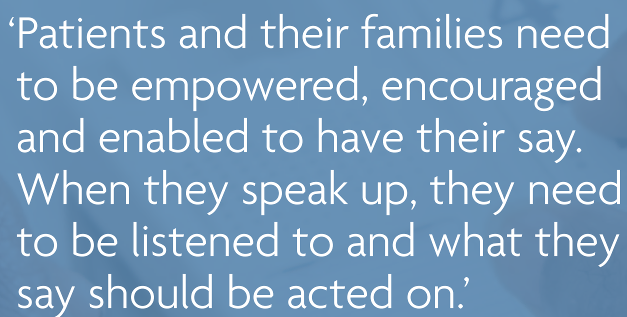
Parliamentary
and Health Service
Ombudsman

Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England 2010-11



'Patients and their families need to be empowered, encouraged and enabled to have their say. When they speak up, they need to be listened to and what they say should be acted on.'

Ann Abraham to the Mid Staffordshire NHS Foundation Trust Public Inquiry

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and Health Service
Ombudsman

Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England 2010-11

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for England
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For additional information on complaint handling, please see our report, A statistical breakdown of complaints about primary care trusts and relevant care trusts (HC 1523).

Our role
The Parliamentary and Health Service Ombudsman considers complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service.

Our vision
To provide an independent, high quality complaint handling service that rights individual wrongs, drives improvements in public services and informs public policy.

Our values
Our values shape our behaviour, both as an organisation and as individuals, and incorporate the *Ombudsman's Principles*.

Excellence
We pursue excellence in all that we do in order to provide the best possible service:
- we seek feedback to achieve learning and continuous improvement
- we operate thorough and rigorous processes to reach sound, evidence-based judgments
- we are committed to enabling and developing our people so that they can provide an excellent service.

Leadership
We lead by example so that our work will have a positive impact:
- we set high standards for ourselves and others
- we are an exemplar and provide expert advice in complaint handling
- we share learning to achieve improvement.

Integrity
We are open, honest and straightforward in all our dealings, and use time, money and resources effectively:
- we are consistent and transparent in our actions and decisions
- we take responsibility for our actions and hold ourselves accountable for all that we do
- we treat people fairly.

Diversity
We value people and their diversity and strive to be inclusive:
- we respect others, regardless of personal differences
- we listen to people to understand their needs and tailor our service accordingly
- we promote equal access to our service for all members of the community.

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Foreword

This is my second annual report on the complaint handling performance of the NHS in England. Using information compiled from complaints to my Office, the report assesses the performance of the NHS in England against the commitment in the *NHS Constitution* to acknowledge mistakes, apologise, explain what went wrong and put things right, quickly and effectively.

In last year's report, *Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England 2009-10*, I concluded that the NHS needed to '*listen harder and learn more*' from complaints. The volume and types of complaints we have received in the last twelve months reveal that progress towards achieving this across the NHS in England is patchy and slow.

This report shows how, at a local level, the NHS is still not dealing adequately with the most straightforward matters. As the stories included here illustrate, minor disputes over unanswered telephones or mix-ups over appointments can end up with the Ombudsman because of knee-jerk responses by NHS staff and poor complaint handling. While these matters may seem insignificant alongside complex clinical judgments and treatment, they contribute to a patient's overall experience of NHS care. What is more, the escalation of such small, everyday incidents represents a hidden cost, adding to the burden on clinical practitioners and taking up time for health service managers, while causing added difficulty for people struggling with illness or caring responsibilities.

In the most extreme example of the last year, a dentist from Staffordshire refused to apologise to a patient following a dispute, which led to Parliament being alerted to his non-compliance with our recommendations. The dentist apologised shortly afterwards and the case is now closed, but it is a clear example of how poor complaint handling at local level can make significant, and needless, demands on national resources.

Two particular themes stand out from my work this year. Poor communication – one of the most common reasons for complaints to us in the last year – can have a serious, direct impact on patients' care and can unnecessarily exclude their families from a full awareness of the patient's condition or prognosis. Secondly, in a small but increasing number of cases, a failure to resolve disagreements between patients and their GP has led to their removal from the GP's patient list – often without the required warning or the opportunity for both sides to talk about what happened. As GPs prepare to take on greater responsibility for commissioning patient services, this report provides an early warning that some are failing to handle even the most basic complaints appropriately.

As we work to improve local complaint handling with health bodies across England, we welcome the increased national scrutiny of the NHS complaints system. In June, Parliament's Health Committee reported on its Inquiry into complaints and litigation in the NHS, reinforcing the value of complaints information. The Health Committee concluded that there is a need for a change in the culture of complaint handling in the NHS, with clear guidance for staff and regular feedback on complaints about them and their teams. The ongoing Public Inquiry into Mid Staffordshire NHS Foundation Trust is also examining the mechanisms in place for listening to patients and learning from the feedback they present. The Inquiry's report is expected to be published next year.

The reformed NHS complaints system is now in its third year of operation. A direct relationship between the Ombudsman and health bodies is embedded within the complaints system's structure and the past year has shown how constructive engagement between the Ombudsman and the NHS can generate positive results for patients. Where health bodies have engaged directly

‘There remains some way to go before a culture is created throughout the NHS that is open to complaints, sees these in the light of systemic weaknesses and supports staff.’

Complaints and Litigation, report of the Health Committee, June 2011

with the Ombudsman, using our data and theirs to identify areas for improvement, we have seen complaint figures drop. As the story of Mr T, on page 12, illustrates, when the NHS listens to patients and takes action on what they say, it can make a direct and immediate difference to the care and treatment that patients experience.

Alongside this local engagement, there has been an encouraging response from NHS leaders, regulators, professional bodies and the Government to some of our gravest concerns about healthcare in England. In October 2010 the Department of Health published a report on progress made to improve the care and treatment of people with learning disabilities, following the recommendations in *Six Lives: the provision of public services to people with learning disabilities*, published jointly by my Office and the Local Government Ombudsman in March 2009. There is still much more work to do, but the progress report confirmed that all NHS bodies have carried out a local review of services offered to people with learning disabilities. In February 2011 *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*, called for a transformation in the experience of older people in hospital and under the care of their GP. The consequences of this report are being considered at national and local level by NHS leaders, practitioners and policy makers. On both these issues there needs to be clear and consistent action across the NHS in England, with patient feedback and complaints information collated and monitored as an indicator of the progress of change.

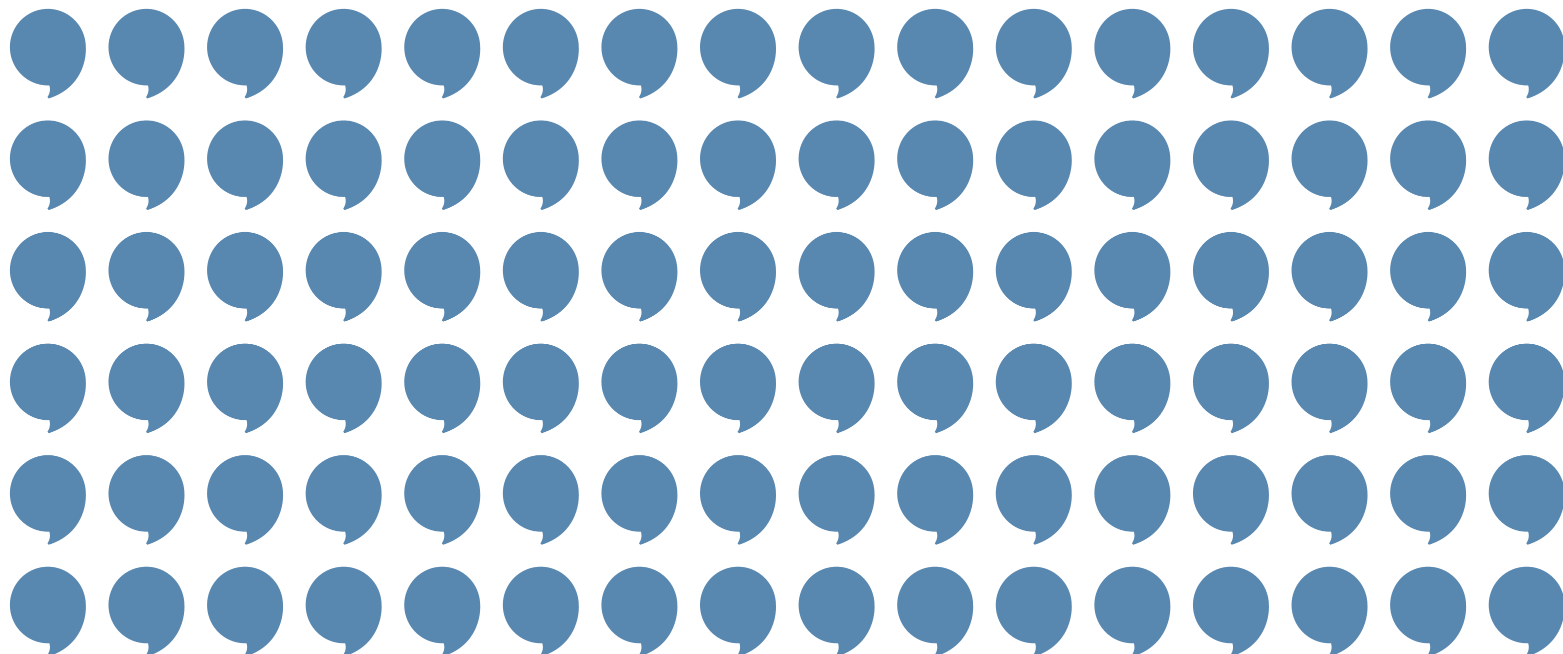
This is my last review of NHS complaint handling before I retire later this year. Nine years ago, when I was appointed as Health Service Ombudsman, I saw a complaints system that was long-winded and slow, focused on process not patients, with learning from complaints an occasional afterthought. Now, there is a growing recognition that patient feedback is a valuable resource for the NHS at a time of uncertainty and change. It is directly and swiftly available, covering all aspects of service, care and treatment. But when feedback is ignored and becomes a complaint, it risks changing from being an asset to a cost. As this report illustrates on page 31, last year we secured nearly £500,000 for patients to help remedy injustice caused by poor care and poor complaint handling.

I hope that this report, and the growing body of complaint information now available throughout the NHS, will be a valued resource for frontline staff and complaints managers, NHS boards and leaders, as well as the general public. Complaints have an important role to play in shaping the future of the NHS: helping health bodies prioritise areas for improvement, and enhancing patients’ capacity to make informed choices about their healthcare. The NHS still needs to *‘listen harder and learn more’* from the complaints that it receives.

Ann Abraham
Health Service Ombudsman for England

October 2011

How we work



This report details the complaint handling performance of the NHS in England in 2010-11. We provide an overall snapshot of how we worked to resolve health complaints last year, and a summary of the standards we set for the NHS. On pages 28 to 52, you can read in detail about the reasons for complaints to us, the breakdown of complaints by type of body and English region, and the health bodies that generated most complaints to us last year.

The role of the Health Service Ombudsman is to consider complaints that the NHS in England has not acted properly or fairly or has provided a poor service.

We judge NHS performance against the standards for good administration and complaint handling set out in full in the *Ombudsman's Principles*, which are available on our website at www.ombudsman.org.uk.

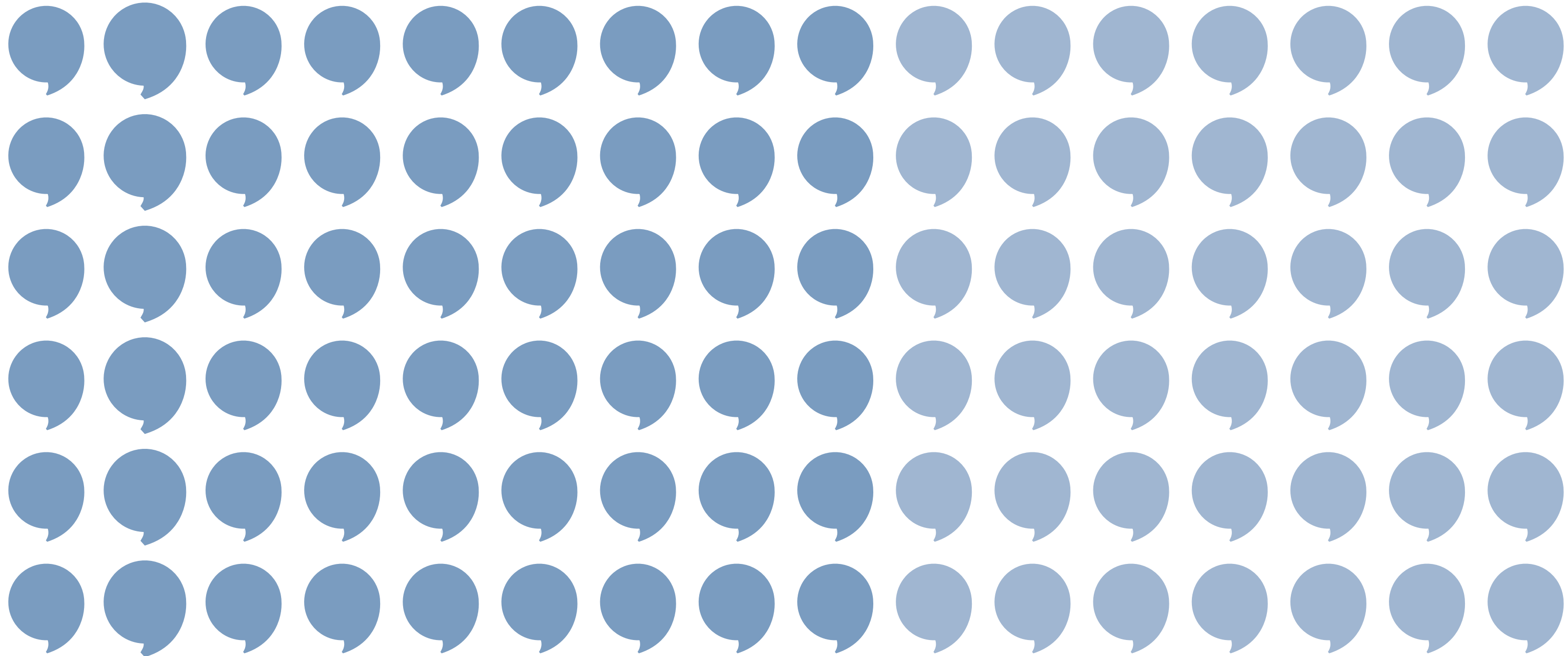
Last year, we resolved a total of 15,186 complaints about the NHS in England.

Helping people complain

We expect health bodies to publish clear and complete information about how to complain, and how and when to take complaints further.

On 9,547 occasions last year, we referred the complainant back to the health body because they had not completed the NHS complaints procedure. A total of 325 complaints about the NHS were about issues outside of our remit.

Complaints about the NHS must be made to us in writing. On 1,137 occasions last year, the complainant withdrew their complaint or did not put it in writing.



Putting things right

Health bodies should put mistakes right quickly and effectively. They should acknowledge mistakes and apologise where appropriate.

On 3,339 occasions last year we were able to reassure the complainant that the NHS had already put things right or that there was no case to answer.

Where things have gone wrong, we ask the health body to apologise and put things right quickly and effectively, without the need for a formal investigation. Last year, 230 health complaints were resolved this way, and a further 257 complaints were resolved when we provided the complainant with an explanation about what had happened.

Learning from complaints

Lessons learnt from complaints should be used to improve public services. Where possible, the complainant should be returned to the position they would have been in if the circumstances leading to the complaint had not occurred.

We accepted 351 complaints for formal investigation and reported on 349 complaints investigated. If a complaint is upheld or partly upheld, we recommend actions for the body in question to take to put things right and to learn from the complaint. Last year, we upheld or partly upheld 79 per cent of health complaints and over 99 per cent of our recommendations for action were accepted.

Our recommendations were not accepted in just one case. Following the publication of our investigation report, which was laid before Parliament, the dentist in question accepted our recommendations. As a result, the current compliance rate with our recommendations is 100 per cent.

Sharing information and learning

The reformed NHS complaints system enables patients who are dissatisfied with the way the NHS has handled their complaint to have direct access to the Ombudsman. Now in its third year, this system is providing an increasingly rich source of information about health bodies and issues complained about as well as generating learning from individual cases.

