

Report to:	Enfield Health and Wellbeing Board, July 2015
Subject:	Complaints Handling: What Good Looks Like
From:	Healthwatch Enfield
Lead:	Deborah Fowler, Chair deborah.fowler@healthwatchenfield.co.uk Lorna Reith, Chief Executive lorna.reith@healthwatchenfield.co.uk 020 8373 6283

1. Summary

- 1.1 Well-run organisations in any sector welcome feedback and complaints as an opportunity to identify and act on areas requiring improvement. The Francis Report into the failings at Mid-Staffordshire NHS Foundation Trust highlighted how essential this is to the health and social care sector, given the impact of their work on people's health and wellbeing.
- 1.2 In November 2014, the Local Government Ombudsman (LGO), Healthwatch England, and the Parliamentary and Health Service Ombudsman (PHSO) jointly published '*My Expectations for Raising Concerns and Complaints*', a User-Led Vision for the complaints system. The joint Report set out universal expectations of good complaints handling, drawn up in co-production with consumers of health and social care services.
- 1.3 In December 2014, the Care Quality Commission (CQC) adopted this new framework for complaints handling in '*Complaints Matter*', and set out its new focus on complaints as a mandatory Key Line of Enquiry for CQC inspections. The CQC said that it "now knows what good looks like" and criticised many health and social care providers for being defensive when faced with complaints and feedback. The CQC now takes into account how well complaints and concerns are handled by an organisation in judging and rating that organisation's responsiveness to its patients, service users, and carers.
- 1.4 The Health and Wellbeing Board and its members are being asked collectively and individually to endorse the framework established by the User-Led Vision for Raising Concerns and Complaints and adopted by the CQC, and to incorporate them into service contracts.

2. Recommendations

The Health and Wellbeing Board:

- 2.1 notes the user-led complaints framework published jointly by the LGO, Healthwatch England and PHSO and adopted by the CQC for use in its inspection regime;
- 2.2 asks commissioners from the CCG, NHS England and local authority to adopt the new complaints framework, as appropriate, in their provider contract specifications relating at least to health and social care, to achieve a consistent approach across Enfield;
- 2.3 asks that, in monitoring *existing* contracts, the CCG, NHS England and local authority commissioners are informed by the new complaints framework and encourage their providers to improve their existing complaints systems;
- 2.4 notes that NHS England has assured the LGO, Healthwatch England and PHSO that it will use the new user-led complaints framework as a performance management tool to be built into the NHS Outcomes Framework;
- 2.5 resolves that, as part of its role in promoting and reviewing integrated care arrangements, the HWB will consider and review how well the user experience of complaints-handling matches the expectations set out by the CQC; and,
- 2.6 notes that when reviewing complaints-handling in provider organisations, Healthwatch Enfield will adopt the user-led complaints framework.

3. Background

3.1 The importance of complaints processes in improving safety and the quality of services for service users has been highlighted in a number of high profile reports since 2013:

- (1) The Francis Inquiry Report into the failings of Mid-Staffordshire NHS Foundation Trust (February 2013)
- (2) The Clwyd Hart Review of NHS Hospital Complaints System - Putting Patients Back in the Picture (October 2013)
- (3) The Healthwatch England Report “Suffering in Silence” (October 2014)
- (4) Joint Report of the LGO, Healthwatch England and PHSO “My Expectations for Raising Concerns and Complaints” (November 2014)
- (5) CQC Report, “Complaints Matter” (December 2014).

3.2 In practice, since the Francis Inquiry Report in 2013 raised public consciousness of the need for transparent systems and the importance of complaints, progress on the ground has been slower than might have been expected. The Healthwatch England Report “Suffering in Silence” (October 2014) highlighted that:

- 26% of people with concerns about their health care did not complain because they were worried about negative repercussions;
- 61% did not complain because they thought they would not be taken seriously;
- 49% of those who did complain never received an apology.

The Report also highlighted the fact that there were 70 different organisations involved in handling complaints just in relation to NHS services and this was extremely confusing for a potential complainant.

3.3 Most recently, in June 2015, the National Audit Office (NAO) released a report called, *‘Public Service Markets: Putting Things Right When They Go Wrong’*. This looks at how the public sector handles and learns from feedback and complaints and, as with the earlier reports, concludes that it frequently does neither very well.

3.4 A significant conclusion in a number of these Reports, and highlighted in the joint Report of the LGO, Healthwatch England and PHSO, “My Expectations for Raising Concerns and Complaints”, is that the way that an organisation deals with complaints reflects its own values of openness and transparency. “Learning” organisations tend to embrace feedback and complaints so that they can learn from them and improve.

4. Approach to Complaints-Handling by the CQC

4.1 The recommendations in the Reports cited above are complementary. The CQC Report (attached as Appendix 1) confirms that it has formally adopted the LGO, HWE and PHSO framework for complaints-handling. Complaints processes will be a significant Key Line of Enquiry in the CQC inspection regime for both health and social care services. CQC inspection reports will now include a description of the provider’s handling of complaints.

4.2 Where the CQC find breaches of complaints-handling standards, they will start to use their range of enforcement powers: warning notices, suspending or cancelling registration and ultimately prosecution. The CQC will actively work with partners to encourage improvement.

4.3 The CQC's study of the state of complaints-handling 'Complaints Matter' (Appendix 1) concludes that although there are limited data about how well providers handle complaints and concerns in the sector, there does appear to be variation in the accessibility of the complaints process, and in the provision of advocacy and support for people who want to complain. As part of its inspection process, the CQC plans to develop more thorough methods of reviewing complaints-handling, so that it can better capture how well health and social care providers encourage, listen to and respond to complaints.

4.4 The CQC standard for assessing complaints reflects the "user-led" vision for complaints-handling developed by the LGO, Healthwatch England and the PHSO, as set out below.

A USER-LED VISION FOR RAISING CONCERNS AND COMPLAINTS



From 'My Expectations for Raising Concerns and Complaints', November 2014, reproduced in 'Complaints Matter', CQC, December 2014

4.5 The CQC see complaints-handling as a good proxy for the open, transparent and learning culture that they would expect to see in well-led organisations. Embedding complaints and concerns in the CQC's regulatory model has two aims:

- to improve how they use the intelligence from concerns and complaints to better understand the quality of care being provided;
- to consider how well providers handle complaints and concerns so as to encourage improvement.

4.6 In pursuing the new complaints Line of Enquiry, the CQC will consider complaints-handling from a *user* point of view, asking:

- whether people who use a service know how to make a complaint or raise concerns, are encouraged to do so, and confident to speak up;
- whether the complaints system is easy to use, people are treated compassionately and given the help and support they need to make a complaint; and,
- whether the outcome of the complaint is explained to the individual, there is openness and transparency about complaints, and concerns are dealt with.

