to assess trusts' self-declarations of compliance against the Government's core standards. If a trust's self-declaration varies from the information that we obtained during our reviews, we may inspect the trust. In turn, this may affect the trust's rating in our annual health check.

All NHS trusts give us an annual report on complaints, setting out the improvements that they have made to their services as a direct result of our recommendations. We have strengthened our process for following up with trusts and now monitor whether or not they comply with all of our recommendations. If they unreasonably refuse to comply, we will escalate the matter through the relevant strategic health authority (SHA) or Monitor (the independent regulator of NHS foundation trusts). We will also involve our regional inspectorate team to work with the trust locally.

We produce quarterly reports for each SHA area to keep a better track of trends in complaints. These reports set out the outcomes of our reviews and the recommendations that we have made for each trust in a region.

While we have been resolving a greater number of cases more quickly, we have never lost sight of the importance of maintaining quality in our work. Therefore, we have taken a number of steps throughout the year to improve our independent review service.

- We have introduced a new quality assurance procedure, and trained our staff how to follow it. This new procedure is integral to our case-handling process as it is focused on early and sustained contact with both parties to the case, and on the quality of our written work. If a piece of work fails a quality assurance check, the case cannot progress until we have taken remedial action.
- We have also recruited a compliance officer who checks a random sample of cases each week to monitor whether case managers and supervisors are complying with the new quality assurance procedure.

Since we assumed responsibility for the second stage of the NHS complaints process, the Parliamentary and Health Service Ombudsman has reported on 819 of the 21,320 cases that we have reviewed. Of the 819 cases, just 314 have been fully upheld against us* – an indication of the high standard of our work.

We have also sent feedback forms to both parties involved in a random sample of 25% of closed cases. The responses to these forms showed that:

- 63% of people felt that their review was fair and independent
- 74% of people felt that their case manager had kept them informed about the progress of their case
- 66% of people felt that the rationale behind our decision was clearly explained.

We aim to improve these figures in the next year, as more cases will be reviewed through our new process.

This report does not cover complaints made about independent healthcare providers because we deal with those complaints in a different way.

*Data received from the Parliamentary and Health Service Ombudsman's office. It covers all of the cases we independently reviewed until 1 August 2007.

We consider reviewing a complaint about an independent healthcare provider when:

