Local complaints systems: how well are they working?

A toolkit produced with local Healthwatch

May 2016

Contents

1   Why work on complaints?

We all have the right to make a complaint if health and care services aren't up to scratch. When the systems for handling those complaints don't work properly, everyone loses out - especially those people who have taken the time and trouble to complain in the first place. This toolkit is designed to help local Healthwatch scrutinise local complaints systems, make recommendations based on findings and follow through on the improvements they ask for.

1.1   What is this toolkit for?

This toolkit will help you find out how effective local complaints handling services are. We've included:

- areas to think about before starting your project;
- example approaches other local Healthwatch have taken;
- example resources to adapt for your area (in the accompanying Resource Pack).

We produced this toolkit in partnership with local Healthwatch in East Sussex, Norfolk, and Wiltshire.

1.2   Why work on complaints?

Many people are unhappy with the care they receive. When a complaint is made, they should receive an effective, timely, and compassionate response that tells them what is going to be done about it.

Complaints provide vital information about how well services are performing. If complaints are not handled properly, situations such as those seen in Mid Staffordshire and Morecambe Bay Trusts and Winterbourne View hospital could be repeated.

Complaints also provide Healthwatch with important information to help us carry out our statutory duties.

Complaints in England

The NHS Constitution sets outs the rights we all have with regards to NHS complaints. This includes the right to have a complaint acknowledged within three working days and for us to go to the Parliamentary and Health Service Ombudsman (PHSO) if we are not satisfied with the 'local' resolution.

To complain about care homes or social care services we can contact the provider directly, or contact the local council if they are paying for the service. If we are not satisfied with the response, we can go to the Local Government Ombudsman (LGO).

In recent years, reports including the Clywd-Hart report, the Francis report, and those by Sir Don Berwick and Sir Bruce Keogh, have demonstrated failures with NHS complaints handling. Hard Truths, the government's response to the Francis Inquiry, set out a number of commitments to improve this. We need to make sure that services are sticking to these commitments.

Healthwatch and complaints

We have raised concerns about the difficulties care home residents and other social care users face when wanting to complain about the quality of care they receive. Our report, Suffering in silence, was the result of a joint investigation between Healthwatch England and local Healthwatch.

Local Healthwatch told us that people:

- are not given the information they need to complain;
- do not have confidence in the system to resolve their concerns;
- find the complaints system complex and confusing;
- need support to ensure their voices are heard;
- need to know that health and social care services learn from complaints.

For more information about Suffering in Silence, and the changes that have happened since it was published, see the Appendix. You can also find more detail about My Expectations, the user-led vision for complaints handling we produced together with the LGO and PHSO.

See the Appendix for more about the new NHS Duty of Candour, and the problems we have finding useful data about complaints from people receiving social care.

To what extent does your local Healthwatch focus on complaints?

You might provide or commission the NHS Complaints Advocacy service for your area. You might offer a signposting service and more general support for people who have feedback about services. You may already have strong relationships with local complaints teams, or be developing them:

The challenge we face in terms of complaints...is the slightly different approach taken by each of the commissioners/providers and making sure that we have up to date information...It has also been a challenge to persuade some of the bigger organisations that it is important that the public

can easily access information about how an organisation continually learns and takes action from the outcome of complaints.