4.7 The CQC Line of Enquiry will also include a requirement on providers to demonstrate a *positive* culture around complaints and feedback, including the expectation that they will show what changes have been made as a result of their complaints and feedback.

5. Duty of Candour and Whistleblowing

5.1 The CQC is explicit that it wants complaints and feedback from health and social care staff to be properly dealt with as well. This is supported by the new "Duty of Candour" and also by Whistleblowing Policies, as complaints by staff can be particularly valuable in highlighting concerns about service failures. The introduction of a statutory Duty of Candour is a major step towards implementing a key recommendation from the Mid-Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry). The Duty of Candour will place a requirement on providers of health and adult social care to be open with patients when things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation registered by the CQC.

5.2 Following a February 2015 review of Whistleblowing policies and procedures in NHS Trusts by Sir Robert Francis, the Government announced that NHS Hospital Trusts would be expected to appoint "Speaking up Guardians" to support staff who raise concerns about safety, quality of services, bullying and other significant

issues within their organisations. It was clear from the evidence collected as part of the “Freedom to Speak Up Review”, which heard evidence from 600 individuals and received 19,000 replies to an on-line survey, that in many cases staff felt that the Whistleblowing policy in their trust was not adequately protecting them.

6. The Local Picture

- 6.1 The Healthwatch Enfield experience relating to complaints processes in local provider organisations suggests that the priority given to this area of work is not yet what the new CQC standard will require, both in respect of complaints-handling and of using that intelligence to improve services. Some of the signposting enquiries received by Healthwatch Enfield are, in essence, complaints. But we find that people have rarely used the formal complaints process, whether because they are unaware of how to access it, or because they are concerned about personal ramifications, or because they lack the belief that it will make any difference.
- 6.2 In the recent audit undertaken by Healthwatch Enfield of the information made available to patients by Enfield GP practices, a positive finding was that all Enfield GP practice websites now include information on “how to make a complaint”. Over time, we also plan to visit all practices to see if they display visible posters or notices about the complaints process. We have not conducted similar information audits of other NHS-funded providers such as dentists or opticians, nor do we have systematic evidence relating to social care providers. However there is some evidence from recent CQC inspections of local care homes that there is a need for greater attention to complaints-handling.
- 6.3 We do have knowledge and experience of complaints processes in the three local NHS Trusts from our and our neighbouring Healthwatch’s involvement in patient experience committees and quality/contract review meetings. We also receive a number of signposting enquiries from service users relating to failures in the complaints processes at the trusts. The dedicated resources necessary for managing the complaints process, from dealing with the initial enquiry to improving the system and embedding the learning, have not always been in place. In practice, response targets have often not been met, which causes further frustration for the complainant.
- 6.4 We hope that the early adoption by providers in Enfield of the new standards for complaints-handling will raise the general level of complaints services locally and help providers to welcome complaints as representing opportunities for improvement.

7. The HWB Role re Complaints-Handling

- 7.1 Increasingly, there are factors that add further complexity for potential complainants in what is already a difficult landscape. In particular, there is the

move towards greater service integration between health and social care, as well as commissioning of services across a larger geographical area. Although integration is generally welcome, this blurring and extension of boundaries, together with the outsourcing of services, can make for user confusion as to who is providing a service and who is responsible for its quality. Participants at Healthwatch Enfield's Conference 'How Complaints and Feedback can improve Services' in April 2014 expressed their concerns about the complexity of knowing who to complain to amid a myriad of complaints processes.

- 7.2 The HWB has a unique role in the local health and social care economy of promoting and overseeing greater service integration. It is essential that feedback and complaints from patients and service users are captured and fully acted on, even as services continue to develop, merge, and change. As part of its strategic overview of ongoing service change initiatives, the HWB will no doubt wish to be kept informed as to how well feedback and complaints are being handled by sector participants providing increasingly integrated services.

8. Next Steps Locally

- 8.1 The decision by the CQC to include complaints as a Key Line of Enquiry and to adopt the user-led vision framework from the LGO, HWE and PHSO Report should encourage providers to implement more effective complaint-handling systems. To encourage prompt adoption of the principles, Healthwatch Enfield would like to see commissioners reflect the standards in their new contract documentation and at contract review meetings with providers. This is reflected in the recommendations to the HWB.
- 8.2 From a Healthwatch perspective, an effective complaints system and a good system for collecting broader feedback, are fundamental to improving patient and service user experience and the quality of care. We agree with the CQC that complaints-handling is a proxy for an open, transparent and learning culture that one would expect to see in well-led organisations. The introduction of the new CQC standard is an opportunity to promote good practice across all health and social care providers in Enfield and we therefore ask the HWB and its member organisations to adopt the new standards so that people in Enfield can benefit from enhanced complaints-handling that meets CQC standards and that contributes to local providers being 'learning' organisations.
- 8.3 Healthwatch Enfield intends to review information it receives about complaints-handling by local providers against the new standards.

Appendix 1

CQC 'Complaints Matter' Report, December 2014



COMPLAINTS

MATTER



© Care Quality Commission 2014

Published December 2014

This publication may be reproduced in whole or in part in any format or medium for non-commercial purposes, provided that it is reproduced accurately and not used in a derogatory manner or in a misleading context. The source should be acknowledged, by showing the publication title and © Care Quality Commission 2014.

CONTENTS

FOREWORD	2
SUMMARY	4
1. INTRODUCTION	8
2. COMPLAINTS AND CONCERNS MATTER TO CQC	11
Complaints in CQC's new approach to regulation	13
Intelligent Monitoring	17
Inspection	17
Requiring and encouraging improvement	20
Concerns raised by staff (whistleblowing)	21
3. STATE OF COMPLAINTS IN HEALTH AND SOCIAL CARE SERVICES	24
NHS acute, mental health and community health services	24
Adult social care and primary care services	33
4. CONCLUSION	39



FOREWORD

Complaints matter – to individuals, to health and social care services and to CQC.

They matter for people using services, who deserve an explanation when things go wrong and want to know that steps have been taken to make it less likely to happen to anyone else.

They matter for health and social care organisations, because every concern or complaint is an opportunity to improve. Complaints may signal a problem – the information can help save lives, and well-handled concerns will help improve the quality of care for other people.

Complaints matter to CQC, because they tell us about the quality of care. They tell us about how responsive a provider is, how safe, effective, caring and well-led they are. We can use our powers as a regulator to shine a light on good and bad handling of complaints and encourage organisations to improve.

CQC has placed feedback from people who use services at the heart of our work, because every concern is an opportunity for services to improve the quality of care. We also want to hear about positive experiences so we can highlight good and outstanding care.