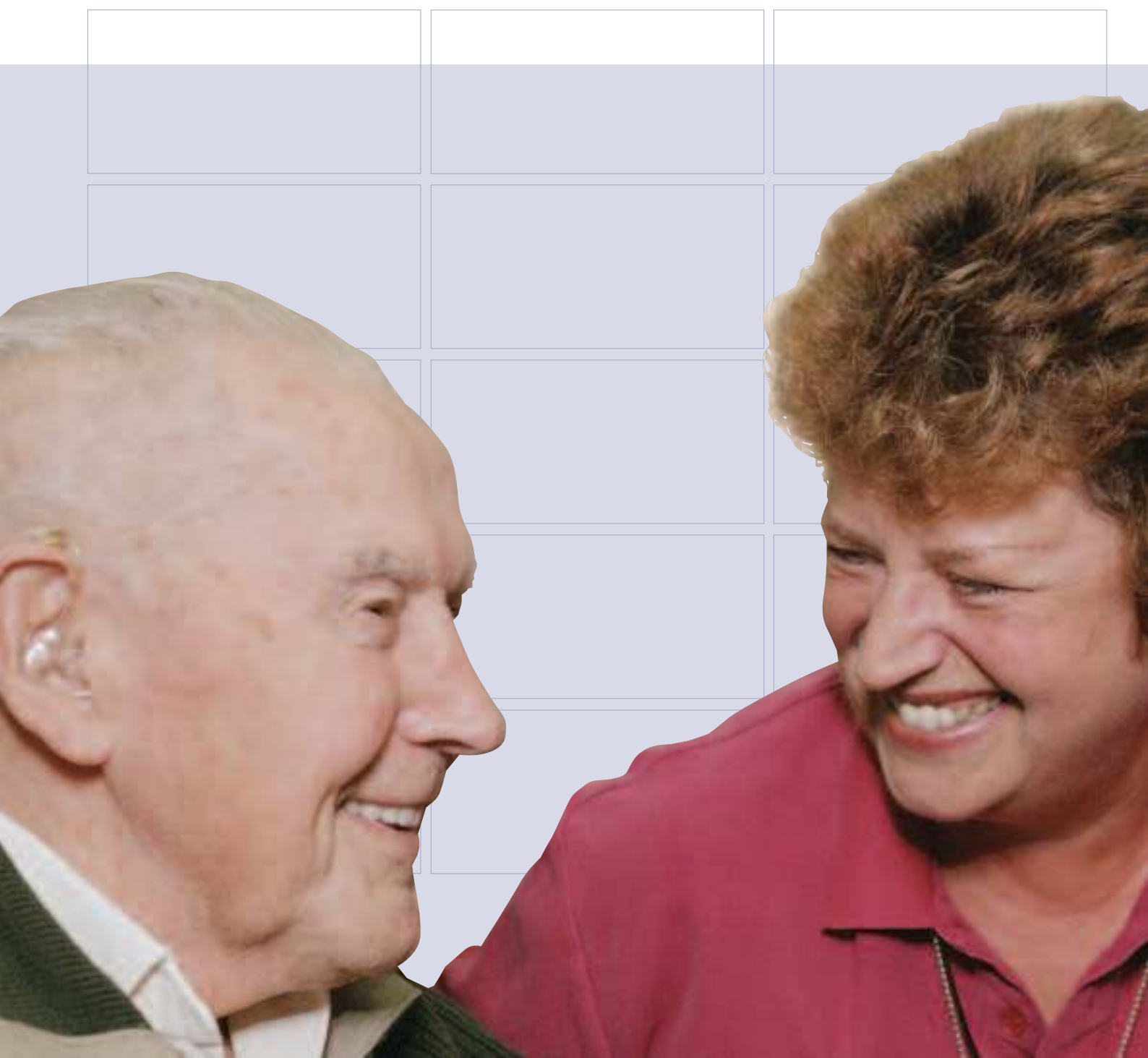
- the provider has breached its conditions of registration
- there is suspicion or evidence that the provider is unfit, or that it is not complying with the regulations or national minimum standards for independent healthcare
- patients may be at immediate or potential risk
- a serious failure in services is identified.

We expect the independent healthcare provider to carry out the first stage of its process for handling complaints and try to resolve the complaint at the local level. We check whether or not there are further options available to the complainant within the provider's process for handling complaints. If there are none, we can review the complaint to see if there is evidence of a breach of the regulations or non-compliance with the national minimum standards.

More information about our role in reviewing complaints about independent healthcare providers is available on our website: www.healthcarecommission.org.uk.

Conclusions and next steps

We saw many examples of good practice in the over 10,000 complaints that we reviewed this year. However, we also saw too many examples where the trust could have done more to resolve the complaint.



This year, we referred 26% of the complaints that we received back to the trust for further work because we found that the trust had not done enough to resolve the complaint. When we added this figure to the complaints we upheld or partially upheld in favour of the complainant because the response was not accurate or comprehensive, we found that procedures for handling complaints were not satisfactory in around half of the cases that we reviewed.

This was also borne out by the number of recommendations that we made to trusts about their procedures for handling complaints, and about the need to improve their services through learning from complaints. Some trusts still need to make significant improvements to the way that they handle complaints.

However, we saw some areas of improvement this year and should remember that complaints were made about only a small fraction of the millions of cases where the NHS provided care and treatment.

We were pleased that many trusts were using the increased timescales in the amended NHS complaints regulations to deliver better outcomes for complainants. We also saw more evidence that some trusts were using the lessons that they had learned from complaints to improve their services and prevent further complaints.