Local Healthwatch

In Norfolk, the shadow Healthwatch Board had identified that complaints handling was an issue of great concern to the public before the local Healthwatch began operating. They later found that a high number of their enquiries were about NHS complaint handling processes. Healthwatch Norfolk created its own map of local NHS and social care complaints processes, showing the range of organisations that may be involved in a complaint:
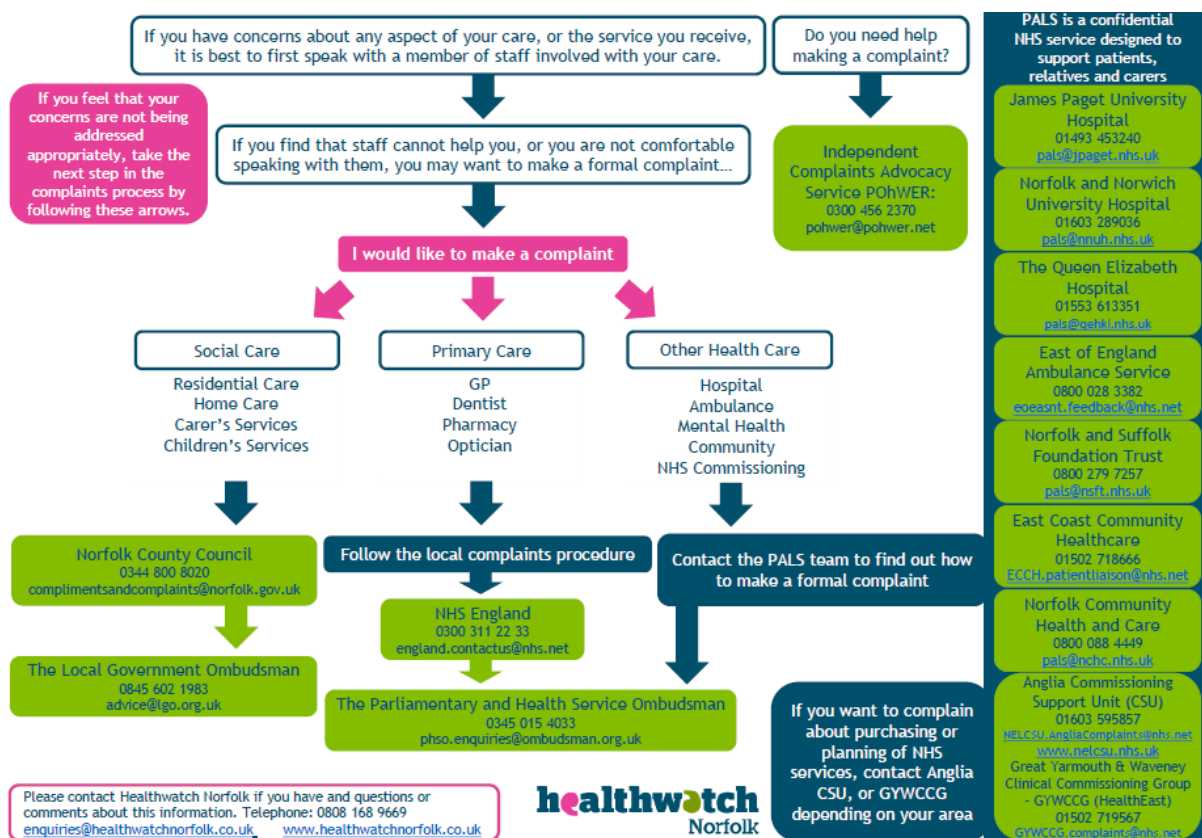
What can I do to help improve complaints systems?

There are a number of approaches you can take, depending on the issues in your area, your aims, and the resources you have available. Here are a few examples of things local Healthwatch have done:

- collating data which is already locally available, such as in the form of Board reports;

- desk research to explore how easy it is to find out about complaints processes;

- targeted lay review of complaints outcomes in a Trust;
- developing memoranda of understanding for local NHS complaints processes.

For more information about the data available on NHS complaints, see the Appendix .

Whichever method you choose, it's important that you include a patient perspective in your work. A Trust may be able to supply you with documents that detail their commitments to handling complaints effectively, but that on its own is likely to tell you little about how the system is actually working for patients.

Local Healthwatch have included the patient perspective in a number of ways: for example, through focus groups, through scrutinising complaints made, and by contacting patients who have been through the complaints process.