Complaints and feedback from people who use services is a central part of our ‘Intelligent

Monitoring’ of health and social care providers.

We are also making it central to our inspections,

and will include a lead inspector for complaints and

staff concerns in large inspection teams. How well health and social care providers handle complaints will feed into our regulatory judgements about how responsive they are to people’s needs.

CQC’s new approach to inspection, with this strong focus on complaints, has just begun and there is a distance to go before we are able to offer a clear and comprehensive picture of complaints handling across all the sectors we inspect.

We take complaints seriously – and we expect providers to do so too. All our new inspection reports will describe complaints handling. Poor practice will be found and acted on. Good practice will be shared.

This report provides a snapshot in which some things are already fairly clear. There is wide variation in the way complaints are handled and much

more could be done to encourage an open culture where complaints are welcomed and learned from. While most providers have complaints processes in place, people’s experiences of the systems are not consistently good.

And we know, from the thousands of people who contact CQC each year, that many don’t even get as far as making a complaint. Sometimes they don’t want to make a fuss. Some are put off by the confusing system or worried about the impact that complaining might have on their care.

We will hold health and social care services to a high standard of listening and acting on people's concerns. We are committed to apply the same standards to ourselves and we know we need to do more to explain to people what we will do with their information if they tell us about their experience of care.

We will continue to work on making it easier to give us good quality feedback, and work with our partners to improve people's experience beyond CQC.

It's time for all of us – regulators, providers, professionals and commissioners – to make the shift to a listening and learning culture that encourages and embraces complaints and concerns as opportunities to improve the quality of care.



Professor Sir Mike Richards
Chief Inspector of Hospitals



SUMMARY

Complaints matter in health and social care and for too long they have not been taken seriously enough. Too often complaints are met with a defensive culture instead of a willingness to listen and learn.

This report does two things: it describes how complaints and concerns fit into CQC's new regulatory model, and it presents early findings on the state of complaints handling in hospitals, mental health services, community health services, GP practices, out-of-hours services and adult social care services.

Several reports have influenced our work on complaints, including the public inquiry led by Sir Robert Francis QC, and the complaints review by the Rt Hon Ann Clwyd MP and Professor Patricia Hart, which led to this report from CQC.

Complaints and concerns matter to CQC

CQC is not directly responsible for resolving individual complaints for people¹; this is the role of providers and the ombudsmen. However, we do want to hear from people who experience or know about poor care because we use this information when we are inspecting services.

About 50 concerns about services are raised with CQC every day through our National Customer Service Centre. This number is increasing as public awareness of CQC grows.

We use feedback from people who share their experience with us in many ways. It feeds into our Intelligent Monitoring of the quality of services and it helps us decide when to inspect a service. We may decide to bring forward a comprehensive inspection or carry out a focused inspection based on concerns shared with us.

Complaints and concerns in our new approach to regulation

Embedding complaints and concerns in CQC's regulatory model has two aims:

- z To improve how we use the intelligence from concerns and complaints to better understand the quality of care.
- z To consider how well providers handle complaints and concerns to encourage improvement.

Complaints handling is an excellent proxy for an open, transparent and learning culture that we would expect to see in well-led organisations.

1. The only exception is complaints relating to use of the Mental Health Act 1983

The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England have set out universal expectations of good complaints handling. We now have a clear vision of ‘what good looks like’ for people who use services – and providers need to meet these expectations.

In October 2014 we introduced a mandatory key line of enquiry for inspections of hospitals, mental health services, community healthcare services, GP practices, out-of-hours services and adult social care services. This looks at how well complaints and concerns are handled. This assessment forms part of our judgement and rating of an organisation’s responsiveness. For consistency in all inspections, this will apply to dentists, independent hospitals and ambulance services from April 2015.

New and robust methods help inspection teams to understand how well providers listen to people’s concerns and learn from them to improve quality.

Before a CQC inspection, we gather information relating to complaints and concerns, including details from partners such as the health and social care ombudsmen, local authorities, Healthwatch England and complaints advocacy services.

We request a range of information from providers before we inspect, such as a summary of complaints from the last 12 months and how these were resolved.

We ask what people who use services think about the way complaints and concerns are handled, using surveys, comment cards, and conversations during inspections, often led by CQC’s Experts by Experience.

During site visits, our inspectors review a sample of complaints files to understand if these have been handled in a way that matches the good practice we expect to see.

On large inspections (in hospitals, mental health services and community healthcare services), we are introducing a lead inspector for complaints and staff concerns to draw evidence together.

Our inspection reports now include a description of the provider’s handling of complaints. And the new fundamental standards include requirements around complaints handling as well as the new duty of candour. Where we find breaches of these standards, we will use our range of enforcement powers: warning notices, suspending or cancelling

registration and ultimately prosecution. We will work with partners to encourage improvement.

Concerns raised by staff (whistleblowing)

A service that is well-led and wants to improve will encourage staff to raise concerns without fear of reprisal.

We want the staff of care providers to tell CQC if they know about poor care. While we have no legal power to protect individual members of staff from actions their employers might take, CQC expects all organisations to have effective arrangements to encourage staff to raise concerns and ensure these are taken seriously. Concerns may sometimes be

termed ‘whistleblowing’, although staff have told us they do not like the word.

We expect complaints and concerns to be used to improve the quality of care, and that employees who raise concern are valued, respected and protected. Reprisals such as victimisation or bullying are unacceptable.

In every inspection and as part of assessing an organisation’s leadership, CQC will look at processes in place to handle staff concerns. This report gives an update on CQC’s work in this area – we plan to publish a fuller account when Sir Robert Francis QC publishes the outcomes of the Freedom to Speak Up review, to which CQC has contributed.

Health and social care services

We have analysed a range of data sources, including existing national data collections, concerns and feedback that we receive directly, our own published inspection reports and information collected directly from providers.

This report presents a partial picture of the state of complaints. It is not comprehensive and in general, caution should be applied in the interpretation of complaints data.

A care provider that actively encourages, seeks feedback and publicises its complaints process is likely to receive more complaints than another with a more defensive approach. However, in general you would expect an organisation providing poorer quality services to also receive higher volumes of complaints.

NHS acute, mental health and community health services

There is far too much poor practice in NHS providers' responsiveness and treatment of people who make complaints. This is backed up by findings in patient surveys.

The total number of written complaints received by all NHS hospital and community health services has increased every year since 2011/12, although this overall increase masks decreases in numbers of complaints in some areas. When considered against estimates of increased activity, the rate of complaints per 1,000 patients has changed little over the last three years.

