



Parliamentary
and Health Service
Ombudsman

Learning from Complaints

Craig Turton, Interim Senior Health Policy Manager

'Making feedback count: Listening to and learning from the patient voice' - 10 September 2013

The Parliamentary & Health Service Ombudsman (PHSO)

Dame Julie Mellor has been in post since January 2012

Dual role:

- Parliamentary Commissioner for Administration
- Health Service Commissioner

Governed by:

- *Parliamentary Commissioner Act 1967*
- *Health Service Commissioners Act 1993*



The role of PHSO

- We investigate complaints that individuals have been treated unfairly or have received a poor service from government departments and other public organisations in the UK and the NHS in England
- We ask people to complain to the organisation they are unhappy about before bringing their complaint to us, eg: complaints about the NHS must first be pursued at local level
- We share information about our work with Parliament to enhance scrutiny of the Government and with the NHS to help make public services better

The post-Francis landscape

- Francis report on the Public Inquiry of the Mid Staffordshire NHS Foundation Trust contained 290 recommendations including effective complaints handling
- Trust Board “*..did not listen sufficiently to its patients or its staff or ensure the correction of deficiencies brought to the Trust’s attention*”
- Francis concluded that Trust failures were a wider systemic problem for the NHS as a whole



Clwyd/Hart review

- Review of NHS hospital complaints handling by Anne Clwyd MP and Professor Tricia Hart expected to report in early October
- *“ Complaints can be the earliest symptom of a problem within an organisation and the NHS should use them to learn from and improve their service. ”* Rt Hon Jeremy Hunt MP
- PHSO has contributed as part of Key Partnership Group; by providing insight from our cases and; by commissioning new research



Clwyd/Hart review: what we have done

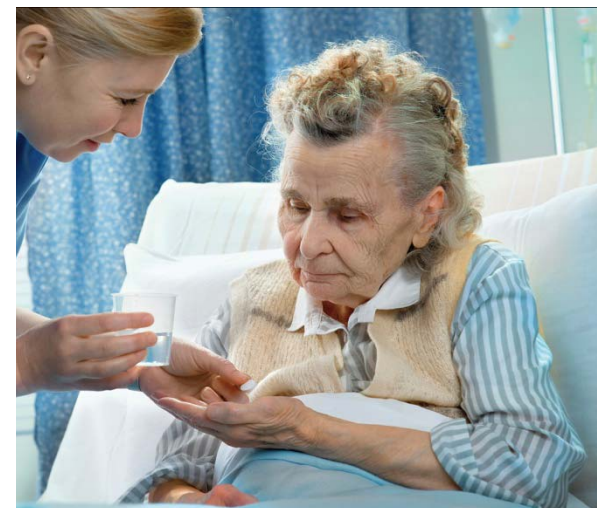
- Desktop research - '*The NHS hospital complaints system: A case for urgent treatment?*' looked at our casework to identify themes from complaints and identify those areas of greatest concern
- Governance research - *NHS Hospital Trust Governance of Complaint Handling*: research from 94 Trust Boards on if/how complaints are used to inform management/strategic decisions
- Collaborative research - '*Designing good together: transforming hospital complaints handling*' - patient/staff co-designed practical recommendations for changing hospital complaints systems
- Submission to the Clwyd/Hart review incorporating the research available on our website: www.ombudsman.org.uk

Governance of complaints handling

- Only 20% of Trust Boards considered a review of learning from complaints and taking resulting action to improve services as a top priority
- Less than half measure patient satisfaction with the way complaints are handled
- Less than two thirds use a consistent approach to reviewing complaints data
- Around a fifth said the information they received was “ineffective” in identifying and reducing risks to patient safety

The Toxic Cocktail

- **The problem:** reluctance by patients to complain combined with defensiveness by hospitals and staff to hear/address concerns
- **This matters because:** complaints are not addressed and opportunities to learn and improve services are lost
- **Why it happens:** people don't know how/who to complain and/or fear not being taken seriously. Staff fear blame culture for admitting failing by themselves, colleagues or by their employer



The Toxic Cocktail

"The NHS in England has a culture of denial and defensiveness when it comes to handling complaints from patients"



Sir David Nicholson, 25 June 2013

A step change is required....

- So that people are listened to
- Problems are resolved
- Hospitals learn from mistakes and use that learning to drive service improvement
- Shift the culture from defensive to open, from a focus on blame to a focus on putting things right

Organisational change in 6 key areas

- **Leadership and governance** - complaints taken seriously and inform leadership decisions. Focus on remedy, not retribution
- **Engagement** - staff engaged in culture change and new open culture encourages patients to be confident in providing feedback
- **Formal mechanisms/practices** - where/how to complain
- **Skills** - complaints knowledge/skills/training for staff
- **Measurement** - complaints are critical management information
- **Accountability** - it should run from ward to Board

Putting things right on the ward

- Patients/carers to know who to go to with questions or concerns
- Staff should receive complaints system training
- PALS should operate 24/7 in line with other hospital services
- Ward supervisors to be visible and carry out rounds to identify concerns
- Patients and carers to feel confident to provide feedback
- Staff should feel supported and informed during and after the complaint



Early intervention



Request/Concern
"My mum can't quite reach her water glass"



Formal Complaint
"My mother became dehydrated and distressed. I want to make a formal complaint."

Ombudsman Investigation
"I struggled to find out where to complain and I still haven't had an honest apology. I want the Ombudsman to investigate"

Putting things right on the Board

- Feedback from patient and staff experience drives service improvement
- Patient experience of complaining measured, deficits in services identified and improved
- Staff supported to learn and change their practice following a complaint
- Leaders to acknowledge service problems and mistakes
- Best practice shared across Trusts



Are we on the same page?



- *"The complaints systems for health and social care are not yet as accessible and responsive as they could be. There is a lack of learning from complaints"* - National Audit Office.
- *"There needs to be a profound change in how the NHS listens to the feedback, concerns and complaints of the patients"* - Healthwatch England.
- *"Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others."* - Ambition 3, Keogh Review of 14 hospital trusts in England.

How do we embed best practice?

- The NHS Constitution
- The National Quality Board



Any Questions?

Thank you

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