Throughout the last year we have been sharing this information at all levels: nationally with Parliament, Government, and senior NHS leaders; regionally with NHS complaints managers; and locally with individual trusts.

Sharing information nationally

We shared our unique perspective on complaint handling in the NHS in our evidence to two major inquiries into patients' experiences – the Complaints and Litigation Inquiry conducted by the Health Committee and the Mid Staffordshire NHS Foundation Trust Public Inquiry.

The Ombudsman told both inquiries that the new NHS complaints system is demonstrating its potential and needs to be given time to prove its worth. Complaints about the NHS now receive faster consideration locally and are referred to us more quickly. In the Ombudsman's evidence to the Mid Staffordshire NHS Foundation Trust Public Inquiry, she identified four critical success factors for the new system. First, the role of advocacy in providing support and encouragement for patients to speak up; second, the need for clear, consistent, comprehensive and meaningful information about complaints; third, the importance of good leadership and governance; and finally, time for the new complaints system to bear fruit.

The Health Committee's report acknowledged the success of the new complaints system and called for the collation of complaints data in a meaningful way to be part of the Government's proposed *'Information Revolution'*. Together with the NHS, the Care Quality Commission (CQC), Monitor, the Department of Health, the NHS Information Centre, National Voices and the National Association of LINks Members we submitted a joint statement in response to the proposals calling for more reliable, meaningful and comparable complaints information to inform learning within and across the NHS.

Complaints information is most effective when it is shared across organisations committed to improving the quality of care and service throughout the NHS. To this end, we proposed that complaints information and associated learning should inform trusts' annual quality accounts, and the Department of Health's revised guidance to trusts on this issue incorporated our proposals. CQC fed the information from our 2009-10 complaint handling performance report into their *Quality and Risk Profiles*, providing an immediate and updated risk assessment for all NHS providers. Summaries of our recommendations for systemic remedy inform the regulators' assessments and help them carry out effective monitoring. In specific cases, where the evidence from our casework raised concerns about the fitness to practise of individual doctors or dentists, we shared information with the General Medical Council and the General Dental Council, so that they could consider appropriate action in relation to the practitioners involved.

Care and compassion?

The shocking issues highlighted in our *Care and compassion?* report featured prominently in our discussions with national leaders, from the Chief Executive of the NHS to the leaders of the professional bodies and regulators. Our report was quickly followed by the CQC's programme of unannounced inspection visits to 100 hospital trusts, which were able to take into account the aspects of care we had highlighted. One fifth of the trusts visited failed to meet all the relevant dignity or nutrition standards, prompting the CQC to call for improvements. In another development, the NHS Confederation, Local Government Group and Age UK set up a commission to look at improving dignity in the care that older patients receive in hospitals and care homes.

Sharing information regionally

Sharing complaints data regionally and locally within the NHS can lead to very tangible improvements in the care and treatment offered to patients. At six regional conferences for nearly 500 complaints managers

across England last year, we highlighted how health bodies in each region had performed in the first year of the NHS complaints system.

We continued our work with South East Coast Strategic Health Authority to help them resolve complaints about their continuing healthcare funding. As we show later in this report (appendix page 74), the number of complaints about South East Coast Strategic Health Authority accepted for formal investigation this year fell to four, down from the twelve complaints we accepted in 2009-10.

Elsewhere, last year's complaint handling performance report, *Listening and Learning*, prompted South West Strategic Health Authority to investigate how their trusts had addressed the issues we had highlighted. The Chief Executive, Sir Ian Carruthers, asked trusts to discuss and act on the SHA's audit results, emphasising that:

> *'Complaints offer NHS organisations an insight and a reflection of the public's and patients' experience ... If learning opportunities are identified and lessons learned, the complaint can also offer an avenue to improve service delivery.'*

Following a consultation, we published our policy, *Sharing and publishing information about NHS complaints: The policy and practice of the Health Service Ombudsman for England*, which came into effect on 1 January 2011.

> 'I have always viewed the Ombudsman as a kind of bogeyman that complainants use to threaten us with. I now realise we actually all want the same thing – a reasonable and acceptable response to complaints.'

Complaints handler at one of our regional conferences

It states that we will share all reports of our health investigations with the relevant strategic health authority and the commissioning body, to help them to monitor performance.

Sharing information locally

During the year we visited the health bodies which generated the largest number of complaints to us, or where we had concerns about specific cases or operational issues, such as delay. These visits set out clearly our expectations for complaint handling and provide detailed analysis about the number of complaints received about the body, the reasons for those complaints and our decisions. Using complaints information to identify areas for improvement can have a tangible effect on complaints to the Ombudsman. For example, the most complained about trust last year, Barts and The London NHS Trust, has reduced the number of complaints coming to us from 146 to 112 (Figure 13 on page 45). The visits also enable us to hear directly about the challenges complaints managers face working with patients, their families and clinical colleagues in a changing NHS.

Our complaints figures often differ from those held by the body concerned because not all the complaints we receive are progressed directly by us. This can highlight issues about complaints being brought to the Ombudsman too soon, before the health body concerned has had an opportunity to resolve the complaint. Here, our discussions can lead to improved signposting by the health body and better information for patients who have a complaint. At present, our legislation limits what information we can share about cases we have not formally investigated. In order to share more information about our casework and help drive improvements in healthcare, we asked the Secretary of State for Health to amend our legislation to remove the existing constraints. This proposal is included in the current *Health and Social Care Bill* which is now going through Parliament.

Communication and complaint handling

The *NHS Constitution* highlights the importance of good communication in order to build trust between healthcare providers and patients and their families. Despite this, poor communication is still one of the most common reasons for people to bring complaints about the NHS to the Ombudsman. Poor communication during care or treatment can be compounded by a health body's failure to respond sensitively, thoroughly or properly to a patient's complaint – resulting in an overall experience of the NHS that leaves a patient or their family feeling that they have not been listened to or that their individual needs have not been taken care of. Poor communication can undermine successful clinical treatment, turning a patient's story of their experience with the NHS from one of success to one of frustration, anxiety and dissatisfaction.

Good communication involves asking for feedback, listening to patients, and understanding their concerns and the outcome they are looking for. It is about keeping patients and their families informed and giving them clear, prompt, accurate, complete and empathetic explanations for decisions. Issues of confidentiality, insensitive or inappropriate language, use of jargon and a failure to take account of patients' own expertise in their condition feature frequently in complaints.

When the NHS fails, it is not always easy for patients to complain. We hear regularly of patients' fears that complaining will affect the quality of their future treatment, or single them out in some way. Patients and their families need to be encouraged to speak up and give feedback, and be confident that their experience will be listened to. When they do complain, the NHS must properly and objectively investigate the complaint, acknowledge any failings and provide an appropriate remedy. Most often this is simply an apology, but it may also include an explanation, financial redress or wider policy or system changes to prevent the same thing happening again.

In last year's *Listening and Learning* report, we told the stories of people who had a poor experience of NHS complaint handling. We repeatedly found incomplete responses, inadequate explanations, unnecessary delays, factual errors and no acknowledgement of mistakes. These all too familiar shortcomings remain amongst the main reasons which complainants give for their dissatisfaction with NHS complaint handling, as Figure 2 on page 29 shows. Opportunities are being missed to learn lessons which have the potential to improve services for others.

Over the next few pages we recount the experiences of people who suffered as a result of poor communication or who were left dissatisfied, frustrated and distressed with the way the NHS dealt with their complaint.

Ignored and excluded from their son's care

Mr L was 21 years old and had severe learning disabilities. He had a polyp removed from his stomach at Luton and Dunstable Hospital NHS Foundation Trust (the Trust). He was discharged but was readmitted the next day and had a tumour removed from his colon. Despite some improvement, Mr L's condition worsened. After further surgery, he died a few days later.

Mr L's parents, Mr and Mrs W, were the experts in their son's needs, but they felt excluded from his care. They said *'even when we kept telling the nursing staff that we thought he was worse we were ignored'*. Had the consultant talked to them about discharging Mr L, they could have explained *'that he was still feeling sick and only wanted to go home because he did not like being in hospital'*. They only learnt that their son was having more surgery when he was about to go into theatre, and were not told what the surgery involved. Unaware just how ill their son was, Mr and Mrs W were not with him when he died. This greatly saddened them. They told us that *'if the doctors had listened to our concerns and noted all the symptoms we had told them of, we feel that his colon cancer would have been diagnosed ... and this may have given him a chance of survival'*.

The Trust should have taken Mr L's learning disability into account while making decisions about his treatment, for example, by involving Mr and Mrs W or the learning disability liaison nurse. Our investigation found that the Trust did not. The consultant wrote to Mr L's doctor saying that '[Mr L] *was a very poor historian and I really could not tell what was going on.* [He] *was mentally sub-normal...'* He apologised to Mr and Mrs W for this extraordinarily inappropriate description which had understandably upset them.

The Trust took action to ensure greater involvement of families and carers in the care of patients with learning disabilities, and agreed to commission an external review of their care of such patients. They apologised to Mr and Mrs W and paid them £3,000 for the injustice caused.

Kept in the dark about their father's illness

Mrs K's 85 year old father had recently had cancer surgery at Gloucestershire Hospitals NHS Foundation Trust (the Trust). He fell the day after he was discharged, and was admitted to the Trust's Cheltenham General Hospital. A Do Not Attempt Resuscitation (DNAR) order was made and then Mrs K's father was moved to a different hospital for palliative care. He developed pneumonia and was moved back to Cheltenham General Hospital, where another DNAR order was made. He died a few days later.

Mrs K complained to the Trust about the level of consultation over the DNAR orders. She was also upset that doctors had told her that her father's condition was not immediately life threatening, when the death certificate showed that he had terminal bladder cancer. Mrs K said *'the deeper the investigation went the more discrepancies became apparent'*. She was *'concerned that other elderly people might encounter similar experiences'* and that she *'would like to prevent more serious outcomes for those who do not have relatives to advocate on their behalves'*.

Our investigation highlighted the importance of good communication with patients and their families. We found that Mrs K's father should have been informed about the severity and finality of his condition and asked if he wanted his family kept updated. Instead, his family were generally kept in the dark about his illness and his deteriorating condition. The level of communication with doctors about his condition did not meet the family's needs, and the family were given limited information about the DNAR orders, which upset them greatly. Mrs K said *'not consulting my father or I was both disempowering and insensitive'*.

Following our recommendations, the Trust drew up plans to provide communication training for medical and nursing staff. The Trust also paid £1,000 to Mrs K and her family, which they donated to a hospice.

Expert patient's requests for medication ignored

Mrs V had an operation at the Croydon Health Services NHS Trust (the Trust – formerly Mayday Healthcare NHS Trust). After a previous operation there, she developed blood clots because the Trust had not properly managed her anticoagulant medication. This time, she was worried about not receiving the right medication, so the Trust agreed that she could go home on the day of the operation and manage her own medication.

However, the discharge letter explaining this did not reach Mrs V's ward and she was kept in hospital overnight. Staff did not deal with her anxious requests for her anticoagulant medication. As Mrs V's husband said, *'my wife fully understands her need for correct daily medication ... She "knows" her own body well'.* He felt *'petrified'*, *'helpless'* and fearful that his wife's life was in danger.

Just days after Mrs V was discharged she returned limping and in pain. She was readmitted to hospital and found to have blood clots. Mrs V had to use crutches for several weeks, and relied on her husband to do everything for her.

When we investigated, Mr and Mrs V said they were pleased that finally *'someone was actually listening to us'*. We found breakdowns in communication about Mrs V's discharge and her medication, and a succession of failures in her care. All of this increased her risk of developing blood clots. The Trust failed to acknowledge that Mrs V had been readmitted to hospital and that the lack of her medication might have contributed to this.

Eventually the Trust apologised to Mr and Mrs V for their poor care and treatment and for their complaint handling. They also drew up plans to prevent the same mistakes happening again, including introducing guidelines for prescribing anticoagulant medication. The Trust also paid Mrs V £5,000 for the injustice caused.

11

Failure to understand a life threatening condition

Mr T was left paralysed in all four limbs after he damaged his spine. He also has an uncommon and life threatening condition called autonomic dysreflexia: a sudden and exaggerated response to stimuli. An episode is a medical emergency and early treatment of the symptoms is crucial.

Mr T was visiting a garden centre with his wife and nurse when he noticed the symptoms of an autonomic dysreflexia episode. He was taken to a hospital run by North Bristol NHS Trust, accompanied by a paramedic from Great Western Ambulance Service NHS Trust. According to Mr T, the paramedic appeared unaware of the importance of early treatment, and the triage nurse in A&E was also unfamiliar with his condition. Mr T described *'two hours of unmitigated hell and anxiousness'* as he waited longer than he should have to see a doctor.

Mr T complained to us that both Trusts failed to understand and deal with his condition appropriately. He said he did not want individual members of staff *'hauled over the coals'* as all he wanted was to raise awareness of autonomic dysreflexia. Although a rare condition, people with a spinal cord injury worry that it is not known about.

We swiftly resolved the complaint and there was no need for a formal investigation. Both Trusts met Mr T to discuss how to raise awareness of autonomic dysreflexia. Mr T later told us that someone he knew with a spinal injury had recently been taken to hospital, and had been impressed and surprised to be asked if she was susceptible to autonomic dysreflexia. In Mr T's own words: *'evidently the educative information about AD* [autonomic dysreflexia] *given to their staff by the two Trusts has had the desired effect'*. This was exactly the outcome he wanted.

Left feeling that *'complaining gets you nowhere'*

Mrs Q takes medication daily for a kidney disease and always carries the medication in her bag. While Mrs Q was an inpatient in Guy's and St Thomas' NHS Foundation Trust (the Trust), a pharmacy technician asked her if she had brought her own medication with her. Mrs Q said *'yes'*, and the technician told her she was not supposed to have any drugs with her. Mrs Q said she had not realised this and handed over all her medication.

The next day, the same technician asked Mrs Q where her medication was. She replied that she did not know, having had no access to the drug cabinet by her bed. The technician then insisted that Mrs Q empty out her bag, in front of other patients and nurses. This embarrassed and upset Mrs Q.

Mrs Q complained that the technician had been disrespectful to her, as she had *'belittled me and made me look like a thief'*. She wanted the technician to apologise and felt the Trust had not handled her complaint well. She told us she had no idea what the Trust had done following her complaint and if they had disciplined the technician. This meant she had no reassurance that the member of staff involved would not cause similar problems in the future. She was left feeling that *'complaining gets you nowhere'*.

Following our intervention the Trust sent Mrs Q a more detailed response to her complaint and apologised for the technician's behaviour. They also told her that they had taken disciplinary action against the technician. Mrs Q was very satisfied with this outcome.

A flawed investigation into an alleged assault

Ms J has a borderline personality disorder, which means she sometimes has little physical or mental awareness. During a therapy session at Avon and Wiltshire Mental Health Partnership NHS Trust (the Trust), Ms J became distressed. She went into a nearby room and lay down on the floor under her coat. Later, a clinician called in two security guards to remove her and one of them allegedly kicked Ms J.

Ms J complained to the Trust that she had been assaulted, saying that after the incident her *'levels of distress were massive'* and she had thought of harming herself.

The Trust took nearly a year to respond formally to Ms J's complaint. Our investigation uncovered serious flaws in the Trust's two investigations into the incident. Neither was independent or thorough. The Trust did not take statements from all the key witnesses, nor seek advice about the wisdom of calling in security guards given Ms J's condition. The Trust's formal response to Ms J lacked authority because it was not signed by the chief executive or nominated deputy, as required by the Trust's own policy, and made no mention of any potential learning for the Trust. The Trust's response did not give proper respect to Ms J's account of events. She felt bewildered and frustrated: *'It was bad enough being kicked by the security guard. It has now all been made even worse by a very unsatisfactory complaints process'.*

In line with our recommendations, the Trust apologised to Ms J for the considerable distress and inconvenience they had caused her, and paid her compensation of £250. They also agreed that their executive board would consider our investigation report, and that they would commission an independent review into their complaint handling function.

A two year wait for answers

Mr C's sister died during palliative chemotherapy at East and North Hertfordshire NHS Trust (the Trust). Mr C described the impact of her death on his family as *'immense'* and said his surviving sister had *'not only lost her sister but also her closest friend and soul mate'*.

Dissatisfied with the Trust's response to his complaint, Mr C came to us because he wanted to know exactly what had happened during his sister's final hours.