We found variable practice in complaints handling throughout the different stages of complaints management. However, there was more evidence of good practice than poor. Most poor practice reported by inspectors related to providers' responsiveness and treatment of people who complain. Most positive practice was found where providers learned lessons from complaints and demonstrated actions taken due to complaints.

People do not consistently receive information about how to complain and they find complaining stressful. We are concerned about the timeliness of investigations of complaints, and people feeling that their concerns are not taken seriously or adequately addressed.

Adult social care and primary care services

There is less evidence available for us to analyse and judge how well complaints and concerns are handled.

Many providers report that they receive very few complaints (five or less over a 12-month period). There is much positive practice at all stages in the process of making a complaint. However, in response to a survey about complaints handling, many inspectors felt they did not have enough evidence, often because the locations inspected reported receiving very few complaints.

The large majority of people using adult social care services said they knew how to raise concerns, and they were very positive about the actions of care agencies in response to complaints made. People's feedback about adult social care and primary care services highlighted issues with the timeliness of investigations of complaints and responses. People felt that their concerns were not taken seriously or adequately addressed.

Based on negative feedback from websites, combined with our survey that showed inspectors often had insufficient evidence around complaints handling, we believe that our picture does not fully represent how well providers encourage, listen to and respond to complaints and concerns in adult social care and primary care.

We consider that much more could be done to encourage an open culture where concerns are welcomed, particularly as high numbers of providers in these sectors report that they receive very few or no complaints at all.

Conclusion

Improving the data available in these sectors will be crucial to presenting a truer picture of the state of complaints.

CQC's new and more thorough methods of reviewing complaints handling will allow inspectors to get a more comprehensive picture of the state of complaints. We will continue to review inspection findings and refine our methods if necessary.

We understand that the next stage of reform to the Health and Social Care Information Centre data

collection will focus on improving response rates and quality of primary care returns, and will consider the extension of the collection to adult social care. We hope these changes are implemented as a priority.

This report paints a partial picture of the state of complaints in health and social care services, but some things are clear: there is wide variation in the way complaints are handled and much more

could be done to encourage an open culture where concerns are welcomed and learned from.

Most providers have complaints processes in place, but people's experience is not consistently good.

CQC will continue to work closely with partners so that everyone – regulators, providers, professionals and commissioners – makes the shift to a listening culture that encourages and embraces complaints and concerns as opportunities to improve the quality of care.



1. INTRODUCTION

Complaints matter in health and social care. For too long they have not been taken seriously enough.

It is still common for people who have suffered poor care to have their negative experience compounded when they make a complaint. Too often, complaints are met with a defensive culture, instead of a willingness to listen and learn.

Feedback from people who use services – compliments, concerns or complaints – should be valued. Every concern must be seen as an opportunity to improve the quality of care.

At CQC, we take complaints and concerns seriously – and we expect the same of providers. Putting the views of people at the centre of everything we do is our top priority.

This report sets out the work we are doing to place concerns, complaints and feedback at the heart of quality regulation. We are on a journey and have some way to go. The report also draws together for the first time early findings from our new inspections, to give us an indication of the state of complaints handling in health and adult social care services.

Several reports have influenced our work in this area. In their review of the NHS complaints system in October 2013, the Rt Hon Ann Clwyd MP and Professor Tricia Hart called for complaints to be taken seriously.² They received 2,500 responses

to their review, some from people who had not complained because they felt the process was too confusing or they feared for their future care. CQC took part in this review and made the following pledges:

- z To develop the way we use complaints information, as well as other views and feedback from people who use services in our surveillance model, to ensure they are embedded consistently and given significant weighting.
- z To analyse the number and themes of complaints and feedback we receive directly.
- z To work closely with and share information with our regulatory partners about complaints.
- z To strengthen how we consider complaints as we develop our approach to assessing the quality and safety of hospitals and other services.

The Secretary of State for Health commissioned the Clwyd/Hart review in response to the second Francis Inquiry report, published in January 2013. Sir Robert Francis QC called for regulators to make better use of the information contained in complaints.

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

FRANCIS RECOMMENDATIONS FOR CQC RELATING TO COMPLAINTS

- z **Recommendation 38:** CQC should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local relationship managers. Any bureaucratic or legal obstacles to this should be removed.
- z **Recommendation 39:** CQC should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.
- z **Recommendation 40:** It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.
- z **Recommendation 121:** CQC should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.

CQC has also taken part in inquiries led by the Health Select Committee and the Public

Administration Committee looking at aspects of complaints handling in health and social care.

Recent reports from the Local Government Ombudsman, the Parliamentary and Health Service Ombudsman and Healthwatch England clearly demonstrate that, although actions have been taken to improve the complaints system, there is a long way to go before people who use services, and those close to them, feel an improvement.

CQC's approach to complaints in our regulatory model has been developed over time and through consultation. We have worked with people who have made complaints, staff who have raised concerns, and providers that we regulate. The work has benefited from the support and advice of our National Safety Advisor, James Titcombe, and also

Dr Kim Holt, who worked with CQC on secondment for six months.

FOCUS GROUP WITH PEOPLE WHO HAVE MADE COMPLAINTS

In September 2014, CQC held a joint workshop with the Patients Association and nine members of the public who had experience of serious healthcare failures and of navigating the complaints system. This was to listen to their experiences, and gather feedback on CQC work to improve its assessments of how well providers encourage, respond and learn from complaints.

Many of the people who attended the event had lost loved ones as a result of poor care. One person described the response to their complaint:

“...an absolute nightmare. They deny everything... and take months to reply to anything. You ask them specific questions and you end up with very general policy statements.”

This experience was typical of other people who spoke to us. These are examples of organisations failing to undertake high-quality investigations following serious healthcare failings, and patients and families finding that the complaints process failed to adequately respond to their concerns.

We have tested our new approach during inspections, including in-depth pilots with the Patients Association on 11 acute hospital

inspections. National partners have been involved in the development of this work through the Department of Health Complaints Programme Board. This has included several opportunities to share our work with voluntary sector partners.

CQC has been working to improve how it incorporates concerns raised by care staff in its regulation. Mostly, we treat concerns in the same way, regardless of whether they are raised by people who use services, those close to them, or staff.

However, CQC is a prescribed body under the Public Interest Disclosure Act. This means that employees of health and social care organisations can make disclosures to us where they have concerns about their employing organisation. This report gives an update on CQC's work in this area – we plan a fuller account when Sir Robert Francis QC publishes the outcomes of the Freedom to Speak Up review, to which CQC has contributed.

In their review of NHS complaints, the Rt Hon Ann Clwyd MP and Professor Patricia Hart asked CQC to report on complaints handling in acute trusts that we inspected in the year following their report.

This report does two things: it describes how complaints and concerns fit into CQC's new regulatory model, and it presents early findings on the state of complaints handling in hospitals, mental health services, community health services, GP practices, out-of-hours services and adult social care services.