A SCOPING EXERCISE: HEALTHWATCH WILTSHIRE

Healthwatch Wiltshire interviewed service providers face-to-face; ran focus groups with local people; held telephone interviews with service providers and local people; analysed complaints policies, PALS and complaints leaflets and easy read documentation; and reviewed websites to see how easy it was to find information about making a complaint or giving feedback. Healthwatch Wiltshire's resulting recommendations were ratified by the local Health and Wellbeing Board.

CREATING A DECLARATION OF UNDERSTANDING AND RUNNING A PEER REVIEW: HEALTHWATCH EAST SUSSEX

Following the launch of the My Expectations vision, Healthwatch East Sussex worked with local complaints managers and patients to create a declaration of understanding about how to manage complaints. They worked with East Sussex Hospitals Trust to train a group of volunteers to independently audit both their formal complaints process and the experiences of patients using the complaints process.

AUDITING PROCESSES AND BRINGING COMPLAINTS MANAGERS TOGETHER: HEALTHWATCH NORFOLK

Healthwatch Norfolk encouraged all health and social care providers to sign up to a joint protocol to improve consistency in approach where complaints cover multiple organisations and were invited by four local NHS Trusts to audit their complaints processes. They are also hosting a county-wide forum twice a year for complaints managers from health and social care.

2 How to plan and project manage

As with any project, you need to think about what you want to achieve, who you need to involve and how you will involve them. Make sure you are clear about any internal approval that is needed for the work, and that you have a project plan with clear milestones.

IDENTIFYING CLEAR AIMS FOR A PROJECT: HEALTHWATCH WILTSHIRE

Healthwatch Wiltshire had four main aims for their work:

To provide local people with a map of local complaints information so that they would know who to contact should they wish to raise a concern or complaint about a health or social care service;

To identify gaps in provision of information relating to raising a concern or making a complaint;

To identify any innovative practices or examples of enhanced service within the provider network that may be shared with others to enable them to further develop their own services;

To develop communication channels and build relationships with all of the major health and social care providers in the county to encourage ongoing sharing of data relating to concerns and complaints. This would allow Healthwatch Wiltshire to carry out its duty as an 'overseeing eye' and to identify at an early stage any areas of concern so that action could be taken.

Depending on your aims you could involve:

- local NHS Complaints Advocacy or social care advocacy providers
- Citizens Advice
- local Trusts and care providers
- CCGs
- the Local Authority
- Healthwatch staff and volunteers
- members of the public

You may need to contract the work to another organisation.

When you're mapping local complaints systems, it may be helpful to refer to the diagram that was used in Suffering in Silence, showing how many organisations have a stake in complaints handling. You can find it in the Appendix.

CREATING A PROJECT SCOPING DOCUMENT: HEALTHWATCH NORFOLK

Healthwatch Norfolk created a 'project scoping' document including the following headings, along with an Invitation to Tender, so that they could contract another organisation to deliver some of their work:

Background

Objectives of the project

Outputs

Consultation with stakeholders

Proposed methodology

Proposed timescale

Outside the scope of the project

Possible constraints of completing the project

PLANNING A LAY REVIEW PROJECT: HEALTHWATCH EAST SUSSEX

Healthwatch East Sussex completed a detailed Project Initiation Document (PID) to plan their lay review project. The PID included a revision history and a distribution list, as well as sections that covered:

1.   Project background / context

2.   Objectives

3.   Project scope

4.   Constraints

5.   Assumptions

6.   Outline business benefits

8.   Project budget

9   Project plan and milestones

10. Project organisation structure

11.   Project communication plan

12.   Risks

What issues do I need to consider?

There are a number of other issues to consider. For example, if you're planning to use volunteers for any aspect of the work, how will you train and recruit them? Scrutinising complaints processes may involve some risk - how will you make sure this is minimised with regards to safeguarding and confidentiality?