Our investigation did not uphold Mr C's complaint about the Trust's care of his sister. However, we found very poor complaint handling. The Trust did not review the clinical notes promptly and clarify events while key people's memories were still fresh. Some written statements taken by the Trust were undated and unsigned, other sources of information they gave to Mr C were unclear, and still further information did not tally with the clinical records. There were no records to back up some of the Trust's statements.

The Trust used unhelpful medical jargon at a local resolution meeting with Mr C and did not clear up points that Mr C had not understood. The Trust did not apologise to Mr C for their poor record keeping. They also did not refer to professional standards and guidance when investigating his concerns, or when committing themselves to improving the monitoring of observations and record keeping.

Describing to the Trust how their answers to his concerns had affected him and his family, he said, *'We feel that your avoidance by giving minimal answers has prolonged our suffering'*. Mr C was put through two years of distress as he struggled to make sense of what happened to his sister at the end of her life.

The Trust apologised to Mr C and used his case study in training sessions for staff in how to investigate and respond to complaints.

Unfair removal from GP patient lists

Often a patient's experience of the NHS begins with their GP. It is common for the relationship between a patient and their GP to be long established and to extend across an entire family. In the last year, we received an increased number of complaints about GPs, some of which suggest that GPs are failing to manage relationships with patients properly, resulting in a breakdown in communication and patients being removed from GP patient lists without fair warning or proper explanation.

Last year, the number of complaints about people being removed from their GP's list of registered patients accounted for 21 per cent of all complaints about GPs investigated, a rise of 6 per cent over 2009-10. We accepted 13 complaints for investigation about removal from GP patient lists and completed 10, all of which were upheld.

There is clear guidance for GPs about removing patients from their lists. NHS contracts require GPs to give patients a warning before they remove them, except where this would pose a risk to health or safety or where it would be unreasonable or impractical to do so. The British Medical Association's guidance stipulates that patients should not be removed solely because they have made a complaint. It also says that, if the behaviour of one family member has led to his or her removal, other family members should not automatically be removed as well.

Our casework shows that some GPs are not following this guidance. In the cases we have seen, GPs have applied zero tolerance policies without listening to and understanding their patients or considering individual circumstances. Decisions to remove a patient from their GP's list can be unfair and disproportionate and can leave entire families without access to primary healthcare services following an incident with one individual.

It is not easy for frontline staff to deal with challenging behaviour, and aggression or abuse is never acceptable. However, patients must normally be given a prior warning before being removed from a GP's list. The relationship between a GP practice and their patient is an important one which may have built up over many years. Despite this, we have seen cases where practices have removed entire families after a few angry words from one individual, without giving them a warning or taking the time to understand the cause of the anger and frustration.

The case studies that follow tell the stories of patients and their families who were removed from GP patient lists during periods of great anxiety about the terminal illness of a loved one or the health of a young child. In one case, the decision to remove the patient was made by the member of staff involved in the altercation. As GPs prepare for the increased commissioning responsibilities outlined in the Government's health reforms, it is essential that they get the basics of communication right.

For more information about the total number of complaints about GPs received, accepted for formal investigation and reported on please see Figures 6, 10 and 12 (pages 35, 41 and 43).

‘The decision to remove a patient from the list should be considered carefully and preferably not made in the heat of the moment.’

British Medical Association guidance

A terminally ill mother removed from a GP's patient list

Miss F's mother was terminally ill. Miss F is a registered nurse and she and her sister cared for their mother at home. One evening, the battery failed on the device which administered Miss F's mother's anti-sickness medication. Miss F did not want to leave her mother without medication while waiting for the district nurse to call, so she changed the battery herself and successfully restarted the device.

The next day, a district nurse told the family's GP Practice about this. The Practice discussed the incident with Miss F and decided that the doctor-patient relationship with the family had broken down. The Practice asked the local primary care trust to remove all three family members from their patient list.

Miss F and her sister complained to the Practice about the removal decision, but were unhappy with the response. They asked the Ombudsman for help. Miss F said that, as a nurse, she knew her mother was dying and that she needed care around the clock. She was therefore very upset at spending precious time visiting the Practice, trying to persuade them to change their mind. She would rather have spent that time caring for her mother. Miss F also said the family's removal from the list left their mother *'totally distraught'* when she died just a few weeks later. She felt strongly that the Practice had let down her mother and was *'totally devastated and distressed by our continual uncalled for treatment by professionals/GPs'*.

Our investigation found that the Practice had given Miss F's family no warning that they risked being removed; they did not communicate their concerns about the doctor-patient relationship properly; and failed to consider other courses of action. The Practice also took Miss F's mother off their list even though she had not been involved in the disagreement. They did not consult her or give her any choice in the matter. All of that left Miss F and her sister having to find a new GP for the whole family at a hugely stressful time.

The Practice's poor complaint handling compounded the family's distress. For example, when Miss F and her sister pointed out that no warning had been given and questioned why their mother had been removed at such a critical time, the Practice said that they did not wish *'to go into specific details'*. This failure to answer reasonable questions unnecessarily drew out the complaints process.

The Practice apologised to Miss F and her sister for the distress and inconvenience they had caused. They also drew up plans setting out how they would avoid a recurrence of their failings.

Mother and baby removed without warning

Ms D's baby daughter was due to be immunised. The day before the jabs were due, the GP Practice said they had miscalculated baby J's age and could not immunise her for another week. Ms D's family were going abroad in a few days, expecting baby J to have been immunised by then. Ms D was worried about travelling and rearranged the flights.

The day before she was due to fly out, Ms D took baby J to the Practice's baby clinic. Unfortunately, the nurse was off sick and no one else was available to immunise baby J. Ms D was annoyed and upset by this. She allegedly said *'what part of flying tomorrow do you stupid people not understand?'* and was said to have deliberately knocked over a vase. Ms D denied both allegations. She returned from her holiday to find a letter from the Practice telling her that her behaviour had been unacceptable, and both she and baby J were to be removed from the list.

The Practice's hasty actions shocked and frustrated Ms D, and gave her no chance to improve relations with them. Baby J needed regular monitoring, and Ms D was worried that her daughter's health was put at risk by their removal from the Practice list. Also, Ms D has epilepsy and needs regular prescriptions, so the need to find a new practice was also a concern to her.

Ms D was unhappy with the way the Practice dealt with her complaints about what had happened and she came to the Ombudsman.

We investigated Ms D's complaint about the Practice's decision not to immunise baby J and found that they had acted reasonably on both occasions. We also found that the Practice had responded quickly to Ms D's subsequent complaint and provided evidence-based reasons for not immunising baby J. We did find, however, that the Practice had removed Ms D and baby J from their list without warning. The Practice also failed to follow professional guidance which says removal should be carefully considered and only used *'if all else fails'*; and that other family members should only be removed in rare cases.

The Practice did not consider why Ms D was so distressed and how the relationship could be rebuilt. The Practice also did not think about baby J's needs.

This case was all the more alarming because the Ombudsman had previously investigated a similar complaint about the same Practice in 2006. At that time the Practice said they would follow the rules in future, but they clearly did not do so in Ms D's case. We asked the Practice to prepare plans to prevent a recurrence. They have since reviewed their procedures and arranged training for clinicians. The Practice also apologised to Ms D and paid her compensation of £250.

Patient removed after disagreement with the practice manager

Mrs L and her husband had been registered with their GP for over 15 years. While she and her husband were waiting for their flu jabs, Mrs L became involved in a disagreement with Practice staff about unanswered telephone calls. After the incident Mr L wrote to the Practice to complain about the practice manager's attitude to his wife and to ask for an apology. He said the practice manager had twice said he would *'get you* [Mrs L] *struck off for this'*.

Mrs L then received a letter from her GP saying that she had been abusive and used strong language. This had *'intimidated'* and *'humiliated'* Practice staff, who asked the GP to get Mr and Mrs L removed from the patient list. The GP suggested to Mrs L that the situation might be retrieved if she apologised to the practice manager.

Mrs L wrote back *'shocked and horrified'* by the letter, saying *'never before have I had a cross word with anyone in your practice'*. She was particularly upset by the threat to remove her husband and did not see why he should be penalised for what had happened. Mrs L said she was happy to meet the practice manager, but refused to apologise. The practice manager then sent Mrs L a letter signed on behalf of the senior partner, informing her that she was being removed from the list. (Mr L left the Practice of his own accord.) Mrs L then escalated her complaint to Stockport Primary Care Trust (the Trust), which made enquiries of the Practice and agreed with their actions.

Upset about being removed from the list because of a *'simple disagreement'*, Mrs L came to the Ombudsman. She said she had *'been made to feel like a criminal of some sort'*, and that the Trust had simply sided with the Practice.

Our investigation showed that the Practice had removed Mrs L without warning and had not followed their own zero tolerance policy. On top of that, the removal letter was signed by the practice manager, the very person Mrs L had complained about. The Practice also failed to deal with all of Mr and Mrs L's complaints. For their part, the Trust did not check if the Practice had followed the rules or their own policies and they did not fully respond to her complaint. They missed the opportunity to ask the Practice to put things right.

The Practice and the Trust each apologised to Mr and Mrs L and paid them compensation totalling £750. The Practice appointed a new complaints manager and updated their guidance on removing patients. The Trust also revised their policies on removing patients, to prevent a recurrence of their failings.

Removal after a dispute about missing medical records

Mrs M got into a dispute with her GP Practice when they could not find some of her medical records which had been transferred to them by another practice a year earlier. Mrs M waited at the Practice for about an hour while staff rang round trying to find her records. In fact, the Practice already had the records in question, but they had not recorded receipt on their computer system and had then misfiled them. Mrs M was very worried about the apparent loss of her records and felt that Practice staff were not taking her concerns about that seriously. She disliked the receptionist's manner towards her and left the reception saying that she would be making a complaint.

On receipt of Mrs M's complaint the Practice carried out a thorough search for the missing records and eventually found them. They then set up a meeting with Mrs M to go through her records and to discuss her complaint. Mrs M telephoned to cancel the meeting as it was extremely short notice and she felt things were being rushed. The Practice later noted that Mrs M's manner during the call was unpleasant. The next day Mrs M received a letter from the Practice saying that staff had been trying to resolve her concerns about her records, but were upset by what they described as her intimidating attitude and manner. The Practice said Mrs M's *'persistent belligerence'* gave them no option but to ask her to find another GP, as her relationship with the Practice had obviously broken down.

Mrs M disputed that she had been belligerent, and felt the Practice were not taking her concerns seriously. The letter from the Practice left Mrs M feeling *'upset and again stressed further'*. She was *'totally aghast'* and *'dismayed'* at the way the Practice had treated her and *'saddened that actions had been escalated to this stage'*. She complained to the Ombudsman, seeking an apology from the Practice.

We resolved Mrs M's complaint quickly, without the need for a formal investigation. After we spoke to the Practice, they apologised to Mrs M for removing her from their list without warning. They also explained that they had changed their procedures and would follow the rules about removing patients in future. We gave Mrs M further assurance by sending her the Practice's new procedures for recording receipt of incoming medical records.

Overview of complaints to the Ombudsman 2010-11

Here we report on the complaints we received about the NHS as a whole and how they were resolved. Further on we give more details about the complaints we received, broken down by strategic health authority region and by type of NHS body – **see pages 34 and 35.**

Our year at a glance

In 2010-11 we received **15,066** health complaints, compared to 14,429 in 2009-10, and continued work on 1,308 carried over from 2009-10.

We resolved **15,186** complaints, compared to 15,579 in 2009-10, and carried over 1,188 into 2011-12.

9,547 complaints were made to us before the local NHS had done all they could to respond. We gave the people making those complaints advice about how to complain to the NHS, and how to complain to us again if they were not satisfied with the response from the NHS.

We also gave advice on **325** complaints that were not in our remit, such as complaints about privately funded healthcare. We signposted people to the correct organisation to complain to, where possible.

For **3,339** complaints we reassured the complainant that there was no case for the NHS to answer, or we explained how the NHS had already put things right.

We achieved a swift resolution in **487** complaints. We resolved **230** of those complaints by intervening directly with the NHS, compared to 219 in 2009-10. In a further **257** complaints we provided the remedy ourselves. Often, this involved our clinical advisers providing the complainant with a clear explanation about what had happened.

On **1,137** occasions last year, the complainant chose not to progress their complaint further, or did not put the complaint in writing, as the law requires.

We accepted **351** complaints for formal investigation, compared with 346 in 2009-10.

We reported on **349**[1] complaints investigated. Of which, **79%** were upheld or partly upheld.

The two most common reasons complainants gave us for dissatisfaction with NHS complaint handling were poor explanations and no acknowledgement of mistakes.

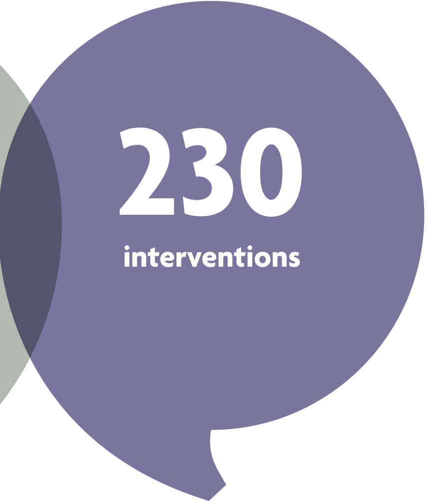
The two most common reasons complainants gave us for dissatisfaction with the NHS in the first place were clinical care and treatment and poor communication.

1. The number of complaints reported on is different from the number accepted for investigation because some investigations were not completed in the year and others from the previous year were reported on.

15,066
complaints received

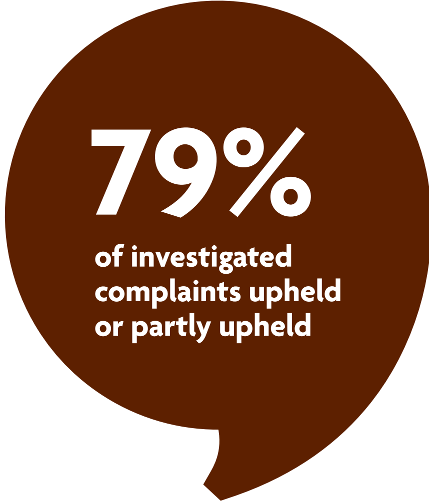
15,186
complaints resolved

487
complaints resolved
through swift
resolution including...