Where the report presents information on the state of complaints, we considered existing national data collections, such as the Health and Social Care Information Centre's (HSCIC) annual publication of written NHS complaints. We also reviewed concerns that came directly to our National Customer

Service Centre, feedback submitted through our online 'Share Your Experience' form, our published inspection reports, and information collected directly from providers to inform our new inspection model. For adult social care, and GP and out-of-hours services, we also asked our inspectors about how these providers handled complaints in the inspections they carried out, between August and October 2014.

This creates a partial picture; only now are we fully implementing our new approach to regulation. Some of our analysis is based on samples of available data and may not be representative of the sector as a whole.

This report presents an impression of the state of complaints. It is not comprehensive and, in general, caution should be applied in the interpretation of complaints data. We would expect an organisation providing poorer quality services to also receive higher volumes of complaints. But organisations that openly welcome feedback may have higher rates of complaints too.

In CQC's monitoring and inspection activity, we treat numbers and rates of complaints – high or low – as indicators to prompt potential further investigation.

We know that people want services to be open and to encourage people to speak up. We must not assume that rising numbers of complaints mean worsening care. If we do, we risk making it less likely for services to value concerns and to use them to help improve the quality of care.



2. COMPLAINTS AND CONCERNS MATTER TO CQC

People who are unhappy with the care or treatment they have received from any NHS or social care service should contact the service directly to make a complaint. This gives providers the chance to try to put things right.

If people are not happy with the outcome of the complaint or how it was dealt with, they can ask the Health Service Ombudsman or the Local Government Ombudsman (for adult social care, both publicly and privately arranged and funded) to investigate it. The ombudsmen are free, independent complaints services. If they decide that the service has got things wrong, they can make recommendations to put things right.

CQC is not directly responsible for resolving individual complaints for people³; this is the role of providers and the ombudsmen. However, we do want to hear from people who experience or know about poor care because we use this information when we are inspecting services.

Concerns raised by people using services, their families and friends, and staff working in services all provide vital information that helps us to understand the quality of care. We also want to hear about positive experiences so we can highlight and share examples of good and outstanding care.

Feedback from people who share their experience is used in many ways:

- z To feed into our ongoing Intelligent Monitoring of the quality of services.
- z To help us decide when to inspect a service – we may decide to bring forward a comprehensive inspection, or carry out a focused inspection based on concerns shared with us.
- z To help shape our lines of enquiry before an inspection, to ensure we direct our resources to areas of greatest concern.
- z To raise concerns with providers and seek a response. We may ask for verbal assurance that a matter has been dealt with, ask for evidence or request an investigation by the provider's manager and a report back to CQC.

Many people contact CQC feeling that they have nowhere else to go. They have tried to raise their concerns with providers, commissioners and ombudsmen. Some are frustrated that CQC can only look at issues that have a bearing on the current quality and safety of care provided. We were concerned that there appeared to be a gap for people who have a historic complaint. We welcome the Parliamentary and Health Service Ombudsman's statement that for serious health cases which are outside of the normal 12 month period specified in law, the Ombudsman will positively consider

3. The only exception is complaints relating to use of the Mental Health Act 1983.

whether an effective investigation is possible given the passage of time.

Just as there are people who feel they have exhausted every option, we know there are many people who never reach the stage of making

a written complaint. They are put off by a confusing system or worried about the impact that complaining might have on how they are treated. Healthwatch England recently estimated that 250,000 incidents went unreported last year. These are said to be people who felt unable to complain.⁴

We support Healthwatch England's call for there to be 'no wrong door' for complaints and concerns and are working to make it a reality. For example, we have an agreement with the Local Government

Ombudsman to make direct phone transfers so that no matter who receives the initial call, people are put through to the organisation best placed to address the issue they are raising. Similarly, complainants should not have to think hard about which ombudsman to turn to where they have a complaint about health or social care services. We welcome the recommendations by the Public Administration Select Committee for a unified ombudsman service.

CQC receives a huge number of contacts from people telling us about poor care and this number is increasing across health and social care sectors. In 2013/14, there was a total of 18,455 concerns about regulated services received by our National Customer Service Centre – about 50 a day.

We cannot be sure what has caused this increase but we know the public's awareness of CQC is increasing. In May 2014, 55% of people had heard of CQC compared to 22% in 2012. The concerns that people share with CQC are valued and we are working hard to encourage more people to share their experience with us by making it as easy as possible for people to give us feedback.

Improving the experience of individuals giving feedback to CQC and using the information effectively in our regulatory activities will create a

virtuous circle. A survey by YouGov for Healthwatch England suggested that 82% of people would be more likely to raise a concern about poor care if they knew the information would be used to inform CQC's inspection processes.⁵



CQC is working to better understand how we can gain the maximum value from the feedback people give us. This includes developing our qualitative analysis techniques, and ensuring that we collect feedback in the most efficient and effective way.

We want to make listening and responding with compassion and clarity a core competence of CQC staff. We are developing training so that all our employees are clear about their role in handling feedback and concerns about the providers we regulate. We are also reviewing our own corporate complaints procedure (for complaints about CQC, rather than concerns about the providers we regulate).⁶

CQC has reviewed its own whistleblowing policy and in January 2014 appointed a non-executive director (Michael Mire) with responsibility in this area. This in line with a recommendation in the Clwyd/Hart report.

4. www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf

5. www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf

6. www.cqc.org.uk/content/complain-about-cqc

'TELL US ABOUT YOUR CARE' / PARTNERSHIPS WITH THE COMMUNITY AND VOLUNTARY SECTOR

To increase our access to people's experiences of care (both good and bad) CQC has established partnerships with a number of national health and social care charities. We currently work with the Patients Association, the Relatives & Residents Association, Carers UK, Mind, Action against Medical Accidents and (from November 2014) The Silver Line. Through the partnerships, we can demonstrate the range of action that we take in response to this information.

We receive an average of 280 items of feedback each month across all the partners. Of these, 42 (15%) are positive comments and 238 (85%) are concerns about care.

Of the 238 concerns, on average 24 (10%) are serious enough to prompt us to make a safeguarding referral to the local council because someone may be at risk of, or experiencing, abuse. Fourteen concerns (6%) prompt us to carry out a responsive inspection or bring forward the date of a planned inspection.

On average, 57 concerns (24%) prompt us to raise the issues with the service provider and seek a response from them. This ranges from a discussion with the provider and verbal assurances, or a request for evidence (such as staff rotas), to a request for an investigation to be carried out by the registered manager and a report submitted to CQC. It also includes requesting a copy of the provider's response to the complaint, where an individual has indicated they are intending to make a complaint to the service.