RECRUITING AND PREPARING VOLUNTEERS FOR A PEER REVIEW: HEALTHWATCH EAST SUSSEX

Healthwatch East Sussex used Enter and View protocols for their peer review, so had access to a robust recruitment and training programme. This included:

• Application, reference and DBS checks;

• Enter and view training;

• Safeguarding adults;

• Deprivation of Liberty safeguards (DoLs);

• Mental Capacity Act (MCA) awareness;

• Report writing;

• Data protection and confidentiality;

• Induction relevant to the project: understanding NHS complaints and local hospital complaints process; the role of independent advocacy support services and the Parliamentary and Health Services Ombudsman; organisational Duty of Candour.

They put additional safeguards in place to manage any potential conflict of interest that might arise, and made sure that confidentiality and data protection were managed well.

You could also think about how you will evaluate the systems you are looking at. In Wiltshire, local Healthwatch wanted to use some national criteria to decide

whether providers were meeting an acceptable standard. Their 'Evaluating Processes' document shows how they did this, and can be found in the accompanying Resource Pack.

Both the Francis and Clywd-Hart reports made a series of recommendations for improving the way in which the NHS manages and responds to complaints. The Department of Health responded to these recommendations in Hard Truths. Healthwatch Wiltshire used those recommendations that had been accepted in part by the Department as a benchmark for local services.

3 How to choose a methodology and analyse findings

When deciding on a methodology, think again about what you want to achieve with your work. There are some examples below of a range of methods and media that have been used by other local Healthwatch.

DESK RESEARCH AND QUESTIONNAIRES: HEALTHWATCH NORFOLK

In order to gain information from all organisations that commission and provide NHS healthcare in Norfolk, Healthwatch Norfolk engaged with a wide range of NHS organisations, including acute Trusts, Community Trusts, the local Ambulance Trust, providers of the local 111 service, a number of CCGs, and the local Commissioning Support Unit and NHS England team. Stakeholders completed questionnaires and the information available to the public on each organisation's website was also reviewed.

The second phase of the project was to ask for feedback directly from complainants about their experience of making a complaint. Each provider organisation (and NHS England) randomly selected a number of people who had made a complaint within the past six months (and where the complaint had been closed) to receive a questionnaire for completion. Respondents could return questionnaires to a freepost address or fill them out online.

FOCUS GROUPS WITH LOCAL PEOPLE: HEATHWATCH WILTSHIRE

Healthwatch Wiltshire contacted the complaints or Patient Advice and Liaison Service (PALS) departments of the majority of the major providers of local NHS health and publicly funded social care services. They asked complaints teams about their policies and procedures as well as plans for future work, methods of reporting statistics relating to complaints and service evaluation procedures.

In addition to this, Healthwatch Wiltshire studied policies and procedures, leaflets, posters and websites from all of these providers to determine whether the information given to consumers was fit-for-purpose, easy to understand and to find, and up-to-date.

Most importantly, they engaged with local people of all ages so that they could provide their views of navigating the system, asking local people to recount their experiences and

highlight good and poor practice. They encouraged local people to think about what a 'good' experience for patients would look like. They also asked people who had thought about making a complaint or raising a concern but decided not to do so to say what had prevented them from going ahead.

A COMPLAINTS CONFERENCE: HEALTHWATCH EAST SUSSEX

In March 2015 Healthwatch East Sussex hosted a conference that brought together patient, carer and service user representatives, providers, commissioners, advocacy organisations and other interested parties with an interest in health and social care to work together to develop a Declaration of Understanding on Managing Complaints for East Sussex.

They publicised the work with a video on YouTube.

What support can I get with designing and carrying out my research?

The Healthwatch Research and Intelligence guidance pack on the Healthwatch Hub contains useful guidance to support your work, including sections on:

- Planning and carrying out focus groups;
- Working with interpreters;
- Interviewing vulnerable adults;
- Designing surveys;
- Structuring your report and making recommendations.

You can contact research@healthwatch.co.uk with any methodology and analysis questions.