Unfortunately, many of the areas of poor practice that we highlighted in last year's report were still occurring too often.

- Many trusts did not use the full range of options available to them to resolve complaints. For example, trusts did not offer complainants an apology, meetings with staff

to explain what had happened, financial compensation for loss, remedial treatment, or support to get further treatment to remedy any harm or sense of injustice the patient had suffered.

- Letters that confirmed the outcome of a complaint were often of poor quality, with the emphasis more on the process of the investigation rather than the outcome for the patient. We saw many letters where the trust did not use empathetic language when it was needed and did not explain complex medical terms.
- Many trusts did not test their responses to complaints against existing national guidance to support their statements that care was of a suitable quality.

We saw many cases where trusts had genuinely learned from things that had gone wrong and had taken remedial action, but did not tell the complainant. Therefore, the complainant was concerned that no action had been taken and asked us to review their complaint.

We call upon trusts to make sure that their systems for handling complaints are effective, and focused on resolution and learning lessons. We recommend that their systems are:

- **accessible to everyone who uses the service**
 - information about how to make a complaint is easily available and easily understood by everyone who uses the service
 - staff are trained to respond to an initial complaint with confidence, and to make any immediate changes required, and know how to escalate matters appropriately if immediate resolution is not possible

- trusts analyse whether the main source of complaints (such as one particular ethnic or social group) represents the majority of people who use their services, and are proactive in encouraging feedback from under-represented groups
- **easy to use by anyone who wants to make a complaint**
 - complaints can be made in a variety of ways that are convenient to the complainant (such as via the trust's helpline, the internet, an easy-to-complete form, or meetings outside office hours)
 - the steps that need to be taken to resolve complaints are easy to follow and logical to everyone involved
 - trusts use a range of possible responses to resolve complaints
 - trusts direct complainants to other organisations that can help them to make a complaint (such as the Independent Complaints Advocacy Service)
- **sympathetic to the complaints**
 - staff treat all complainants sympathetically and courteously
 - trusts offer appropriate counselling or care when grave or distressing complaints are made
- **focused on resolving matters**
 - staff are authorised to use a range of measures to resolve complaints
- trusts seek to resolve complaints, rather than just 'process' them
- trusts agree the type of response (such as a report, letter or meeting) with the complainant, and it is appropriate to the issues raised
- trusts are flexible with the type of remedy that they provide (such as offering apologies in person rather than in writing, holding meetings with the complainant to discuss issues, and involving complainants when they make improvements to services)
- **non-adversarial**
- **able to provide a robust examination of the issues raised**
 - a clear plan and policy for examining complaints is available
 - recognised techniques (such as root cause analysis) are used to formulate the response, if this is appropriate to the seriousness of the issues raised
 - relevant evidence and statements are gathered and explained to the complainant
 - staff who are involved in the complaint contribute to the response wherever possible
 - senior staff manage the overall response to make sure that it is accurate and appropriate
 - independent input is used when it is appropriate (such as in very complex or emotive cases) to demonstrate openness and transparency in processes and response

- **able to ensure that an appropriate remedy is provided if a problem is found**

- a flexible range of remedies is available, and staff are authorised to use them to resolve complaints

- **linked to the trust's service improvement agenda**

- trusts gather information about complaints in a systemic way and use it as a learning tool, and share it with other professional groups and departments
- senior staff make sure that recommended improvements are followed through, and build feedback into models of service delivery
- commissioners gather and act upon feedback about services
- trusts have proactive mechanisms for feedback that allow those who have made a complaint to tell trusts whether they have felt the impact of improvements.

Many complaints would not have been made if patients were not concerned about poor communication and the attitude of staff. We often found that a patient's care and treatment was in line with established standards, but that the trust didn't give the patient or their relatives a clear, understandable explanation of what the treatment involved. This led to uncertainty about what happened to a patient and a complaint was made. Our clinical advisers saw this trend across all of the clinical areas. Trusts do not need significant resources to improve communication. We urge them to put a greater focus on communication and 'customer' care.