230
interventions

351
complaints
accepted for
formal investigation

349[1]
investigated
complaints
reported on


79%
of investigated
complaints upheld
or partly upheld

Reasons for complaints

Figure 1

Issues raised about poor care or treatment[2] 2010-11

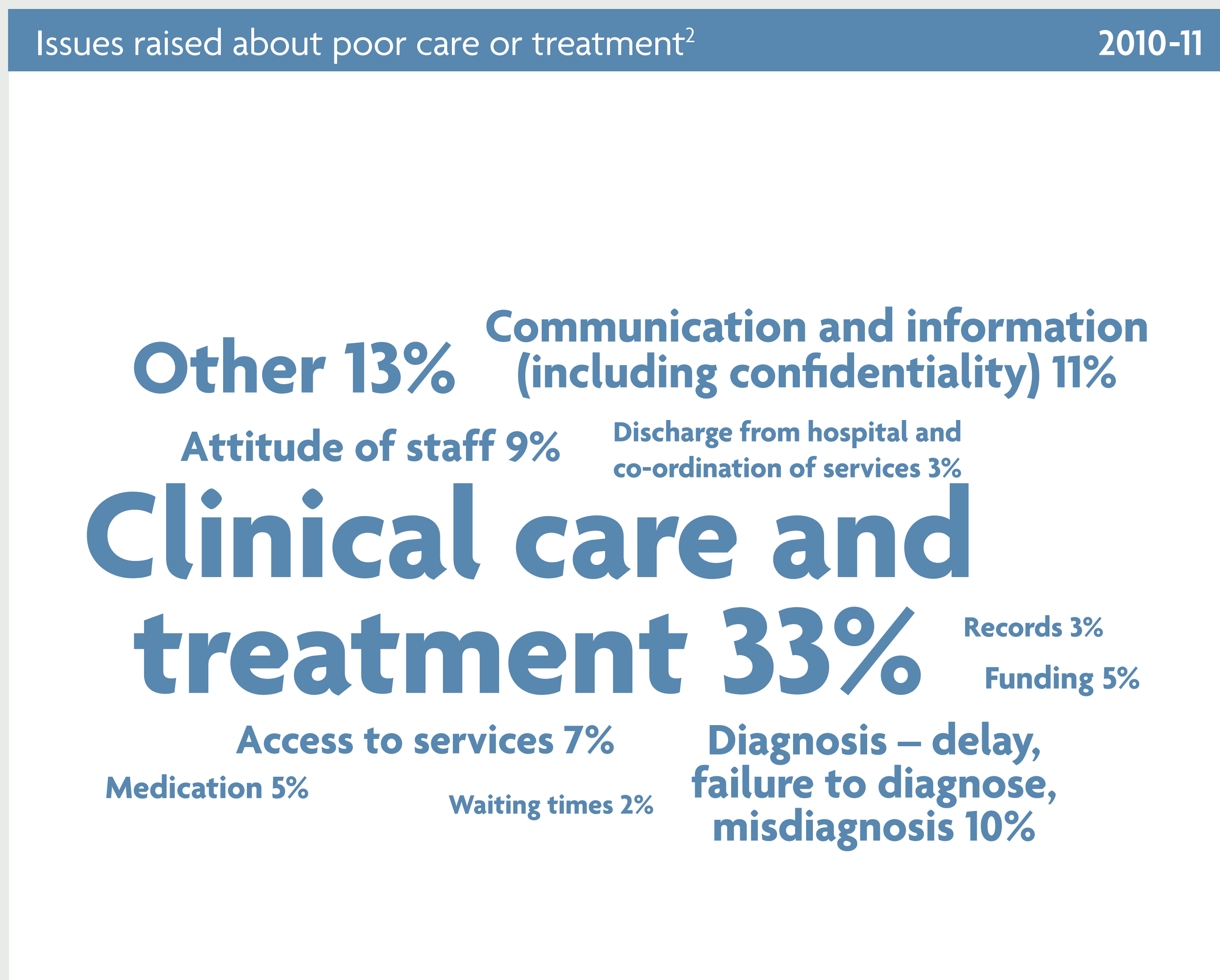


Figure 1 shows the most common reasons for complaints. Some complaints cover a range of different issues and can have multiple subjects. The most common reason for complaints is clinical care and treatment. We do not have separate subject categories for every aspect of care and treatment but we have categories for the most common issues we see, such as diagnosis and medication. The second most common reason given for complaints was communication, a theme which runs throughout this report.

2. The keywords in Figures 1 and 2 reflect the issues raised by complainants. We assign keywords to complaints that are not taken forward at our discretion or because they are premature. Complaints which are taken forward for investigation are assigned further keywords according to the issues we identify when investigating the complaint.

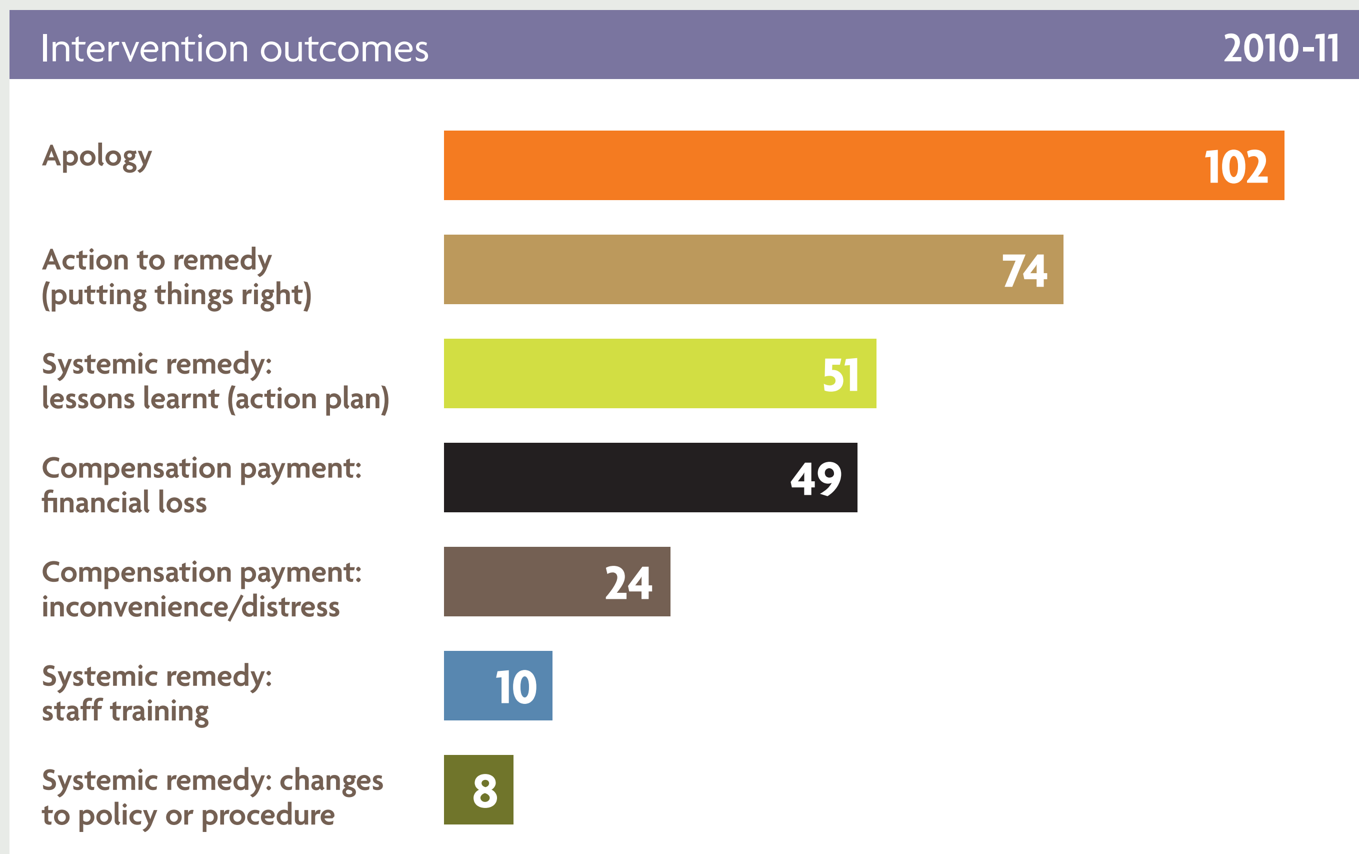
Figure 2

Issues raised about complaint handling[2] 2010-11

Figure 2 shows the most common reasons complainants gave us for being unhappy with the way the NHS handled their complaint. Poor explanations and failure to acknowledge mistakes account for over a third of the reasons given by complainants.

Complaint outcomes

Figure 3



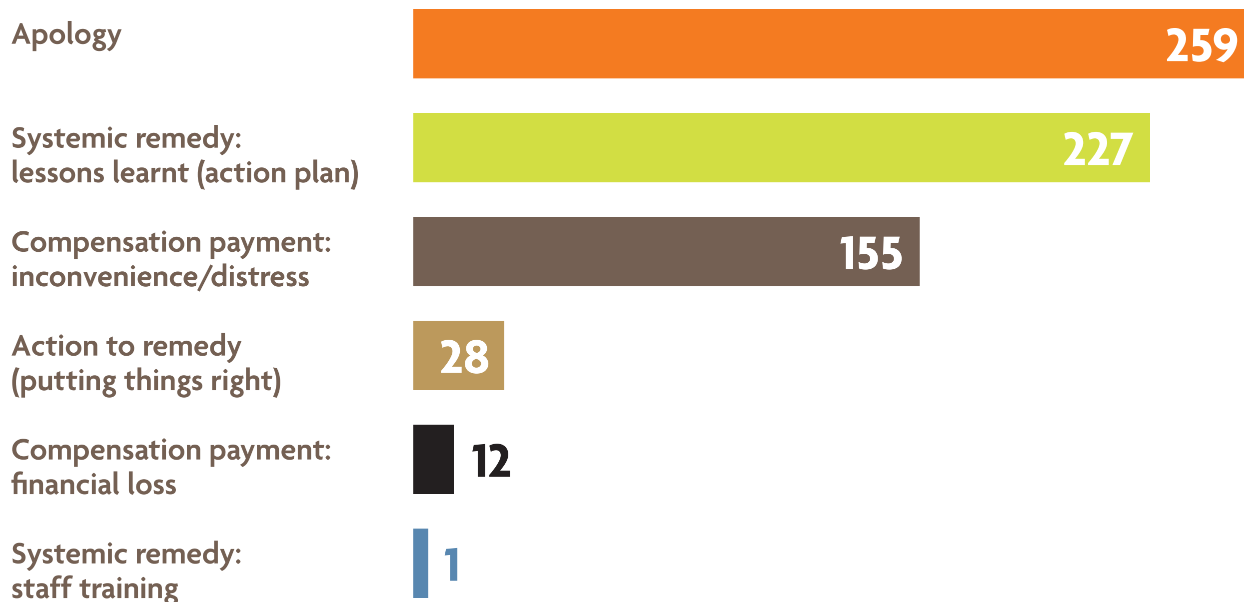
318[3]
Total

The outcomes we secured through our interventions included apologies, compensation and securing changes to prevent the same problems occurring again.

In 230 complaints last year we resolved the matter by working with the complainant and the health body to reach a swift and satisfactory conclusion, without the need for a formal investigation. 44 per cent of the complaints we resolved through intervention involved an apology and 32 per cent involved action by the body to put things right.

3. Where a complaint is resolved, there may be more than one outcome, for example, an apology and a compensation payment. This is why the total number of outcomes is greater than the number of complaints resolved by intervention or through investigation.

Figure 4



682[3]
Total

The outcomes we secured through our investigations included apologies, compensation and securing changes to prevent the same problems occurring again.

We upheld or partly upheld 276 of the 349 complaints we reported on. This was 79 per cent, compared to 63 per cent in 2009-10.

We made **682** recommendations following our investigations, compared to 202 recommendations in 2009-10. Of the recommendations we made in 2010-11, **259** were for an apology. We are securing increased financial compensation for complainants – we made **167** such recommendations, totalling £463,244.

Where the problems we have found are systemic, rather than a one off, we have recommended that the health body produces an action plan to show how it has learnt lessons. We made **227** such recommendations and informed CQC and Monitor of the relevant cases so that, as regulators, they could follow them up.

Levels of acceptance of our recommendations remain very high – with 99 per cent of recommendations accepted last year. In the one case where our recommendations were not accepted, we laid our investigation report before Parliament and the practitioner has since complied with our recommendations.

It is important that health bodies put things right promptly and we are focusing on the speed of compliance with our recommendations.

Please Post
Your
Comments
Here

NHS complaint handling performance 2010-11

This section provides detailed information on the complaints we received, broken down by strategic health authority (SHA) region as well as by type of NHS body, during 2010-11. Further information on individual bodies' performance is available on our website – www.ombudsman.org.uk.

This national data complements the local reporting on complaints by each NHS body, including their annual report on complaints and annual quality accounts.

Complaints can provide an early warning of failures in service delivery, but a small number of complaints does not necessarily mean better performance. It could mean that information about how to make a complaint is poor. NHS boards must demand regular information about complaints and their outcomes. They should have complaints high on their agenda and think about how they can learn from complaints on a regular basis.

Our snapshot of complaint handling by the NHS contributes to learning not just on a local level, but across the NHS in England.

NHS complaint handling by strategic health authority region and by body type

Figure 5

Complaints received by SHA region 2010-11

Total number of complaints
(Complaints received per 100,000 inhabitants)

Does not include complaints relating to the Healthcare Commission, special health authorities or where the strategic health authority is unknown.

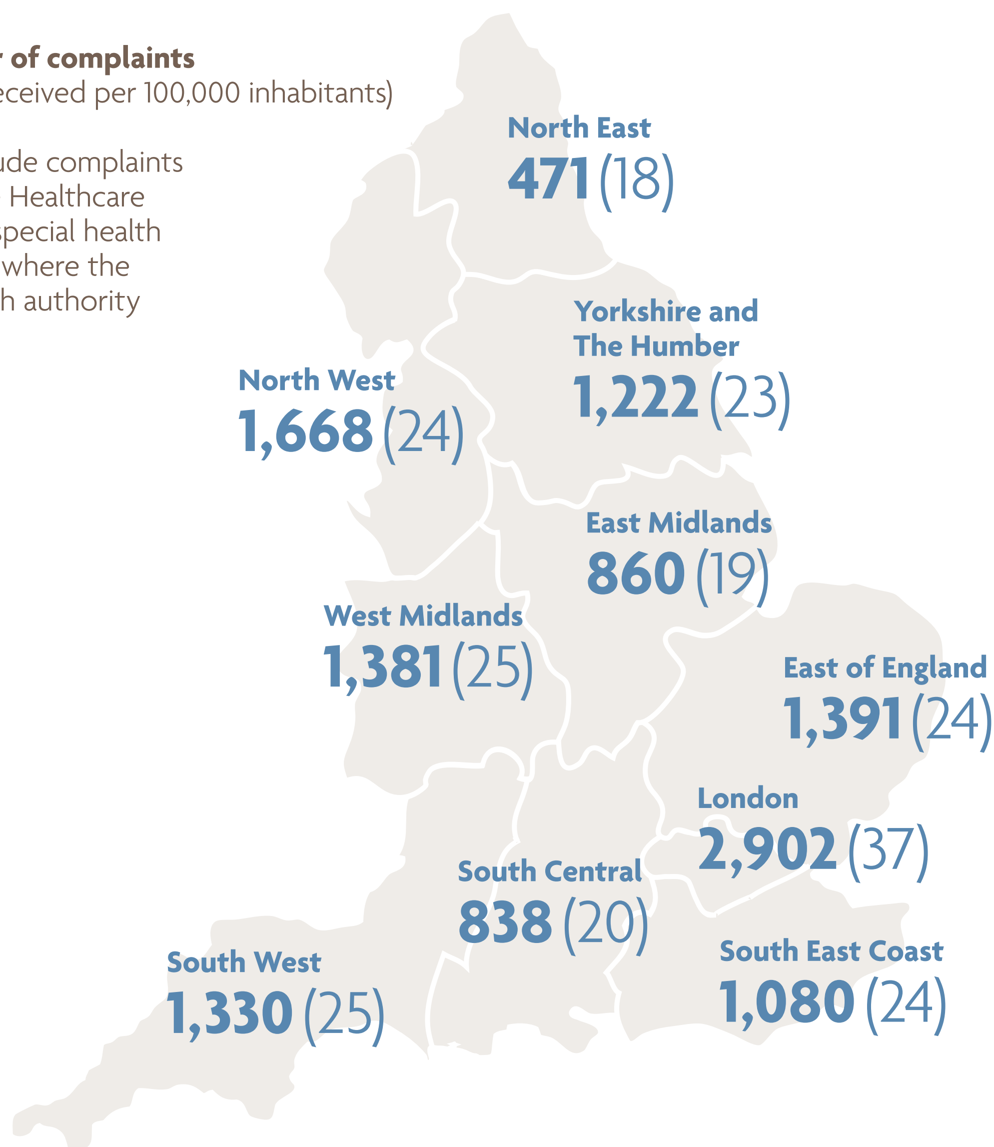


Figure 5 shows the health complaints received by the Ombudsman in 2010-11, grouped by the strategic health authority region in which they originated. To account for the difference in population in each region, the figure in brackets shows the number of complaints received per 100,000 inhabitants[4]. There were more complaints to the Ombudsman about the NHS in the London region than any other. We received the fewest complaints about the NHS in the North East region. However, outside of London there is little variation in the number of complaints received per 100,000 population, which is similar to last year. Figure 9 on page 40 shows how many complaints were accepted for formal investigation by strategic health authority region.