Other guidance is also available. For example, if mystery shopping is likely to form part of your project, you'll want to make use of the Market Research Society's Guidelines for Mystery Shopping Research.

What about Freedom of Information?

The Freedom of Information (FOI) Act is a useful tool if you need to get information from a public body that would otherwise be difficult to find. If you want to find out more about FOI and how you might use it, you can read Healthwatch England's guidance.

How do I create materials?

Depending on the methodology you choose, you may need a range of different materials to carry out your project. The Healthwatch Research and Intelligence Guidance Pack should be useful, and is available on the Healthwatch Hub.

We've included examples of the kind of materials you may need in the accompanying Resource Pack which you will need to adapt for your own use.

Letters introducing the project

These letters introduce the complaints projects to stakeholders.

3. Introductory Letter to Trusts

This is in the form of an invitation for Trusts to send a representative to a briefing meeting.

4. Introductory Letter to Complainants Taking Part in a Survey

This letter introduces the survey that was carried out with people who had complained about local NHS services.

Research tools

5. Discussion Topics for a Public Focus Group

This document lists discussion topics for a focus group with members of the public about complaining.

6. Interview Schedules for Use with PALS Teams

These interview schedules were used to as prompts in conversations with PALS team members about complaints processes.

7. Questionnaire for NHS Organisations

Interviewers carried out this questionnaire with NHS representatives.

8. Questionnaire for People Who Have Made a Complaint

This questionnaire takes complainants through their experience of making a complaint.

9. Questionnaire for People who have Considered Making a Complaint

A questionnaire for people who have made a complaint, considered making one in the past, or are thinking about making one now.

10. Face-to-Face Complainant Interview Recording Sheet

Uses the My Expectations framework to ask complainants about their experiences.

11. Follow-up Face-to-Face Recording Sheet

A recording sheet for interviews with patients, using the My Expectations Framework.

12. Complaints Audit Form

A form for use in reviewing NHS complaints.

13. Volunteer Complaints Prompt Sheet

A document that takes volunteers through the aims and context of a lay review of complaints.

14. Volunteer Complaints Recording Sheet

A form where volunteers in the lay review recorded their findings.

Where can I get help analysing my findings?

Make sure that you build in enough time to analyse your findings. If you need some help approaching this part of the task, please contact research@healthwatch.co.uk

4   How to report findings and make recommendations

Local Healthwatch who have worked on complaints told us that it's important to include a timescale for recommendations, as well as identifying who is responsible for making them happen.

Sharing examples of good practice can give stakeholders a really concrete idea of what has worked elsewhere.

Have a look back at the work that Healthwatch England and other local Healthwatch have done to see whether the recommendations made are relevant to your local area.

The local Healthwatch who contributed to this report had made recommendations aimed at a large number of stakeholders, from providers to local Healthwatch themselves. Some recommendations were relatively small scale but could have a big impact (such as making changes to websites so that complaints information could be found more easily), whereas others would involve ongoing commitment (such as committing to six-monthly audits of complaint processes).

CONVENING A COMPLAINTS MANAGERS' FORUM: HEALTHWATCH NORFOLK

Healthwatch Norfolk's recommendations were:

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

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

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

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

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

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

5 How to implement and review recommendations

Once the project is complete and your recommendations have been made, it's important to monitor the implementation of the changes you have suggested and to see whether things have got better for patients and the public.

Here are some examples of how local Healthwatch have planned, implemented and reviewed change based on their recommendations. You can find all these documents in the accompanying Resource Pack on the Healthwatch Hub.