Many of the complaints that we highlighted in this report were about the basic elements of hospital care, such as nutrition, privacy and dignity, and record-keeping. Although the patient's overall treatment may have been successful, issues with these basic elements made the patient and their relatives feel like they had had a bad experience. Trusts can also make improvements in these areas without needing a significant increase of resources. We encourage trusts to make sure that they comply with the benchmarks in *Essence of Care*,⁴ and to audit their compliance regularly.

The key finding of this report is that, although there are many examples of good practice in the way that the NHS handles complaints, there is also a great deal of work that needs to be done before it has a system that meets the needs of the complainants. The system should be used as a rich and valued tool, using patient feedback to help to improve services. This finding is consistent with the finding in our recent complaints audit² and in the Parliamentary and Health Service Ombudsman's recent annual report.¹⁸

Next steps

We aim to build on the improvements that we made to our performance this year by making further improvements to our independent review process. We are also committed to delivering on our key targets. In the first quarter of 2007/2008, we met our target of resolving 95% of cases within 12 months. This year we are confident that we will also meet our target of resolving 65% of all cases within eight weeks. At the same time, we will remain focused on maintaining and improving the high levels of quality of our reviews.

We have a comprehensive plan for communicating with our key stakeholders in the next year. We will regularly feed back what we have learned from complaints to the NHS – for example, through a programme of speaking engagements with health and social care complaints staff, and through our quarterly updates to strategic health authorities and Monitor on complaints about trusts in their area. We will also focus on ensuring that our recommendations are acted upon and that our assessment work reflects the importance of complaints.

Building on our recent complaints audit, we will help to drive improvements in the way that complaints are handled at the local level. We will help the NHS to prepare for the Government's proposed new arrangements for handling complaints. We will also give more information and share best practice on effective ways for handling complaints, including case studies.

Alongside this report, we are launching a toolkit to improve the way that trusts handle complaints. Together with the Parliamentary and Health Service Ombudsman's guidance, such as the *Principles of Good Administration*¹⁹ and the *Principles of Remedy*,²⁰ our toolkit will help to support trusts to resolve complaints at the local level. We will work closely with the Parliamentary and Health Service Ombudsman to make sure that the guidance offered in these documents is consistent.

We firmly believe that the best way to resolve a complaint is for the trust to engage effectively with the complainant. This will ensure that there is an appropriate response, that lessons are learned, and that these lessons are used to improve patient care. We are committed to feeding back what we learn from complaints to the NHS so that improvements can be made.

We will work with other interested parties, such as the Parliamentary and Health Service Ombudsman, the Commission for Social Care Inspection, and the Department of Health, to prepare for the proposed new arrangements for handling complaints. We welcome the emphasis on local resolution of complaints, and the enhanced role for the Parliamentary and Health Service Ombudsman in the process.

However, there is a lot of work that still needs to be done in some areas. Trusts will need to increase the capacity of frontline complaints departments, as well as having strong leadership at board level on handling complaints and learning lessons from them, to make sure that the proposed new arrangements work.

The proposed new regulatory framework will be an excellent opportunity to make NHS trusts accountable for their services. Trusts should be encouraged to better respond to cases through the new clear and measurable national standards, which are focused on local resolution. Boards should have a clear legal responsibility for responding effectively to complaints and ensuring that lessons are learned from them. In addition, contracts that commission services from trusts need to clearly set out the expectations for the trust's performance. This needs to be followed up with vigour by commissioners, whose activity in this area should also be accountable through the standards.

The new regulator should continue to be involved in assessing trusts' performance against the national standards, and local improvement networks should be involved in evaluating how trusts are performing on a local level. This evaluation should be considered in the proposed new regulatory framework.