4. Office of National Statistics 2009 mid-year population estimates.

Figure 6

Complaints received by body type 2010-11

6,924 (46%)
NHS hospital, specialist and teaching trusts (acute)

2,714 (18%)
Primary care trusts

2,581 (17%)
General practitioners

1,356 (9%)
Mental health, social care and learning disability trusts

707 (5%)
General dental practitioners

240 (2%)
Strategic health authorities

226 (2%)
Ambulance trusts

97 (1%)
Pharmacies

88 (1%)
Care trusts

79 (1%)
Special health authorities

36 (0%)
Healthcare Commission

18 (0%)
Opticians

15,066
Total

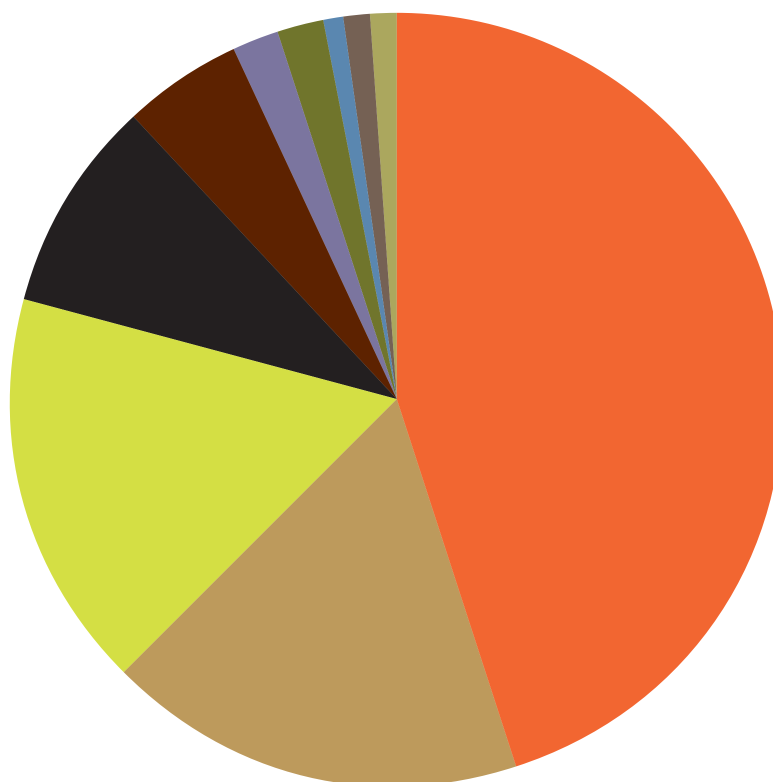


Figure 6 shows that almost half of the complaints which we received were about acute trusts, and about 40 per cent were about primary care services (this includes complaints about GPs, general dental practitioners, pharmacies, opticians and primary care trusts (PCTs)). This mirrors the pattern we saw last year and is reflected in the complaints accepted for formal investigation (Figure 10 on page 41).

Figure 7

Complaints received by SHA region and body type

	Ambulance trusts	Care trusts	GDPs*	GPs	Healthcare Commission	Mental health, social care and learning disability trusts
East Midlands SHA	21		32	133		97
East of England SHA	27	13	40	215		155
Healthcare Commission					36	
London SHA	42	22	80	431		321
North East SHA	10	2	11	83		42
North West SHA	26	3	62	223		148
South Central SHA	8		23	115		62
South East Coast SHA	27	10	49	147		138
South West SHA	32	12	65	160		109
Special health authority						
West Midlands SHA	12	19	36	204		104
Yorkshire and The Humber SHA	16	7	39	173		96
Unknown SHA	5		270	697		84
Total	**226**	**88**	**707**	**2,581**	**36**	**1,356**

Figure 7 shows a breakdown of the type of body complained about by strategic health authority region. As Figure 5 shows, the London region has by far the greatest number of complaints per 100,000 population. However, even allowing for this they represent an even greater proportion of complaints about mental health and acute trusts. The inclusion of six London acute trusts in the ten most complained about trusts reflects this (Figure 13 on page 45).

* General dental practitioners

2010-11

NHS hospital, specialist and teaching trusts (acute)	Opticians	Pharmacies	PCTs	Special health authorities	SHAs	Total
359		4	193		21	**860**
615	2	7	290		27	**1,391**
						36
1,575	1	6	406		18	**2,902**
257		1	60		5	**471**
865	2	6	305		28	**1,668**
338	1	6	258		27	**838**
490		5	191		23	**1,080**
634	1	9	262		46	**1,330**
				79		**79**
749	2	4	237		14	**1,381**
614	1	8	247		21	**1,222**
428	8	41	265		10	**1,808**
6,924	**18**	**97**	**2,714**	**79**	**240**	**15,066**

Interventions by strategic health authority region

Figure 8

Interventions by SHA region 2010-11

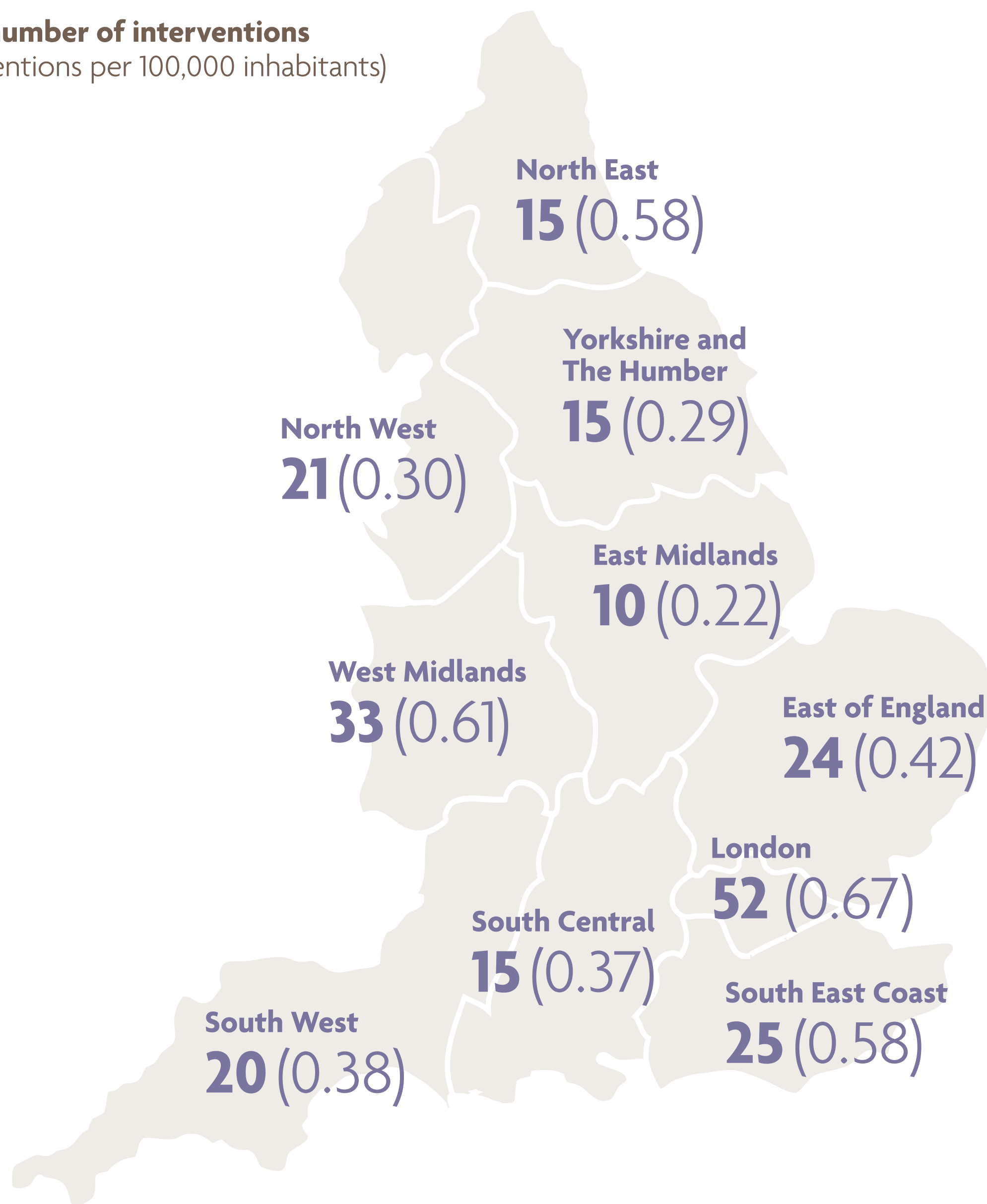


Figure 8 shows a breakdown of the interventions completed, by strategic health authority region.

Investigations by strategic health authority region and by body type

Figure 9

Complaints accepted for formal investigation by SHA region 2010-11

Total number of complaints accepted
(Complaints accepted per 100,000 inhabitants)

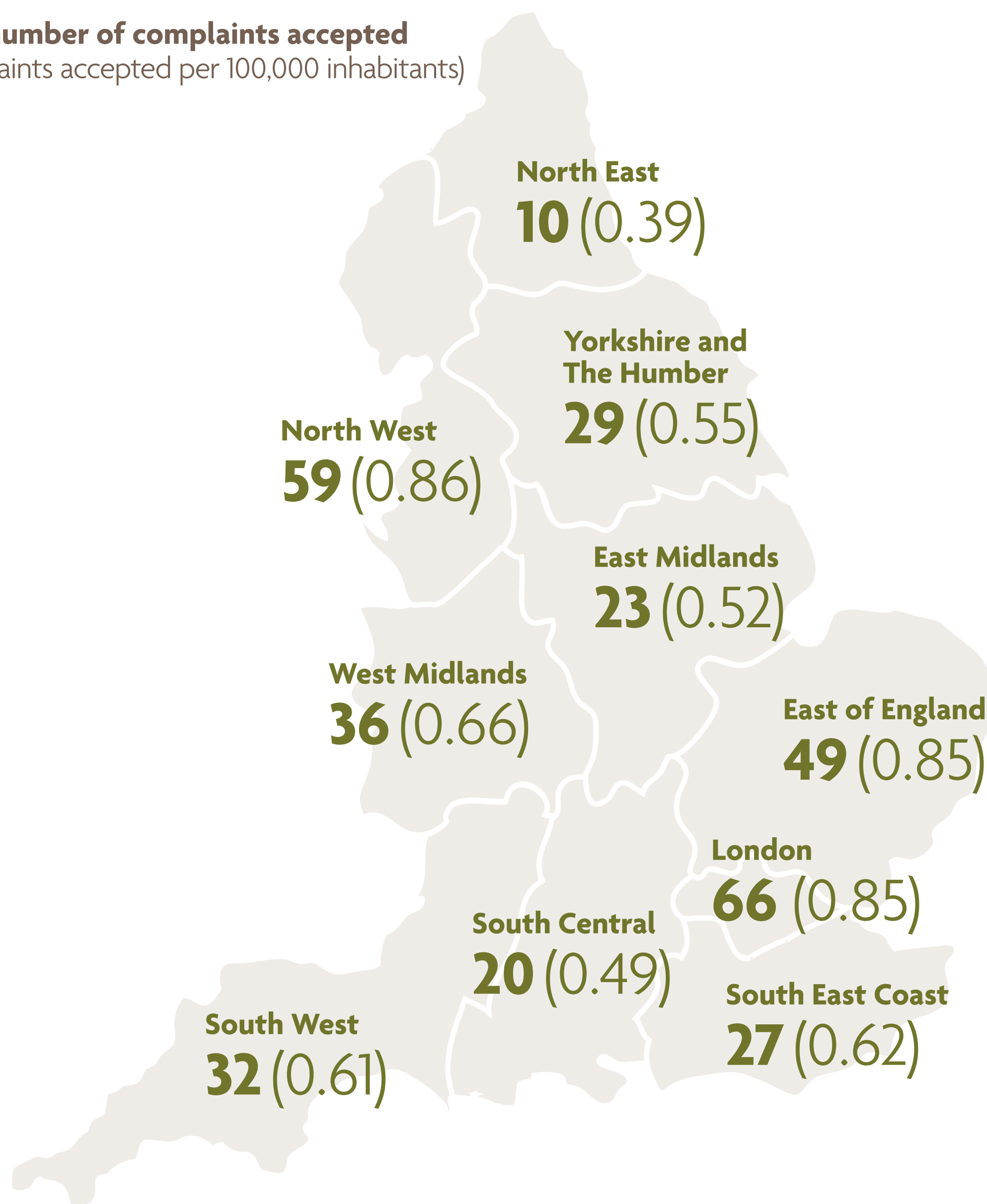


Figure 9 shows a breakdown of complaints accepted for formal investigation, by strategic health authority region.

Figure 10

Complaints accepted for formal investigation by body type 2010-11

177 (50%)
NHS hospital, specialist and teaching trusts (acute)

66 (19%)
General practitioners

54 (15%)
Primary care trusts

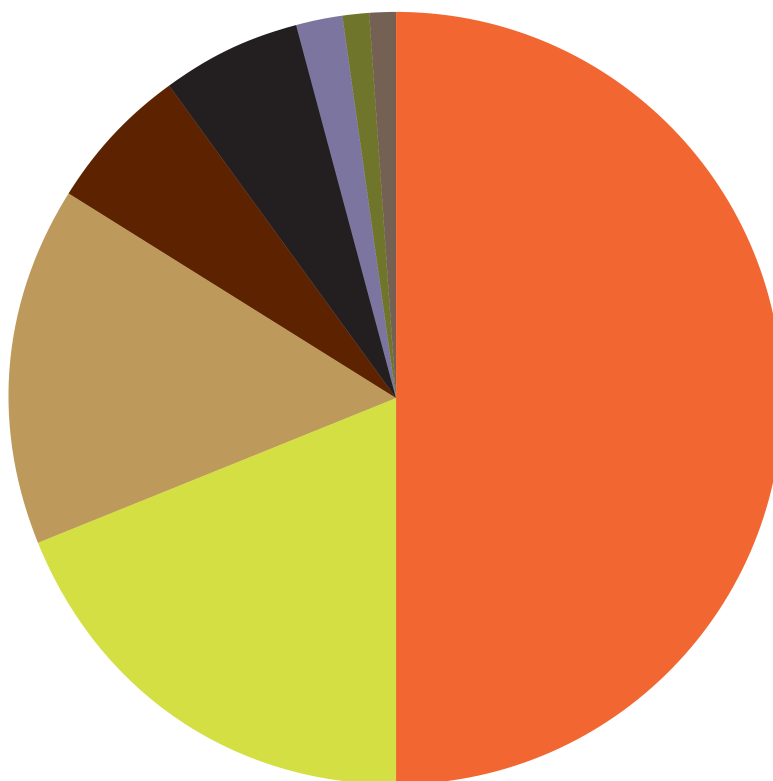
22 (6%)
General dental practitioners

20 (6%)
Mental health, social care and learning disability trusts

6 (2%)
Strategic health authorities

4 (1%)
Ambulance trusts

2 (1%)
Care trusts



351
Total

Figure 11

Complaints investigated and reported on by SHA region 2010-11

Total number of complaints
(% Total upheld complaints)

Does not include complaints relating to the Healthcare Commission.