In Wiltshire, local Healthwatch created a plan to review the implementation of the recommendations they made: (15. Forward Review Plan). The local Health and Wellbeing Board had ratified these and asked for an update in January 2016. To compile their report for that update, Healthwatch Wiltshire developed a template for PALS and complaints managers to report on their progress (16. Update: Recommendations for Providers) They then updated the Health and Wellbeing Board. (17. Update: Health and Wellbeing Board)

In Norfolk, local Healthwatch supported the creation of a joint protocol on complaints handling (18. Joint Protocol for Health and Social Care Complaints) They also committed to chairing and hosting the complaints managers' forum, using these Terms of Reference (19. Complaints Managers Forum Terms of Reference).

6   Appendix

6.1   'Suffering in silence'

This report explored consumer experience of the health and social care complaints process, and found that:

- There are 70 different organisations involved in complaints handling across health and social care, creating an incredibly complex and often frustrating landscape for patients to navigate;

- Two thirds of those who experienced/witnessed poor care in the previous two years said they hadn't raised a complaint. Of those who did complain, 3 in 5 did not feel their complaint was taken seriously enough;

- People also told us they were reluctant to speak up because they felt nothing would change as a result; with 8 out of 10 saying that seeing other people's complaints having impact would encourage them to make their own voices heard.

6.2   Developments since 'Suffering in silence'

To address the concerns that Suffering in Silence found, we produced Every Complaint Matters, a seven step plan for creating a complaints system that gives patients what they need.

In 2015 we published a set of standards for health and social care complaints advocacy services, setting out what people should be able to expect from these services.

The NHS Mandate is the document that sets out the government's objectives and budget for NHS England. It reflects our suggestion that insight from complaints needs to be used to improve services and references My Expectations, the user-led vision for complaints that we created jointly with the PHSO and the Local Government Ombudsman (LGO). The diagram below summarises the My Expectations vision. Healthwatch England (along with NHS England and the CQC) is also supporting the PHSO's work on GP complaints services.

A user-led vision for raising concerns and complaints

| I felt confident to speak up. | I felt that making my complaint was simple. | I felt listened to and understood. | I felt that my complaint made a difference. | I would feel confident making a complaint in the future. |

1 Considering a complaint
- I knew I had a right to complain
- I was made aware of how to complain (when I first started to receive the service)
- I understood that I could be supported to make a complaint
- I knew for certain that my care would not be compromised by making a complaint

2 Making a complaint
- I felt that I could have raised my concerns with any of the members of staff I dealt with
- I was offered support to help me make my complaint
- I was able to communicate my concerns in the way that I wanted
- I knew that my concerns were taken seriously the very first time I raised them
- I was able to make a complaint at a time that suited me

3 Staying informed
- I always knew what was happening in my case
- I felt that responses were personal to me and the specific nature of my complaint
- I was offered the choice to keep the details of my complaint anonymous and confidential
- I felt that the staff handling my complaint were also empowered to resolve it

4 Receiving outcomes
- I received a resolution in a time period that was relevant to my particular case and complaint
- I was told the outcome of my complaint in an appropriate manner, in an appropriate place, by an appropriate person
- I felt that the outcomes I received directly addressed my complaint(s)
- I feel that my views on the appropriate outcome had been taken into account

5 Reflecting on the experience
- I would complain again, if I felt I needed to
- I felt that my complaint had been handled fairly
- I would happily advise and encourage others to make a complaint if they felt they needed to
- I understand how complaints help to improve services

6.3   Duty of Candour

The statutory Duty of Candour has been introduced in response to a recommendation from the Francis Inquiry. The Duty means that NHS organisations registered with the CQC must now take a number of steps when a 'notifiable safety incident' has occurred. One of these steps could be helping patients to access the complaints system.

A notifiable safety incident may be: the death of a patient when due to treatment received or not received (not just their underlying condition); severe harm - in essence permanent serious injury as a result of care provided; or moderate harm - in essence non-permanent serious injury or prolonged psychological harm.