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Appendix – Process improvements

Improving our independent review service

The first two years of our independent review service were characterised by a need to keep up with demand. Our review process was designed on the basis that we would receive around 5,000 requests for an independent review each year, reflecting the number of requests made through the previous system. The actual number of requests that we received, some 8,000 per year, created a number of challenges for us – both organisational and in terms of the process that we used.

Our review service aims to meet our service level agreements in three key areas:

1. acknowledging all requests for an independent review within two working days
2. completing 65% of all reviews within eight weeks of receipt
3. completing 95% of all reviews within 12 months of receipt.

We met the first point consistently in the first two years, but the second and third points were not achieved in this timeframe.

As we did not meet these last two key areas, we conducted a comprehensive review of our process for handling complaints, which was designed to help us to:

- deliver a service within an agreed timeframe
- reduce the amount of work in progress, measured by having fewer than 3,000 cases open at the end of the reporting year

- provide greater visibility of the way that we learned lessons from the independent review process
- give assurance that we resolve all cases as soon as it is practical to do so, while maintaining the quality of our work.

The review focused on four key areas:

- improving our processes
- consistency
- establishing a performance-centred culture
- improving our access to clinical advice.

Improving our process for independently reviewing complaints

To inform the review of our process for handling complaints, we not only looked at the learning and experience that we had acquired in the first two years of our operation, but we also actively sought the input of some of our key stakeholders. For example, we organised a number of conferences with NHS complaints managers and sought the views of organisations such as the Parliamentary and Health Service Ombudsman and the Independent Complaints Advocacy Service.

Following our internal review, we implemented an improved process with seven clearly defined stages for managing second-stage complaints (see figure 8). It aims to:

- allow a case to be managed by one person
- facilitate case resolution at the earliest stage

within the process, while maintaining high-quality standards

- address 'bottlenecks', where the process could be constrained by a lack of resources
- use administrative support for routine, well-defined tasks
- improve communication across our complaints team
- improve our communication with the complainant and the people complained about
- provide a clear end for the review, where all follow-up activity is done by another specifically resourced and directed team.

Through stages 2, 3, 4 and 6, our improved process works around a cycle of gathering and considering information, and making decisions. The aim is to reach a fair and robust decision at the earliest stage so that the interests of both parties are addressed as quickly as possible. Our improved process puts greater emphasis on early contact between the case manager

and all parties involved – usually by telephone – to discuss the issues that have not been resolved by the trust. This makes it easier for us to explain to trusts why complainants are not satisfied, so that all parties can work together more effectively to resolve the complaint.

The seven-stage process improves our potential to resolve a case as quickly as possible, but in no way compromises the depth of the review that is required to fully address the complaint. Figure 9 overleaf shows the inputs and outputs of our processes.

Consistency

When we reviewed our process, we evaluated all aspects of our work to ensure consistency. We updated our standard response and decision letter templates, considered the rules that govern the progression of a review from one stage of the process to the next, and implemented an improved quality assurance system and more comprehensive performance reporting.

Figure 8: Our improved seven-stage process for independently reviewing complaints