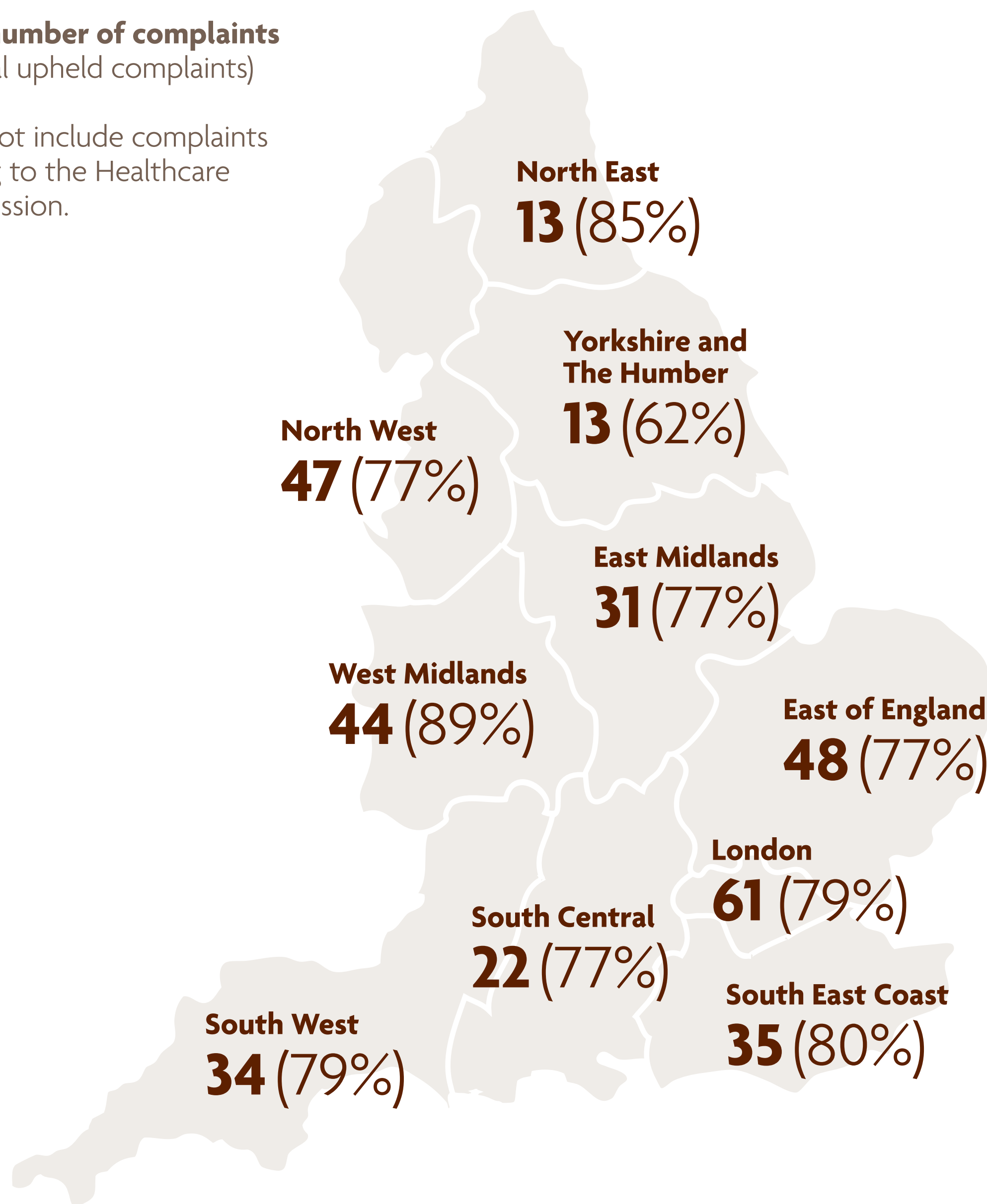


Figure 11 shows the number of complaints we investigated and reported on by strategic health authority region and the percentage uphold rate. The rate is the total of upheld and partly upheld complaints.

Figure 12

Complaints investigated and reported on by body type

	2010-11	Uphold rate
NHS hospital, specialist and teaching trusts (acute)	211	82%
General practitioners	48	88%
Primary care trusts	30	63%
Mental health, social care and learning disability trusts	22	59%
Strategic health authorities	15	87%
Ambulance trusts	12	83%
General dental practitioners	10	60%
Healthcare Commission	1	100%

349
Total

Figure 12 shows the number of complaints we investigated and reported on by type of body and the percentage uphold rate. The rate is the total of upheld and partly upheld complaints.

Most frequently complained about NHS bodies

In the appendix (page 57) we publish the full list of complaints about NHS bodies that we have received, resolved through intervention, and investigated in 2010-11. Here in this section, we extract the data for those bodies that have generated the most work for us during the year.

Heart of England NHS Foundation Trust are the most complained about body and have moved up from 13th place last year. We are working with this Trust to identify what lessons can be learnt from the large number of complaints about them.

Although Barts and The London NHS Trust are still in the top ten bodies about which we have received a complaint, the number of complaints we received about them has reduced by 23 per cent since last year. The number of complaints about this Trust that we received before they had done all they could to resolve matters locally has also reduced. They have listened to and learnt from us and their patients.

Complaints received

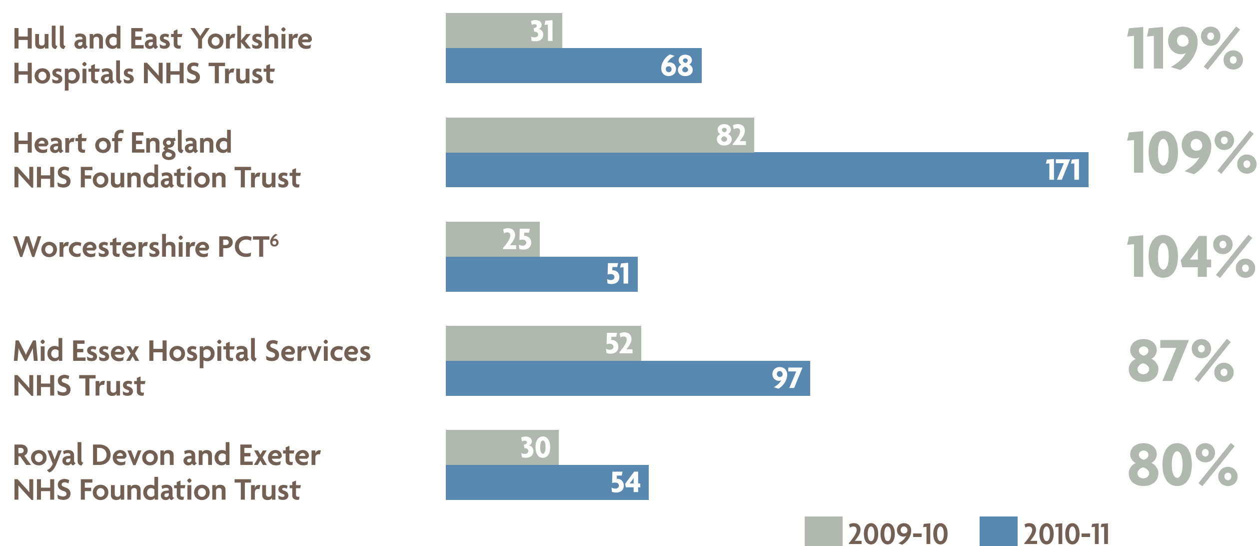
Figure 13

Top ten health bodies by complaints received

Health body	2010-11	2009-10
Heart of England NHS Foundation Trust	171	82
Guy's and St Thomas' NHS Foundation Trust	123	112
Leeds Teaching Hospitals NHS Trust	117	102
Barts and The London NHS Trust	112	146
King's College Hospital NHS Foundation Trust	112	90
East Kent Hospitals University NHS Foundation Trust	110	89
Imperial College Healthcare NHS Trust	101	112
Barking, Havering and Redbridge University Hospitals NHS Trust	100	93
Mid Essex Hospital Services NHS Trust	97	52
South London Healthcare NHS Trust	95	88

Figure 14

Highest % increase in complaints received[5]



Highest % decrease in complaints received

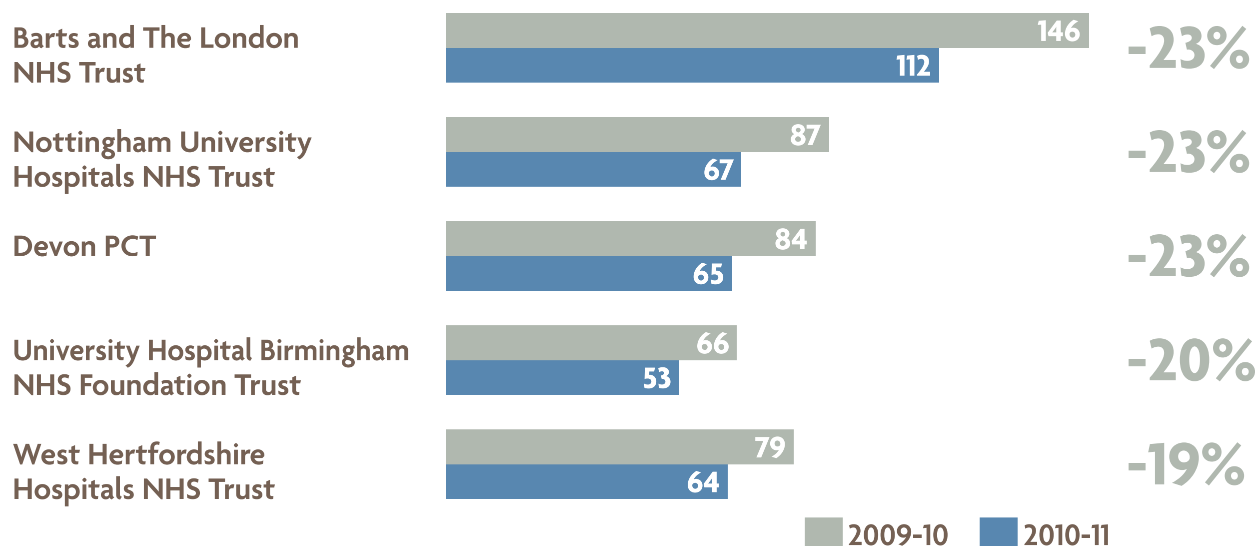


Figure 14 shows the top five bodies about which we have received the highest percentage increase or decrease in numbers of complaints. Mid Essex Hospital Services NHS Trust were 46th last year but are now in 9th place. On the other hand, Nottingham University Hospitals NHS Trust have fallen from 9th to 31st place this year and Devon PCT have fallen from 10th to 34th.

5. We have included only those bodies about which we have received at least 50 complaints.
6. Complaints about individual PCTs include complaints about independent treatment centres, GPs, general dental practitioners, pharmacies and opticians.

Interventions

Figure 15

Top ten health bodies by interventions

	2010-11	2009-10
Guy's and St Thomas' NHS Foundation Trust	5	1
Hampshire PCT	4	1
Hull and East Yorkshire Hospitals NHS Trust	4	1
Waltham Forest PCT	4	0
Barts and The London NHS Trust	3	5
Basildon and Thurrock University Hospitals NHS Foundation Trust	3	0
Brighton and Sussex University Hospitals NHS Trust	3	1
Coventry and Warwickshire Partnership NHS Trust	3	0
East Kent Hospitals University NHS Foundation Trust	3	2

For 14 bodies there were 3 interventions, generating a list of 18 bodies overall.

	2010-11	2009-10
Hastings and Rother PCT	3	0
Lambeth PCT	3	1
North Tyneside PCT	3	0
Northumbria Healthcare NHS Foundation Trust	3	1
Pennine Acute Hospitals NHS Trust	3	0
Sandwell and West Birmingham Hospitals NHS Trust	3	3
Sheffield PCT	3	1
The Dudley Group Of Hospitals NHS Foundation Trust	3	1
The Royal Wolverhampton Hospitals NHS Trust	3	0

Investigations

Figure 16

Top ten health bodies by complaints accepted for investigation

Health body	2010-11	2009-10
West Hertfordshire Hospitals NHS Trust	11	1
Heart of England NHS Foundation Trust	8	3
Cambridgeshire PCT	6	0
Somerset PCT	6	2
East Sussex Hospitals NHS Trust	5	4
Derby City PCT	4	0
East Sussex Downs and Weald PCT	4	6
Guy's and St Thomas' NHS Foundation Trust	4	1
Isle of Wight NHS PCT	4	1
Leeds Teaching Hospitals NHS Trust	4	1

13 bodies each had 4 complaints accepted for investigation, generating a list of 18 bodies overall.

	2010-11	2009-10
Leicester City PCT	4	0
North Yorkshire and York PCT	4	1
South East Coast Strategic Health Authority	4	12
South London Healthcare NHS Trust	4	4
St George's Healthcare NHS Trust	4	2
Stockport PCT	4	3
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	4	0
University Hospital of North Staffordshire NHS Trust	4	1

Four bodies have moved from having no complaints accepted for investigation about them to being in the top ten this year. It is also notable that West Hertfordshire Hospitals NHS Trust had only one complaint accepted last year but are up to eleven this year. More positively, East Midlands Ambulance Service NHS Trust, Devon PCT and Peterborough and Stamford Hospitals NHS Foundation Trust had no complaints accepted for formal investigation in 2010-11, despite having been in the top ten of bodies with complaints accepted for investigation in 2009-10.

Figure 17

Top ten health bodies by complaints investigated and reported on

	Reported on 2010-11	Uphold rate 2010-11	Reported on 2009-10
South East Coast Strategic Health Authority	13	92%	1
East Midlands Ambulance Service NHS Trust	6	83%	0
Pennine Acute Hospitals NHS Trust	6	83%	3
University Hospital Birmingham NHS Foundation Trust	6	83%	0
University Hospitals of Morecambe Bay NHS Foundation Trust	6	83%	1
Barking, Havering and Redbridge University Hospitals NHS Trust	5	100%	1
Heart of England NHS Foundation Trust	5	80%	0
Nottingham University Hospitals NHS Trust	5	60%	1
South London Healthcare NHS Trust	5	80%	4
The Royal Wolverhampton Hospitals NHS Trust	5	100%	2

Figure 17 shows the number of complaints we investigated and reported on for each body listed and the percentage uphold rate for these complaints. The rate is the total of upheld and partly upheld complaints.

The increased number of complaints reported on for South East Coast Strategic Health Authority reflects how we have worked with them to resolve a group of complaints about continuing healthcare funding. Other changes in this Figure may reflect the fact that we have reported on a larger number of complaints in 2010-11 than in 2009-10.

Looking to the future

Now in its third year of operation, the reformed NHS complaint handling system is providing a robust framework for resolving patients' complaints more quickly, simply and effectively than before. The system is sound and demonstrating its potential and only needs time and effective operation by the NHS to prove its worth.

Current developments in the broader health landscape provide the opportunity to enhance the benefits the system offers to patients and health bodies alike. The growing recognition of the need to capture meaningful, accurate and accessible information about complaints means the new system can be much more than just a swifter, simpler process for handling complaints. Instead, it has the potential to become a unified source of learning for the NHS nationally, and a trigger for improvement at local level, enabling patients and local communities to access the information they need to make the right choices about their healthcare.

Much of the work that will enable this to happen is already in train. The Department of Health has committed that it will start to publish complaints data by hospital in October 2011 and foundation trusts will also shortly be required to provide information on complaints. The '*Information Revolution*' provides a framework for making this information available, yet information about complaints is not yet included. We hope that in its response to the '*Information Revolution*' consultation, the Department of Health will take the opportunity to develop and include standardised indicators and measures for both complaints and lessons learnt, so patients can compare like with like.

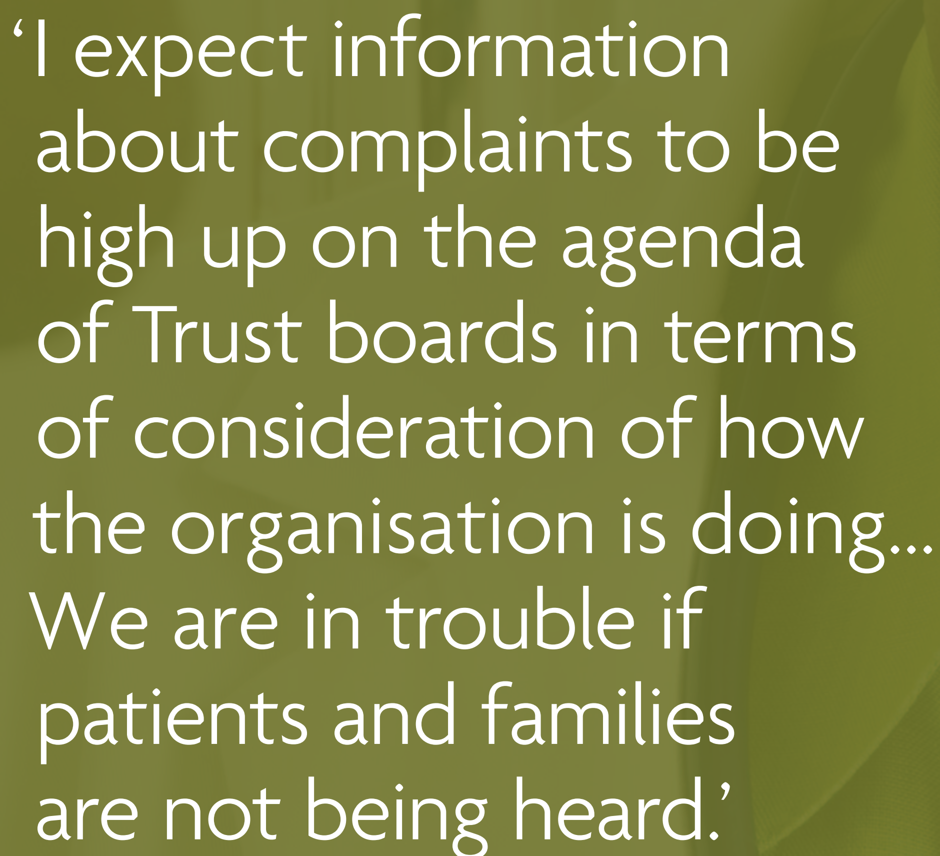
Effective alliances between bodies will be important in enabling the collation, sharing and analysis of data. We look forward to working with our existing contacts, and building new relationships with clinical commissioning groups, the NHS commissioning board and HealthWatch, to contribute to a common picture of complaint handling across the NHS in England. If the proposed changes to our legislation in the *Health and Social Care Bill* are passed, we will be able to share more detailed information with a wider range of health bodies about our decisions on individual complaints.