A 'relevant person' is defined as the service user (patient) or a person lawfully acting on their behalf if the service user is deceased or lacks capacity. NHS bodies must:

- Make sure they act in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services;

- Tell the relevant person as soon as is reasonably practical after becoming aware that a notifiable safety incident has occurred and provide support to them in relation to the incident, including when giving the notification (in the CQC guidance, this might include supporting access to the complaints process, for example);

- Provide an account of the incident which, to the best of the health service body's knowledge, is true of all the facts the body knows about the incident as at the date of the notification;

- Advise the relevant person what further enquiries the health service body believes are appropriate;

- Offer an apology;

- Follow this up by giving the same information in writing, and providing an update on the enquiries;

- Keep a written record of all communication with the relevant person.

For more information about the Duty of Candour, visit the NHS Litigation Authority's website.

6.4   Social care: gaps in complaints data

Whilst the Health and Social Care Information Centre collects national data on NHS complaints, it does not collect data on complaints to councils about social care. Local councils do publish their own annual complaints reports, but there is currently no national oversight of the volume of complaints made to them about social care services, and important failings may be missed.

Although the LGO does publish information the complaints it handles, this only gives us information about cases that reach the second level of resolution. We can assume that there are many more complaints about which we know very little.

Whilst people who need support to complain about NHS services should have access to statutory NHS Complaints Advocacy, there is no equivalent across social care. There is a legal duty under the Care Act for some independent advocacy but this only applies in specific circumstances. So there is a gap in the information available about social care complaints and the support available to service users.

6.5   National data on NHS complaints: a very short introduction

The NHS complaints procedure is the statutory mechanism for dealing with complaints about NHS care and treatment. All NHS organisations in England must operate the procedure.

The Health and Social Care Information Centre Data (HSICIC) collects data on the number of written complaints made by (or on behalf of) patients in England. The data can be broken down into single NHS Trusts. Data have been published annually since 1997-98. The most recent annual publication refers to the period ranging from April 01 2014 to March 31 2015. HSCIC has now begun releasing data on NHS

Hospital and Community Health Services (HCHS) on a quarterly basis, although data from GPs and dentists is still published annually.

Data on complaints are available for the following services:

- Ambulance Trusts;
- Care Trusts;
- Mental Health Trusts;
- Hospital Trusts;
- GP practices;
- Dental practices;
- Pharmacies and clinics,
- Hospital and Community Health Services;
- Regional health bodies,
- Regions;
- Clinical Commissioning Groups.

The following chart shows the latest breakdown of complaints by service area complained about:

2014-15 Hospital and Community Health Services (HCHS): Written Complaints by Service Area, England
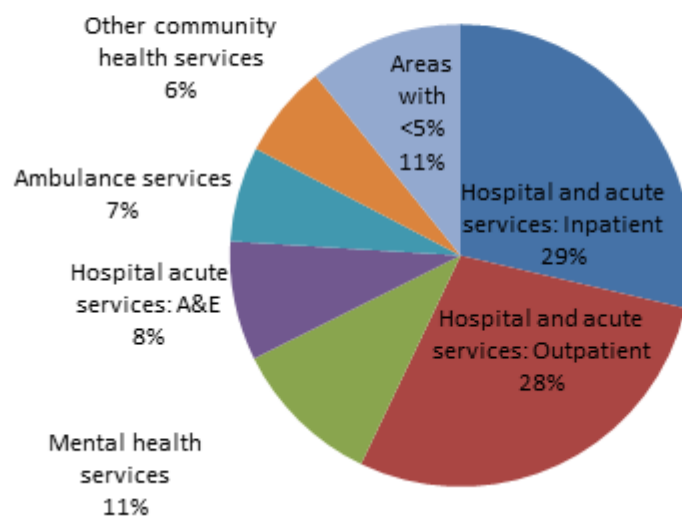
Source: HSCIC (2015), Data on written complaints in the NHS 2014-15, August 2015.

Key subjects complained about include (among others):

- All aspects of clinical treatment;

- Attitude of staff;

- Communication and information to patients;

- Appointments;

- Admissions and discharges.