For around 103 concerns (43%) the relevant inspector advises that no immediate action is required, but the information will be used to inform the next scheduled inspection. Sixteen concerns (7%) require no action because the areas raised had been covered at a recent CQC inspection. And 22 concerns (9%) do not provide enough information or do not prompt any action because the concern is about an experience that took place too long ago and/or there have been changes to the service in the meantime.

Complaints in CQC's new approach to regulation

CQC has a clear purpose: to make sure health and social care services provide people with safe, effective, compassionate and high-quality care, and to encourage services to improve. We put people who use services at the heart of our work.

To fully understand people's experiences of care, the focus of our inspections is on the quality and safety of services, based on the things that matter to people. We always ask five questions of services:

- z Are they safe?
- z Are they effective?
- z Are they caring?
- z Are they responsive to people's needs?
- z Are they well-led?

A service that is safe, responsive and well-led will treat every concern as an opportunity to improve. It will encourage its staff to raise concerns without fear of reprisal. It will respond to complaints openly and honestly.

Embedding complaints and concerns in CQC's regulatory model has two aims: to improve how we use the intelligence from concerns and complaints to better understand the quality of care; and to look at how well providers handle complaints and concerns to encourage improvement (**FIGURE 1**).

FIGURE 1: EMBEDDING COMPLAINTS AND CONCERNS IN CQC'S REGULATORY MODEL



The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England, have set out universal expectations of good complaints handling

(FIGURE 2). We now have a clear vision of ‘what good looks like’ from the point of view of people who use services.

FIGURE 2: A USER-LED VISION FOR RAISING CONCERNS AND COMPLAINTS



We have built on these expectations, with input from a wide range of people with expert and personal knowledge of raising concerns in health and social care. Feedback from people who use services – and from care staff – is now at the heart of our new approach to regulation.

In October 2014 we introduced a mandatory key line of enquiry for inspections of hospitals, mental health services, community healthcare services, GP practices, out-of-hours practices and adult social care services that looks at how well complaints and concerns are handled. We will do the same in sectors where we are still developing our new approach, such as the ambulance sector. The key line of enquiry asks how people's concerns and complaints are listened to, acted on and used to improve the quality of care. Each key line of enquiry is accompanied by a number of prompts that inspection teams will consider as part of the assessment. We call these prompts.

- z Do people who use the service know how to make a complaint or raise concerns, are they encouraged to do so, and are they confident to speak up?
- z How easy is the system to use? Are people treated compassionately and given the help and support they need to make a complaint?
- z Is the outcome explained appropriately to the individual? Is there openness and transparency about how complaints and concerns are dealt with?

Inspection teams use evidence from ongoing local relationships, local and national data, pre-inspection information gathering and on-site inspection to answer the key lines of enquiry.

Following comprehensive inspections, we award ratings on a four-point scale:

- z Outstanding
- z Good
- z Requires improvement
- z Inadequate.

How well providers handle complaints feeds into our overall rating of how responsive they are. The characteristics of each rating include:

- z Outstanding – there is active review of complaints and how they are managed and responded to, and improvements are made as a result across the services.
- z Good – it is easy for people to complain or raise a concern and they are treated compassionately when they do so.
- z Requires improvement – people do not find it easy to complain or raise concerns, or are worried about raising concerns or complaining. When they do, a slow or unsatisfactory response is received.
- z Inadequate – there is a defensive attitude to complaints and a lack of transparency in how they are handled. People's concerns and complaints do not lead to improvements in the quality of care.

Full details of key lines of enquiries, prompts and ratings characteristics can be found in CQC's guidance for providers.⁷

7. www.cqc.org.uk/content/guidance-providers

EXTRACTS FROM INSPECTION REPORTS SHOWING EXAMPLES OF GOOD PRACTICE

THE HANDBRIDGE MEDICAL CENTRE, CHESTER (GP PRACTICE)

The Patient Participation Group worked with the practice to improve services and feedback was welcomed. We found evidence that feedback from patients, public and staff was acted on and improvements made. They told us the practice was very eager to engage with its patients and listened to them.

GREEN ACRES NURSING HOME, LEEDS (CARE HOME)

We saw the record of complaints kept in the home and reviewed how one complaint was dealt with. This showed that when a complaint was made it was taken seriously and investigated fully. We also looked at the record of significant events and saw there was learning from these. We could see that learning from any complaints, incidents and investigations was fed back to staff at meetings and during individual staff supervision, if appropriate. People were clear who they would talk to if they had a concern or complaint. They said they were happy to tell any of the staff.

FRIMLEY PARK HOSPITAL, SURREY (ACUTE TRUST)

Feedback from a 'Friends and Family' test was visible on all wards visited. Along with complimentary feedback and high levels of recommendation, we saw examples of feedback on areas for improvement. This included a comment on noise levels at night and the action taken to resolve this, which included raising staff awareness, settling people earlier, and turning lights off. On a ward we saw that feedback included a request for televisions and improved arrangements for take-home tablets. Action in response to this included the installation of televisions and doctors were to write up take-home medication in a timely manner. The unit displayed the number of plaudits and complaints it received every month for relatives and patients to see. It reported four plaudits and no complaints for July 2014.

MILTON KEYNES URGENT CARE SERVICES (CIC) (OUT-OF-HOURS SERVICE)

We sampled the complaints log from the service and found that where complaints were upheld, the service invited the complainant (after they had received the final outcome letter) to visit the service, meet with staff and managers, discuss the outcome and share ideas from their experience.

BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Staff told us they knew how to support people who used the service, or their carer or relatives, if they wanted to make a complaint. People said that they felt listened to, and that they were able to provide feedback to the service. They knew how to make a complaint and were listened to by the trust when they did this.

All reported incidents were screened by the clinical lead and incidents, complaints and feedback were discussed in the minuted directorate business meetings (held monthly).

We found examples where learning from complaints had been used to change front line practices and training for some staff. For example, within the community services for older people, the trust had a care home liaison service to minimise inappropriate care home placements, particularly for those with rare or complex forms of dementia.

SOLENT NHS TRUST (COMMUNITY HEALTH TRUST)

We found that services actively sought feedback from patients and they told us of improvements they had made. For example, access hours to some children and family clinics had been changed to reflect feedback from parents.

The majority of staff that we spoke with said that the trust listened to their feedback and responded to it. The trust was committed to increasing patient feedback from a range of sources and was piloting innovative methods of real-time feedback on computer tablets, to increase participation.

Intelligent Monitoring

‘Intelligent Monitoring’ is how we describe the processes CQC uses to gather and analyse information about services. This information helps us to decide when, where and what to inspect.

By gathering and using the right information, we can make better use of our resources by targeting activity where it is most needed.