The proposed health reforms emphasise the importance of patients' experiences within the NHS and aim to put patients at the heart of decision making. To achieve this, there needs to be an increased focus for all NHS staff – from those on the frontline to NHS leaders – on understanding and evaluating the totality of a patient's experience, from the minute they pick up the phone to their GP surgery until the time they no longer need NHS care. The types of issues highlighted in this report – communication and the handling of seemingly minor misunderstandings and disputes – are at the heart of the patient's experience.

As the Ombudsman said in her evidence to the Mid Staffordshire Inquiry:

> *'I expect information about complaints to be high up on the agenda of Trust boards in terms of consideration of how the organisation is doing... We are in trouble if either patients and families are not being heard or do not think it is worth speaking up and Boards are not asking questions or being given information about complaints.'*

Throughout all the changes ahead, we will be looking for evidence that the NHS is getting better at asking for feedback and listening to those in its care. As the data in this report shows, too often patients' voices are ignored or unheard. By sharing the learning from the complaints we see, we hope to receive fewer complaints that feature poor communication in the coming year. An effective complaints system will ensure that the NHS listens to individual patients and their families and improves services for the future.



‘I expect information about complaints to be high up on the agenda of Trust boards in terms of consideration of how the organisation is doing... We are in trouble if patients and families are not being heard.’

Ann Abraham, Health Service Ombudsman

Appendix

In this appendix we publish information on complaints about all NHS bodies in 2010-11.

This includes:

- the number of complaints we received;
- the number of complaints we resolved through interventions;
- the number of complaints we accepted for formal investigation; and
- the number of investigated complaints we reported on, and the percentage of those complaints which were fully upheld, partly upheld, or not upheld.

NHS bodies are listed in alphabetical order by their official name, but please note that some are known publicly by another name. For example, we have listed Wirral PCT by its official name but it is also known as NHS Wirral.

Data for primary care practitioners is included in the figures for primary care trusts. For a breakdown of these figures go to the online version of our report at **www.ombudsman.org.uk**.

We record a body as an 'unknown body' where someone asks us how to complain about an NHS body, but he or she is at such an early stage in the complaints process that they do not know, or are unwilling to give us, the name of the body.

The online report also has data from 2009-10 for comparison.

Appendix

Statistical tables by NHS body

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
2gether NHS Foundation Trust	13	0
5 Boroughs Partnership NHS Foundation Trust	7	0
Aintree University Hospitals NHS Foundation Trust	26	1
Airedale NHS Foundation Trust	15	0
Alder Hey Children's NHS Foundation Trust	6	0
Ashford and St Peter's Hospitals NHS Foundation Trust	15	0
Ashton, Leigh and Wigan Community Healthcare NHS Trust	1	0
Ashton, Leigh and Wigan PCT	21	0
Avon and Wiltshire Mental Health Partnership NHS Trust	40	0
Barking and Dagenham PCT	9	1
Barking, Havering and Redbridge University Hospitals NHS Trust	100	1
Barnet and Chase Farm Hospitals NHS Trust	60	1
Barnet PCT	44	0
Barnet, Enfield and Haringey Mental Health NHS Trust	34	1
Barnsley Hospital NHS Foundation Trust	14	0
Barnsley PCT	26	0
Barts and The London NHS Trust	112	3
Basildon and Thurrock University Hospitals NHS Foundation Trust	74	3
Basingstoke and North Hampshire NHS Foundation Trust	13	0
Bassetlaw PCT	9	0
Bath and North East Somerset PCT	20	0
Bedford Hospital NHS Trust	21	0
Bedfordshire PCT	48	0
Berkshire East PCT	17	0
Berkshire Healthcare NHS Foundation Trust	11	0
Berkshire West PCT	41	0
Bexley Care Trust	27	0
Birmingham and Solihull Mental Health NHS Foundation Trust	26	2
Birmingham Children's Hospital NHS Foundation Trust	9	0
Birmingham Community Healthcare NHS Trust	4	0
Birmingham East and North PCT	31	1

2010-11

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	1	0%	0%	100%
0	0	–	–	–
0	2	0%	50%	50%
1	2	0%	0%	100%
0	0	–	–	–
0	2	50%	0%	50%
1	0	–	–	–
1	0	–	–	–
1	2	100%	0%	0%
0	0	–	–	–
3	5	60%	40%	0%
1	3	33%	67%	0%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
3	4	75%	0%	25%
1	3	67%	33%	0%
0	0	–	–	–
1	0	–	–	–
0	1	100%	0%	0%
2	1	100%	0%	0%
1	1	100%	0%	0%
1	0	–	–	–
0	0	–	–	–
1	3	100%	0%	0%
3	0	–	–	–
0	1	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
1	1	0%	100%	0%

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
Birmingham Women's NHS Foundation Trust	14	0
Blackburn with Darwen PCT	9	0
Blackpool PCT	21	0
Blackpool Teaching Hospitals NHS Foundation Trust	58	1
Bolton PCT	26	1
Bournemouth and Poole Teaching PCT	41	0
Bradford and Airedale Teaching PCT	34	0
Bradford District Care Trust	14	0
Bradford Teaching Hospitals NHS Foundation Trust	28	1
Brent Teaching PCT	27	0
Brighton and Hove City PCT	24	1
Brighton and Sussex University Hospitals NHS Trust	80	3
Bristol PCT	44	0
Bromley PCT	29	0
Buckinghamshire Healthcare NHS Trust	32	0
Buckinghamshire PCT	42	1
Burton Hospitals NHS Foundation Trust	15	0
Bury PCT	16	0
Calderdale and Huddersfield NHS Foundation Trust	40	1
Calderdale PCT	9	0
Calderstones Partnership NHS Foundation Trust	1	0
Cambridge University Hospitals NHS Foundation Trust	33	1
Cambridgeshire and Peterborough NHS Foundation Trust	15	0
Cambridgeshire Community Services NHS Trust	3	0
Cambridgeshire PCT	40	0
Camden and Islington NHS Foundation Trust	29	1
Camden PCT	36	0
Central and Eastern Cheshire PCT	29	0
Central and North West London NHS Foundation Trust	49	1
Central Lancashire PCT	58	2
Central London Community Healthcare NHS Trust	9	0
Central Manchester University Hospitals NHS Foundation Trust	70	0
Chelsea and Westminster Hospital NHS Foundation Trust	42	0
Cheshire and Wirral Partnership NHS Foundation Trust	14	0
Chesterfield Royal Hospital NHS Foundation Trust	16	0
City and Hackney Teaching PCT	15	0
City Hospitals Sunderland NHS Foundation Trust	39	1

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
1	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	3	67%	0%	33%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	0	–	–	–
1	1	100%	0%	0%
2	1	100%	0%	0%
0	0	–	–	–
0	1	0%	0%	100%
1	1	0%	0%	100%
2	0	–	–	–
2	2	100%	0%	0%
1	0	–	–	–
1	1	100%	0%	0%
0	0	–	–	–
1	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	0	–	–	–
0	0	–	–	–
6	0	–	–	–
0	0	–	–	–
0	1	100%	0%	0%
3	1	100%	0%	0%
1	0	–	–	–
2	1	100%	0%	0%
0	0	–	–	–
1	0	–	–	–
0	1	100%	0%	0%
0	1	0%	0%	100%
0	0	–	–	–
0	0	–	–	–
1	2	50%	50%	0%

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
Clatterbridge Centre For Oncology NHS Foundation Trust	4	0
Colchester Hospital University NHS Foundation Trust	42	2
Cornwall and Isles of Scilly PCT	45	1
Cornwall Partnership NHS Foundation Trust	9	0
Countess Of Chester Hospital NHS Foundation Trust	16	1
County Durham and Darlington NHS Foundation Trust	37	2
County Durham PCT	13	0
Coventry and Warwickshire Partnership NHS Trust	31	3
Coventry Teaching PCT	31	1
Croydon Health Services NHS Trust	37	1
Croydon PCT	28	1
Cumbria Partnership NHS Foundation Trust	16	2
Cumbria Teaching PCT	21	0
Darlington PCT	18	0
Dartford and Gravesham NHS Trust	21	1
Derby City PCT	18	0
Derby Hospitals NHS Foundation Trust	38	1
Derbyshire County PCT	67	1
Derbyshire Healthcare NHS Foundation Trust	13	1
Devon Partnership NHS Trust	26	0
Devon PCT	65	0
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	57	0
Doncaster PCT	36	0
Dorset County Hospital NHS Foundation Trust	32	2
Dorset Healthcare University NHS Foundation Trust	6	0
Dorset PCT	39	0
Dudley and Walsall Mental Health Partnership NHS Trust	17	0
Dudley PCT	24	0
Ealing Hospital NHS Trust	9	0
Ealing PCT	40	0
East and North Hertfordshire NHS Trust	48	0
East Cheshire NHS Trust	13	0
East Kent Hospitals University NHS Foundation Trust	110	3
East Lancashire Hospitals NHS Trust	37	0
East Lancashire Teaching PCT	29	1
East London NHS Foundation Trust	32	0
East Midlands Ambulance Service NHS Trust	21	1

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	0	–	–	–
1	3	67%	33%	0%
0	0	–	–	–
0	0	–	–	–
1	0	–	–	–
1	1	100%	0%	0%
0	0	–	–	–
1	1	100%	0%	0%
1	1	0%	0%	100%
2	4	75%	0%	25%
0	1	100%	0%	0%
1	0	–	–	–
0	0	–	–	–
2	1	0%	0%	100%
0	0	–	–	–
4	2	100%	0%	0%
0	0	–	–	–
1	0	–	–	–
0	0	–	–	–
1	1	0%	0%	100%
0	1	100%	0%	0%
3	0	–	–	–
0	2	50%	50%	0%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	1	100%	0%	0%
1	0	–	–	–
0	0	–	–	–
0	2	50%	0%	50%
2	3	0%	67%	33%
1	0	–	–	–
3	0	–	–	–
1	0	–	–	–
1	1	100%	0%	0%
0	1	0%	0%	100%
0	6	50%	33%	17%

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
East Midlands Strategic Health Authority	21	0
East of England Ambulance Service NHS Trust	27	1
East of England Strategic Health Authority	27	0
East Riding of Yorkshire PCT	41	1
East Sussex Downs and Weald PCT	41	2
East Sussex Hospitals NHS Trust	56	1
Eastern and Coastal Kent Community Health NHS Trust	1	0
Eastern and Coastal Kent PCT	72	2
Enfield PCT	29	1
Epsom and St Helier University Hospitals NHS Trust	33	1
Frimley Park Hospital NHS Foundation Trust	24	1
Gateshead Health NHS Foundation Trust	25	0
Gateshead PCT	12	1
George Eliot Hospital NHS Trust	18	0
Gloucestershire Hospitals NHS Foundation Trust	50	2
Gloucestershire PCT	31	0
Great Ormond Street Hospital For Children NHS Trust	22	0
Great Western Ambulance Service NHS Trust	19	1
Great Western Hospitals NHS Foundation Trust	27	0
Great Yarmouth and Waveney PCT	29	0
Greater Manchester West Mental Health NHS Foundation Trust	22	0
Greenwich Teaching PCT	24	0
Guy's and St Thomas' NHS Foundation Trust	123	5
Halton and St Helens PCT	15	0
Hammersmith and Fulham PCT	18	0
Hampshire Partnership NHS Foundation Trust	23	0
Hampshire PCT	88	4
Haringey Teaching PCT	38	1
Harrogate and District NHS Foundation Trust	23	0
Harrow PCT	29	0
Hartlepool PCT	8	0
Hastings and Rother PCT	23	3
Havering PCT	34	0
Health and Social Care Information Centre	0	0
Healthcare Commission	36	0
Heart of Birmingham Teaching PCT	34	1
Heart of England NHS Foundation Trust	171	0

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	1	100%	0%	0%
0	1	0%	100%	0%
0	1	0%	0%	100%
2	0	–	–	–
4	2	0%	0%	100%
5	4	25%	50%	25%
0	0	–	–	–
1	0	–	–	–
3	4	100%	0%	0%
1	1	0%	100%	0%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	1	100%	0%	0%
0	1	100%	0%	0%
1	4	50%	25%	25%
1	0	–	–	–
1	0	–	–	–
2	1	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
0	1	100%	0%	0%
4	3	33%	33%	33%
1	2	100%	0%	0%
0	0	–	–	–
1	2	50%	0%	50%
2	2	100%	0%	0%
2	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	1	100%	0%	0%
0	1	100%	0%	0%
1	0	–	–	–
0	0	–	–	–
0	1	100%	0%	0%
2	0	–	–	–
8	5	80%	0%	20%

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	63	1
Hereford Hospitals NHS Trust	18	1
Herefordshire PCT	27	0
Hertfordshire Community NHS Trust	6	0
Hertfordshire Partnership NHS Foundation Trust	32	1
Hertfordshire PCT	91	0
Heywood, Middleton and Rochdale PCT	20	0
Hillingdon PCT	31	0
Hinchingbrooke Health Care NHS Trust	7	0
Homerton University Hospital NHS Foundation Trust	28	1
Hounslow PCT	31	0
Hull and East Yorkshire Hospitals NHS Trust	68	4
Hull Teaching PCT	35	0
Humber NHS Foundation Trust	16	0
Imperial College Healthcare NHS Trust	101	2
Ipswich Hospital NHS Trust	28	0
Isle of Wight NHS PCT	77	2
Islington PCT	38	1
James Paget University Hospitals NHS Foundation Trust	12	0
Kensington and Chelsea PCT	31	0
Kent and Medway NHS and Social Care Partnership Trust	36	0
Kettering General Hospital NHS Foundation Trust	33	0
King's College Hospital NHS Foundation Trust	112	2
Kingston Hospital NHS Trust	26	0
Kingston PCT	10	0
Kirklees PCT	22	1
Knowsley PCT	2	0
Lambeth PCT	38	3
Lancashire Care NHS Foundation Trust	23	0
Lancashire Teaching Hospitals NHS Foundation Trust	72	2
Leeds Partnerships NHS Foundation Trust	22	0
Leeds PCT	84	1
Leeds Teaching Hospitals NHS Trust	117	1
Leicester City PCT	42	1
Leicestershire County and Rutland PCT	74	2
Leicestershire Partnership NHS Trust	22	0
Lewisham PCT	24	0

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
1	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	0	–	–	–
3	2	50%	0%	50%
1	0	–	–	–
0	0	–	–	–
1	0	–	–	–
1	0	–	–	–
0	0	–	–	–
2	1	0%	0%	100%
1	0	–	–	–
0	0	–	–	–
3	1	0%	0%	100%
0	1	100%	0%	0%
4	1	100%	0%	0%
1	0	–	–	–
0	1	100%	0%	0%
0	0	–	–	–
1	0	–	–	–
3	3	33%	33%	33%
2	1	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
2	1	100%	0%	0%
3	1	0%	100%	0%
2	1	0%	100%	0%
1	0	–	–	–
3	0	–	–	–
4	1	0%	0%	100%
4	1	0%	0%	100%
3	1	0%	0%	100%
1	0	–	–	–
0	0	–	–	–