You can also look at the data to see the proportion of complaints about the various different professions.

The most recent publication is available at the link below:

http://www.hscic.gov.uk/catalogue/PUB18021

Health warnings

HSCIC defines a complaint as upheld if any element of the complaint is well founded. However, we should take care in interpreting the data. There is significant variation in recording practice across England. Some organisations classify all complaints as upheld upon receipt of a written complaint whilst others class all complaints as not upheld due to actively responding and resolving the written complaint.

Higher number of complaints between 2013-14 and 2014-15 might be due to an improved collection method. As the process changed, data from 2014-15 data cannot be compared with previous years. As data provision only became mandatory in 2011, year on year comparisons cannot be made before this.

We should look at complaints data jointly with other quality indicators. A high number of complaints in one service does not necessarily imply a bad quality of the service: it may show an open attitude towards patient feedback.

6.6 How complex is the complaints system? This complex…

The following diagram is taken from Suffering in Silence' and gives an idea of just how complicated a complaints journey can be, showing the huge number of bodies that can potentially be involved. If you would like to see a landscape version of this diagram, please visit page 19 of the report online.

How complex is the complaints system? This complex...

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= Links to associated websites

7   References and guidance

Care Quality Commission Regulation 16: Receiving and acting on complaints

https://www.cqc.org.uk/content/regulation-16-receiving-and-acting-complaints

Complaints Regulations local authority social services and National Health Service complaints (England) regulations 2009

http://www.legislation.gov.uk/uksi/2009/309/contents/made

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

http://www.ombudsman.org.uk/__data/assets/pdf_file/0008/22013/Designing_good_together_transforming_hospital_complaints_handling.pdf

Every Complaint Matters

http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/15062015_every_complaint_matters_-_action_plan.pdf

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

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140206_the_francis_inquiry.pdf

Hard Truths. The Journey to Putting Patients First (DH)

https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response

The Health Committee Sixth Report on Complaints and Litigation

http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/786/786i.pdf

House of Commons Health Committee – After Francis, making a difference

http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/657/657.pdf

Listening, responding and improving – A guide to better customer care

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_095408

My Expectations

http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/vision_report_0.pdf

The NHS Constitution

https://www.gov.uk/government/publications/the-nhs-constitution-for-england

The NHS Hospital Complaints System published by PHSO April 2013

http://www.ombudsman.org.uk/__data/assets/pdf_file/0018/20682/The-NHS-hospital-complaints-system.-A-case-for-urgent-treatment-report_FINAL.pdf

The NHS Governance of Complaints Handling published by PHSO June 2013

http://www.ombudsman.org.uk/__data/assets/pdf_file/0008/20897/PHSO-IFF-Governance-of-Complaints-Handling-research-UNDER-EMBARGO-5-JUNE-0001.pdf

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

http://www.ombudsman.org.uk/__data/assets/pdf_file/0005/1040/0188-Principles-of-Good-Complaint-Handling-bookletweb.pdf

A promise to learn – a commitment to act: improving the safety of patients in England (2013) Don Berwick

https://www.gov.uk/government/publications/berwick-review-into-patient-safety

Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry – Executive Summary (published in February 2013)

http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

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

http://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf

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

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

Standards for Independent Complaints Advocacy

http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/healthwatch_advocacy_standards_10022015.pdf

Suffering in Silence

http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/hwe-complaints-report.pdf

8   Acknowledgements

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- Niccolo Stamboglis, Intelligence Analyst at Healthwatch England, for guidance on NHS data;

- Vanessa Todman, Quality Manager at Healthwatch England, for guidance on the support available for research and analysis.

If you would like further information or if you have any queries, please contact Rebecca Owen-Evans on Rebecca.Owen-Evans@healthwatch.co.uk or call 020 7448 1745. Please contact us if you would like this document in another language or format, for example in large print, in Braille or on CD.