Feedback from people who use services is central to this model. In acute NHS trusts, Intelligent Monitoring uses various indicators:

- z CQC National Customer Service Centre qualified whistleblowing alerts⁸
- z CQC’s National Customer Service Centre safeguarding concerns
- z CQC ‘Share your experience’ negative comments
- z NHS Choices negative comments
- z Patient Opinion negative comments
- z Complaints received by CQC
- z Provider complaints (sent to CQC by the HSCIC).

Our approach to Intelligent Monitoring will vary according to the quality and availability of information. For example, there tends to be more information available for NHS trusts than for other providers.

Inspection

Our inspections are at the heart of our regulatory model and are focused on the things that matter to people. There are two types of inspection:

- z A focused inspection is used to follow up specific concerns from earlier inspections, or respond to new information that has come to our attention, including concerns raised with us by people using services or staff concerns.

8. ‘Qualified’ means a disclosure that meets the criteria set out in the Public Interest Disclosure Act (that is, there is harm or risk of harm to people; possible or actual criminal activities; failure to comply with a legal obligation; miscarriages of justice; damage to the environment; or a deliberate attempt to cover up any of the above).

- z A comprehensive inspection reviews the service in relation to the five key questions and leads to a rating on each on a four-point scale. This section relates to comprehensive inspections, unless otherwise stated.

Before the site visit

In addition to our Intelligent Monitoring analysis, we gather a great deal of information relating to complaints and concerns before an inspection.

Our local inspection teams make contact with a wide range of partners to help plan inspections. These vary depending on the sector and more detail can be found on the ‘guidance for providers’ section of our website. Some of the partners we contact to find out more about concerns and complaints and how services handle these include:

- z Professional regulators (for example, General Medical Council, Nursing and Midwifery Council)
- z Parliamentary and Health Service Ombudsman
- z Local Government Ombudsman
- z Royal colleges
- z UNISON
- z Local authority⁹
- z Local Healthwatch
- z NHS Complaints Advocacy
- z Clinical commissioning group
- z Monitor regional team
- z NHS Trust Development Authority regional office
- z NHS England regional director
- z Local voluntary and community groups.

Since September 2013, CQC has written on a quarterly basis to all NHS complaints advocacy services to inform them of our announced inspections and ask for their contributions. Our inspection teams have said that the input they receive is valuable.

9. Adult social care contracts monitoring teams, regarding complaints specifically.

As well as reviewing the information from people who use services, our inspectors use additional methods to gather views ahead of an inspection, such as speaking with community, patient and carer groups.

We request a range of information from providers before we inspect. We ask providers to send us their complaints policies in advance of an inspection, along with a summary of complaints from the last 12 months and how these were resolved.

We are rolling out a 'self-report' for hospitals, mental health services and community healthcare services to tell us how they handle complaints before we inspect. This helps us to know what to focus on during the inspection.

Although our inspections include many opportunities for people who use services to share their views, we want to understand more about the experience of making a complaint. From now on, we will ask providers to share with us any survey they have carried out of people who have complained to them in the last 12 months.

In adult social care, we survey people who use home care services and Shared Lives schemes and those close to them before an inspection. We ask if they know how to complain or raise a concern, and how the organisation and staff handled any concerns they did raise.

WHAT WE ASK IN THE TRUST SELF-REPORT ON COMPLAINT HANDLING

Leadership: Who is responsible for complaints at the trust? Please include the executive and non-executive lead, as well as the individual with day-to-day responsibility and the total number of staff dedicated to complaints.

Governance: Please describe the trust's governance arrangements for complaints: how often are they discussed at board level? What committees review the handling of complaints and compliments, and any themes within them?

Awareness: Describe how patients and relatives are made aware of how they can raise concerns or make formal complaints. Please describe what processes are in place to resolve complaints before they become formal.

Investigation: Describe how complaints are investigated: who leads on investigating complaints and how is this decided? How is the investigation documented? Who checks the responses and is responsible for sign-off?

Timeliness: What are your local standards for providing a response to complaints (timeliness) and how well are you achieving this? Are there any areas that struggle to achieve the standards?

Learning: How do you disseminate learning from complaints? Can you point to any changes made as a result of learning from complaints?

Evaluation: How do you ascertain whether complainants are satisfied with the complaints process and the outcome?

Site visit

Our new approach to inspections provides many opportunities for inspection teams to gather evidence of how well providers handle complaints. For example:

- z Speaking individually and in groups with people who use services.
- z Using comment cards placed in reception areas and other busy areas to gather feedback.
- z Using posters to advertise the inspection to allow people an opportunity to speak to the inspection team.
- z Speaking with a range of staff during the inspection and with focus groups held with staff in hospitals.
- z Interviewing the member of staff with responsibility for complaints.
- z Observing interactions, for example at reception desks, and looking for information about how to complain and give feedback.

We often include ‘Experts by Experience’ on our inspections. Experts by Experience are people who use care services or care for someone who uses health and/or social care services. Their main role is to talk to people who use services and tell us what they say.

Many people find it easier to talk to an Expert by Experience rather than an inspector. Experts by Experience can also talk to carers and staff, and can observe the care being delivered.

During site visits, our inspectors review a sample of complaints files to understand whether these

have been handled in a way that matches the good practice we expect to see.

Inspectors will usually look at up to five complaint files, which should be selected by inspectors, not by the provider. They usually include at least one serious complaint and, if possible, one relating to a person who may find it more difficult to have their voice heard. Most will be closed, which helps the inspector to review the full process from beginning to end, but inspectors may select an ongoing case.

PILOTWORK WITH THE PATIENTS ASSOCIATION

The Patients Association has carried out significant work on standards in relation to complaints in recent years. Its methodology for reviewing the effectiveness of complaints procedures and the experience of complainants provided a useful framework for CQC to learn from and build on its own approach.

CQC worked with the Patients Association in 11 acute hospital trust inspections that took place in late 2013 and early 2014. The inspections trialled methods of pre-inspection analysis and on-site activity to review the effectiveness of providers’ complaints processes, and to understand the experience of complainants and the ability of providers to learn and improve as a result of complaints.

KEY FINDINGS:

- z A pre-inspection survey of people who had complained to the provider was useful in shaping lines of enquiry for the inspection.
- z Having a lead for complaints on the inspection team ensured the information was captured to show evidence for the complaints key line of enquiry.
- z Reviewing complaints files was a robust method for understanding the effectiveness of the complaints process.