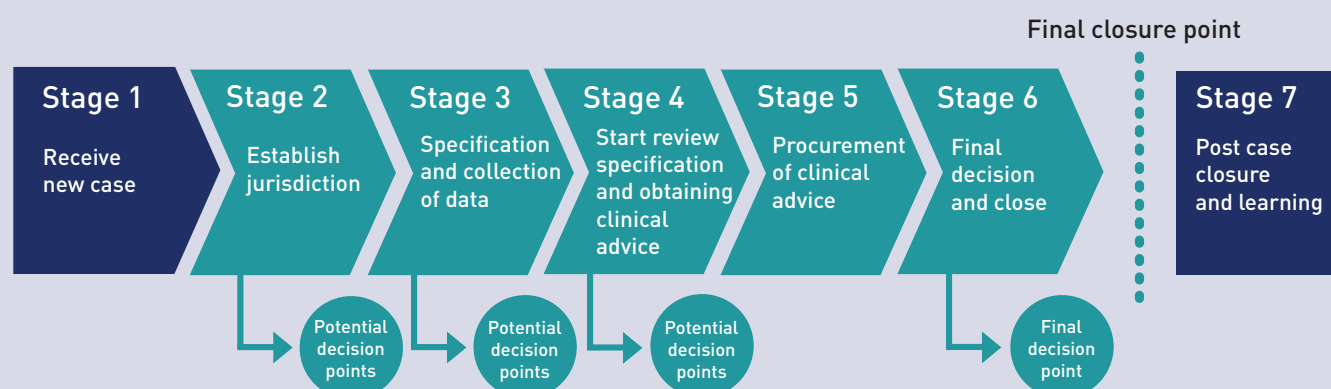
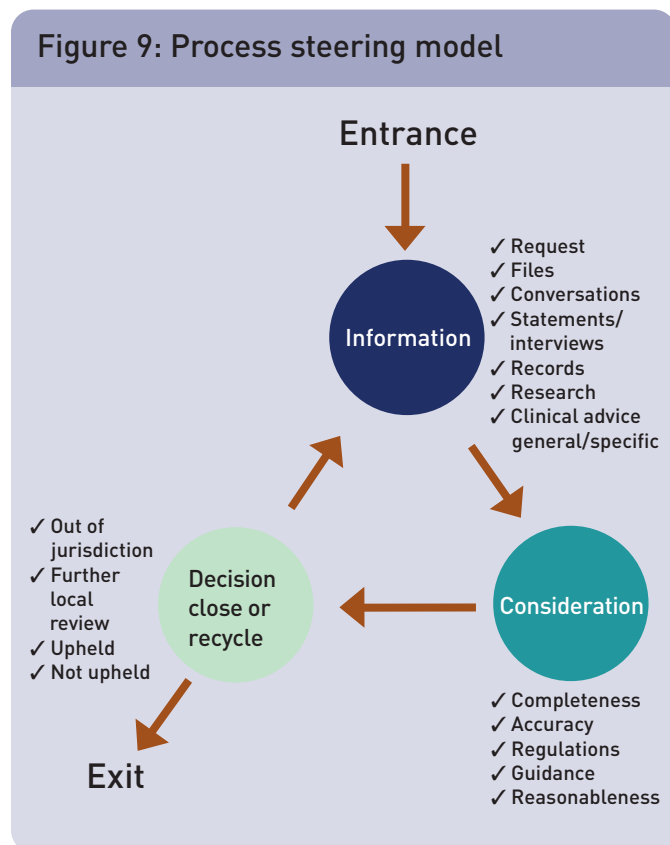


Figure 9: Process steering model



Performance management

We have improved the way that we measure and report our performance in both quantitative and qualitative terms. This is crucial in building stakeholder confidence, and is the centre of our improved way of working.

Improved access to clinical advice

High-quality advice from clinicians is crucial to our independent review service. We can often only test how reasonable a trust's response was by obtaining the input of a clinician who is qualified to comment on the clinical matters in the complaint.

Problems accessing clinical advice caused a major bottleneck in our review service in its first two years. We have taken measures, such as forming a discrete clinical advice procurement team, to make sure that clinical advice can be accessed much more efficiently. This allows us to resolve complaints more quickly.

Our clinical advice procurement team supports case managers by providing clinical advice and managing a clinical adviser database that makes contacting relevant specialists easier.

Our improved process was developed during the first half of the first review year, and established during the second. It is now fully in place and undergoes continual development.

We reviewed our processes at the same time as we continued with a 'business as usual' approach. Consequently, our level of work from the review period shows a trend of consistent improvement. We expect this trend to continue.

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This publication is printed on paper made
from a minimum of 75% recycled fibre

ISBN 978-1-84562-180-3



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