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
Lincolnshire Partnership NHS Foundation Trust	10	0
Lincolnshire Teaching PCT	52	1
Liverpool Community Health NHS Trust	2	0
Liverpool Heart and Chest NHS Foundation Trust	4	0
Liverpool PCT	43	0
Liverpool Women's NHS Foundation Trust	7	0
London Ambulance Service NHS Trust	42	1
London Strategic Health Authority	18	0
Luton and Dunstable Hospital NHS Foundation Trust	33	1
Luton PCT	21	0
Maidstone and Tunbridge Wells NHS Trust	36	0
Manchester Mental Health and Social Care Trust	23	0
Manchester PCT	64	0
Medway NHS Foundation Trust	55	0
Medway PCT	26	0
Mersey Care NHS Trust	31	0
Mid Cheshire Hospitals NHS Foundation Trust	12	0
Mid Essex Hospital Services NHS Trust	97	1
Mid Essex PCT	42	0
Mid Staffordshire NHS Foundation Trust	33	0
Mid Yorkshire Hospitals NHS Trust	48	1
Middlesbrough PCT	4	0
Milton Keynes Hospital NHS Foundation Trust	29	1
Milton Keynes PCT	38	1
Moorfields Eye Hospital NHS Foundation Trust	31	1
National Institute for Health and Clinical Excellence	2	0
National Patient Safety Agency	2	0
Newcastle PCT	15	0
Newham PCT	27	1
Newham University Hospital NHS Trust	29	0
NHS Blood and Transplant	11	0
NHS Business Services Authority	34	0
NHS Direct	23	0
NHS Litigation Authority	7	0
Norfolk and Norwich University Hospitals NHS Foundation Trust	22	0
Norfolk and Waveney Mental Health NHS Foundation Trust	32	2
Norfolk Community Health and Care NHS Trust	7	0

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	1	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	0	–	–	–
1	0	–	–	–
0	0	–	–	–
0	4	100%	0%	0%
3	0	–	–	–
1	1	100%	0%	0%
1	1	100%	0%	0%
3	0	–	–	–
0	2	50%	0%	50%
0	0	–	–	–
0	1	0%	0%	100%
1	0	–	–	–
2	0	–	–	–
0	1	100%	0%	0%
1	0	–	–	–
1	0	–	–	–
0	0	–	–	–
0	2	50%	0%	50%
1	1	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	3	67%	0%	33%
1	1	0%	0%	100%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	0	–	–	–
0	0	–	–	–
0	0	–	–	–

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
Norfolk PCT	62	1
North Bristol NHS Trust	66	2
North Cumbria University Hospitals NHS Trust	20	0
North East Ambulance Service NHS Trust	10	0
North East Essex PCT	42	1
North East Lincolnshire Care Trust Plus	7	0
North East London NHS Foundation Trust	16	1
North East Strategic Health Authority	5	1
North Essex Partnership NHS Foundation Trust	16	1
North Lancashire Teaching PCT	32	0
North Lincolnshire PCT	16	0
North Middlesex University Hospital NHS Trust	39	1
North Somerset PCT	19	2
North Staffordshire Combined Healthcare NHS Trust	9	1
North Staffordshire PCT	20	0
North Tees and Hartlepool NHS Foundation Trust	46	1
North Tyneside PCT	29	3
North West Ambulance Service NHS Trust	26	0
North West London Hospitals NHS Trust	84	2
North West Strategic Health Authority	28	1
North Yorkshire and York PCT	75	0
Northampton General Hospital NHS Trust	34	0
Northamptonshire Healthcare NHS Foundation Trust	16	0
Northamptonshire Teaching PCT	43	1
Northern Devon Healthcare NHS Trust	31	2
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust	48	0
Northumberland Care Trust	5	0
Northumberland, Tyne and Wear NHS Foundation Trust	24	0
Northumbria Healthcare NHS Foundation Trust	21	3
Nottingham City PCT	21	0
Nottingham University Hospitals NHS Trust	67	1
Nottinghamshire County Teaching PCT	29	0
Nottinghamshire Healthcare NHS Trust	36	0
Nuffield Orthopaedic Centre NHS Trust	6	0
Oldham PCT	18	0
Oxford Health NHS Foundation Trust	27	0
Oxford Radcliffe Hospitals NHS Trust	64	1

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
1	1	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
2	3	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
3	0	–	–	–
0	0	–	–	–
0	2	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
0	1	100%	0%	0%
1	2	100%	0%	0%
1	0	–	–	–
0	1	0%	100%	0%
0	1	100%	0%	0%
0	0	–	–	–
4	1	0%	0%	100%
2	4	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
1	1	0%	100%	0%
1	0	–	–	–
0	0	–	–	–
1	2	50%	50%	0%
0	0	–	–	–
0	0	–	–	–
0	5	60%	0%	40%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	1	100%	0%	0%

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
Oxfordshire Learning Disability NHS Trust	1	0
Oxfordshire PCT	42	2
Oxleas NHS Foundation Trust	23	0
Papworth Hospital NHS Foundation Trust	4	0
Pennine Acute Hospitals NHS Trust	61	3
Pennine Care NHS Foundation Trust	27	1
Peterborough and Stamford Hospitals NHS Foundation Trust	28	0
Peterborough PCT	18	1
Plymouth Hospitals NHS Trust	56	2
Plymouth Teaching PCT	44	0
Poole Hospital NHS Foundation Trust	18	0
Portsmouth City Teaching PCT	21	0
Portsmouth Hospitals NHS Trust	40	0
Queen Victoria Hospital NHS Foundation Trust	5	0
Redbridge PCT	24	0
Redcar and Cleveland PCT	9	0
Richmond and Twickenham PCT	19	0
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	1	0
Rotherham PCT	6	0
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	15	0
Royal Berkshire NHS Foundation Trust	33	0
Royal Bolton Hospital NHS Foundation Trust	27	0
Royal Brompton and Harefield NHS Foundation Trust	10	1
Royal Cornwall Hospitals NHS Trust	39	0
Royal Devon and Exeter NHS Foundation Trust	54	1
Royal Free Hampstead NHS Trust	85	1
Royal Liverpool and Broadgreen University Hospitals NHS Trust	38	1
Royal National Hospital For Rheumatic Diseases NHS Foundation Trust	2	0
Royal National Orthopaedic Hospital NHS Trust	23	0
Royal Surrey County NHS Foundation Trust	21	0
Royal United Hospital Bath NHS Trust	48	1
Salford PCT	13	0
Salford Royal NHS Foundation Trust	44	1
Salisbury NHS Foundation Trust	17	1
Sandwell and West Birmingham Hospitals NHS Trust	71	3

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	0	–	–	–
1	0	–	–	–
0	0	–	–	–
0	0	–	–	–
3	6	83%	0%	17%
1	1	0%	0%	100%
0	4	50%	25%	25%
0	0	–	–	–
2	4	100%	0%	0%
0	0	–	–	–
0	1	100%	0%	0%
0	0	–	–	–
0	2	0%	50%	50%
1	1	100%	0%	0%
0	1	0%	100%	0%
0	1	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
1	0	–	–	–
0	0	–	–	–
1	1	0%	0%	100%
0	0	–	–	–
0	1	0%	0%	100%
0	2	50%	50%	0%
0	0	–	–	–
2	0	–	–	–
1	2	50%	0%	50%
0	0	–	–	–
0	0	–	–	–
0	1	0%	100%	0%
3	1	0%	0%	100%
1	0	–	–	–
1	0	–	–	–
0	1	0%	0%	100%
1	3	0%	100%	0%

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
Sandwell Mental Health and Social Care NHS Foundation Trust	10	0
Sandwell PCT	39	1
Scarborough and North East Yorkshire Health Care NHS Trust	35	0
Sefton PCT	26	0
Sheffield Children's NHS Foundation Trust	6	0
Sheffield Health and Social Care NHS Foundation Trust	10	0
Sheffield PCT	48	3
Sheffield Teaching Hospitals NHS Foundation Trust	65	1
Sherwood Forest Hospitals NHS Foundation Trust	37	0
Shrewsbury and Telford Hospital NHS Trust	42	2
Shropshire County PCT	17	0
Solihull Care Trust	15	0
Somerset Partnership NHS Foundation Trust	15	0
Somerset PCT	61	1
South Birmingham PCT	34	1
South Central Ambulance Service NHS Trust	8	0
South Central Strategic Health Authority	27	0
South Devon Healthcare NHS Foundation Trust	36	0
South East Coast Ambulance Service NHS Foundation Trust	27	0
South East Coast Strategic Health Authority	23	1
South East Essex PCT	35	2
South Essex Partnership University NHS Foundation Trust	35	0
South Gloucestershire PCT	17	0
South London and Maudsley NHS Foundation Trust	69	1
South London Healthcare NHS Trust	95	2
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	14	0
South Staffordshire PCT	43	1
South Tees Hospitals NHS Foundation Trust	23	1
South Tyneside NHS Foundation Trust	15	1
South Tyneside PCT	15	0
South Warwickshire NHS Foundation Trust	22	1
South West Essex PCT	48	1
South West London and St George's Mental Health NHS Trust	48	0
South West Strategic Health Authority	46	0
South West Yorkshire Partnership NHS Foundation Trust	19	0
South Western Ambulance Service NHS Foundation Trust	13	0

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	0	–	–	–
1	1	0%	100%	0%
2	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	1	0%	100%	0%
0	1	100%	0%	0%
0	1	100%	0%	0%
1	0	–	–	–
1	2	100%	0%	0%
0	0	–	–	–
1	0	–	–	–
6	2	100%	0%	0%
0	0	–	–	–
1	1	0%	0%	100%
1	0	–	–	–
0	1	100%	0%	0%
1	0	–	–	–
4	13	85%	8%	8%
3	4	50%	0%	50%
0	1	0%	0%	100%
0	0	–	–	–
1	1	0%	0%	100%
4	5	80%	0%	20%
1	1	100%	0%	0%
1	2	100%	0%	0%
1	0	–	–	–
0	2	50%	0%	50%
0	0	–	–	–
0	0	–	–	–
3	0	–	–	–
0	0	–	–	–
1	0	–	–	–
0	0	–	–	–
0	0	–	–	–

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
Southampton City PCT	29	0
Southampton University Hospitals NHS Trust	49	0
Southend University Hospital NHS Foundation Trust	42	0
Southport and Ormskirk Hospital NHS Trust	34	0
Southwark PCT	29	1
St George's Healthcare NHS Trust	60	2
St Helens and Knowsley Hospitals NHS Trust	26	0
Stockport NHS Foundation Trust	31	0
Stockport PCT	36	0
Stockton-on-Tees Teaching PCT	6	0
Stoke on Trent PCT	19	0
Suffolk Mental Health Partnership NHS Trust	24	1
Suffolk PCT	37	1
Sunderland Teaching PCT	22	0
Surrey and Borders Partnership NHS Foundation Trust	38	0
Surrey and Sussex Healthcare NHS Trust	14	0
Surrey PCT	72	2
Sussex Community NHS Trust	9	1
Sussex Partnership NHS Foundation Trust	41	1
Sutton and Merton PCT	31	0
Swindon PCT	22	0
Tameside and Glossop PCT	15	0
Tameside Hospital NHS Foundation Trust	24	0
Taunton and Somerset NHS Foundation Trust	27	0
Tavistock and Portman NHS Foundation Trust	4	0
Tees, Esk and Wear Valleys NHS Foundation Trust	18	0
Telford and Wrekin PCT	16	1
The Christie NHS Foundation Trust	6	1
The Dudley Group Of Hospitals NHS Foundation Trust	56	3
The Hillingdon Hospital NHS Trust	44	0
The Lewisham Healthcare NHS Trust	32	0
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	51	1
The Princess Alexandra Hospital NHS Trust	32	1
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	14	0
The Rotherham NHS Foundation Trust	12	0
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	37	0

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	0	–	–	–
1	3	100%	0%	0%
3	3	67%	0%	33%
1	0	–	–	–
2	0	–	–	–
4	2	100%	0%	0%
1	2	100%	0%	0%
1	1	100%	0%	0%
4	3	67%	0%	33%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	1	0%	0%	100%
1	0	–	–	–
0	0	–	–	–
0	1	100%	0%	0%
2	3	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
2	2	0%	0%	100%
2	1	100%	0%	0%
0	0	–	–	–
3	3	33%	67%	0%
0	1	0%	100%	0%
0	0	–	–	–
0	0	–	–	–
1	0	–	–	–
0	0	–	–	–
0	0	–	–	–
2	1	100%	0%	0%
2	1	100%	0%	0%
1	1	100%	0%	0%
0	3	100%	0%	0%
0	0	–	–	–
0	0	–	–	–
4	3	33%	67%	0%

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
The Royal Marsden NHS Foundation Trust	18	1
The Royal Orthopaedic Hospital NHS Foundation Trust	19	0
The Royal Wolverhampton Hospitals NHS Trust	45	3
The Walton Centre NHS Foundation Trust	10	0
The Whittington Hospital NHS Trust	36	0
Torbay Care Trust	17	0
Tower Hamlets PCT	36	0
Trafford Healthcare NHS Trust	17	0
Trafford PCT	24	0
United Lincolnshire Hospitals NHS Trust	64	0
University College London Hospitals NHS Foundation Trust	87	0
University Hospital Birmingham NHS Foundation Trust	53	1
University Hospital of North Staffordshire NHS Trust	41	1
University Hospital of South Manchester NHS Foundation Trust	37	0
University Hospitals Bristol NHS Foundation Trust	57	0
University Hospitals Coventry and Warwickshire NHS Trust	52	1
University Hospitals of Leicester NHS Trust	68	0
University Hospitals of Morecambe Bay NHS Foundation Trust	44	1
Wakefield District PCT	27	0
Walsall Hospitals NHS Trust	15	1
Walsall Teaching PCT	8	0
Waltham Forest PCT	33	4
Wandsworth PCT	38	1
Warrington and Halton Hospitals NHS Foundation Trust	33	0
Warrington PCT	21	0
Warwickshire PCT	40	0
West Essex PCT	32	0
West Hertfordshire Hospitals NHS Trust	64	2
West Kent PCT	37	1
West London Mental Health NHS Trust	40	0
West Middlesex University Hospital NHS Trust	30	0
West Midlands Ambulance Service NHS Trust	12	1
West Midlands Strategic Health Authority	14	0
West Suffolk Hospitals NHS Trust	8	0
West Sussex PCT	88	2
Western Cheshire PCT	21	1
Western Sussex Hospitals NHS Trust	52	0

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
0	1	0%	100%	0%
0	0	–	–	–
2	5	80%	20%	0%
1	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	2	100%	0%	0%
1	0	–	–	–
3	0	–	–	–
2	4	100%	0%	0%
0	0	–	–	–
1	6	67%	17%	17%
4	2	50%	50%	0%
3	2	100%	0%	0%
1	0	–	–	–
1	1	100%	0%	0%
2	2	50%	0%	50%
2	6	67%	17%	17%
0	0	–	–	–
0	1	0%	100%	0%
1	0	–	–	–
0	0	–	–	–
3	1	0%	100%	0%
1	0	–	–	–
0	0	–	–	–
0	1	0%	0%	100%
0	2	0%	0%	100%
11	4	75%	25%	0%
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
0	0	–	–	–
1	1	100%	0%	0%
0	1	0%	0%	100%
3	2	100%	0%	0%

	Complaints received 2010-11	Complaints resolved through intervention 2010-11
Westminster PCT	46	1
Weston Area Health NHS Trust	21	2
Whipps Cross University Hospital NHS Trust	60	2
Wiltshire PCT	38	0
Winchester and Eastleigh Healthcare NHS Trust	8	2
Wirral PCT	9	0
Wirral University Teaching Hospital NHS Foundation Trust	29	0
Wolverhampton City PCT	32	2
Worcestershire Acute Hospitals NHS Trust	52	0
Worcestershire Mental Health Partnership NHS Trust	7	0
Worcestershire PCT	51	0
Wrightington, Wigan and Leigh NHS Foundation Trust	34	0
Yeovil District Hospital NHS Foundation Trust	13	0
York Hospitals NHS Foundation Trust	34	0
Yorkshire Ambulance Service NHS Trust	16	0
Yorkshire and The Humber Strategic Health Authority	21	0
Unknown	1,930	0
Total	**15,066**	**230**

Complaints accepted for investigation 2010-11	Investigated complaints reported on 2010-11	Investigated complaints reported on: fully upheld %	Investigated complaints reported on: partly upheld %	Investigated complaints reported on: not upheld %
1	0	–	–	–
0	0	–	–	–
2	1	100%	0%	0%
3	2	50%	0%	50%
0	1	100%	0%	0%
0	1	100%	0%	0%
1	2	100%	0%	0%
2	0	–	–	–
0	3	33%	33%	33%
0	1	100%	0%	0%
0	2	100%	0%	0%
0	1	0%	0%	100%
1	1	100%	0%	0%
0	0	–	–	–
0	3	67%	33%	0%
0	0	–	–	–
0	0	–	–	–
351	**349**	**64%**	**15%**	**21%**

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