This method is particularly useful for understanding the tone and content of response letters that are sent to people who have complained. CQC expects responses to be empathetic and to provide a full explanation and apology where appropriate. The NHS Litigation Authority is clear that “saying sorry is not an admission of legal liability; it is the right thing to do”.¹⁰

10. www.nhs.uk/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

Reviewing complaints files is resource-intensive for inspection teams. Based on testing with the Patients Association, we believe that reviewing around five cases is achievable within current resource levels and provides useful insight into complaints handling.

Along with all the methods described here, CQC will keep this under review and make changes if needed.

On large inspections (in hospitals, mental health services and community healthcare services) we are introducing a lead inspector for complaints and staff concerns who will draw this evidence together. All members of the inspection team are responsible for listening and responding to people using services or staff raising concerns, but having a lead gives responsibility for pulling information together to a single individual.

Over the coming months we are rolling out guidance and training to support inspection teams in using these methods effectively to understand complaints handling. The aim is that every inspection will consistently and effectively use the full range of methods from January 2015.

Requiring and encouraging improvement

Our ambition is to see an improvement in the quality of complaints and concerns handling in all services. We believe that this is an important part of ensuring that people receive safe, high quality care.

Our inspection reports will now always include a description of the provider's handling of complaints. For large inspections where the reports tend to be very long, we will ensure that complaints handling features in the summary of how responsive the provider is. We will recognise good practice and set out clearly where complaints handling falls short.

Although we are not an improvement agency we will act to encourage improvement. We will work closely with stakeholders and partners to

drive improvement. For example, local complaints advocacy groups have told us that they are able to inspect reports. In some sectors, we include key lever change by challenging providers who have had issues about complaints handling flagged in their

local partners in the 'quality summits' we hold after inspections to ensure that they are aware of the improvements we require.

POOR PRACTICE AND CQC INTERVENTION

The Parliamentary and Health Service Ombudsman asks NHS providers to send a copy of their responses to complainants to CQC.

We recently received a copy of a letter that was distinctly lacking in empathy. Our inspector contacted the trust's chief executive about the tone of the letter, which we felt missed the opportunity to make a heartfelt apology and to emphasise the positive learning and changes that had been made. CQC will provide feedback like this when it is warranted.

CQC can take enforcement action against registered providers who breach regulations. One of the new fundamental standards, Regulation 16¹¹ (which will come into effect in April 2015, subject to parliamentary process) relates to complaints. It is intended to ensure that anyone can make a

complaint about any aspect of care and treatment planned and/or provided, and to ensure that providers investigate complaints and take appropriate and timely action to rectify any failures identified by the complaint or investigation.

If a provider applying to be registered with CQC cannot demonstrate that it will meet the

requirements of this regulation from its first day of operation, CQC may refuse its application for registration.

In our new comprehensive inspections, we primarily look for good care, rather than checking compliance with regulations. We have ensured that all the

areas covered by the regulations are also covered in our key lines of enquiry. Where care requires improvement or is inadequate, we will also consider whether a regulation has been breached.

www.cqc.org.uk/content/publishing-new-

In focused inspections, where we are following up specific concerns from earlier inspections or responding to new information that has come to our attention, we assess whether the provider has improved so that they are no longer in breach of

regulations, or whether the new concern amounts to a breach of regulations.

Where there is a breach of regulations, CQC has a range of enforcement powers, including

issuing warning notices, suspending or cancelling registration, and prosecution. Monitor or the NHS Trust Development Authority may also decide to take action as a result of CQC's findings, if they relate to NHS foundation trusts or NHS trusts.

The fundamental standards also introduce a new duty of candour. This came into force this autumn in NHS bodies and will apply to other sectors from April 2015. It aims to ensure that providers are open and honest with people who use services if things

go wrong with their care and treatment. To meet the requirements of the regulation, a provider has to:

- z Make sure it has an open and honest culture across and at all levels within its organisation.
- z Tell people in a timely manner when particular incidents have occurred.
- z Provide in writing, a truthful account of the incident and an explanation about the enquiries and investigations that it will carry out.
- z Offer an apology in writing.
- z Provide reasonable support after the incident.

This organisational duty of candour sits alongside the existing duty of candour for professionals. It means that every care professional must be open and honest with patients if something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

The new duty of candour will, for the first time, place a legal duty on all provider organisations to be open and honest with patients and families following serious cases of avoidable harm or death. Where processes for identifying and properly investigating serious incidents in health and social care are poorly implemented, people may turn

to the complaints system to seek answers and assurances that lessons have been learned. There should be no need for people who use services, or their families or friends affected by serious failures, to raise a written complaint.

We welcome the Parliamentary and Health Service Ombudsman's recent decision to review the quality of investigations in 250 cases involving serious healthcare failings. CQC wants to make sure that the quality of incident investigations – and the learning – is audited as part of its inspection process. This will feed into our overall rating of the organisation.

If a provider fails to do any of the things listed above and breaches the duty of candour, CQC can use its range of enforcement powers or move directly to prosecution without serving a warning notice.

Concerns raised by staff (whistleblowing)

Every concern is an opportunity for services to improve and for CQC to understand more about the quality of care. A service that is well-led and wants to improve will encourage staff to raise concerns without fear of reprisal.

Whereas complaints tend to follow an experience of poor care, concerns raised by staff are often an attempt to prevent something going wrong. Staff draw on their knowledge and experience of service delivery, and the issues they raise provide vital information about potential risks of poor quality or harm. Concerns may sometimes be termed 'whistleblowing', although staff have told us they do not like the word.

CQC is a prescribed body under the Public Interest Disclosure Act 1998. This means that employees of health and social care organisations can make disclosures to us where they have concerns about

their employing organisation. CQC wants staff to tell us if they know about poor care. Many already do. Between 1 April 2014 and 31 October 2014, some 5,638 staff contacted CQC. These contacts are logged by a team at CQC's National Customer Service Centre

and they are tracked to ensure the relevant inspector responds to them in a timely manner.

CQC uses this information to inform its regulatory activities. We know we need to do more to explain what action we take when people bring us

information, and to provide clarity over what we can and cannot do.

For example, people often think CQC can protect them from any detrimental impact if they disclose information, but we have no legal power to protect individuals from actions their employers might take. However, CQC expects all organisations to have effective arrangements to encourage staff

to raise concerns, to ensure that these are taken seriously, that they are used to improve the quality of care, and that employees who raise concerns are valued, respected and protected from any

detriment. Victimisation or bullying is unacceptable. We will look at the process in place to handle staff concerns in every inspection as part of assessing the leadership of an organisation.

Information shared with CQC will be dealt with in confidence and we will not disclose people's identity without consent. Staff can also raise concerns anonymously. However, it can be difficult to investigate issues of quality and safety and preserve anonymity.

People with historic cases also contact CQC in the hope that we can help resolve their concerns or hold a provider to account for its actions. While each case provides learning for us about the problems that can occur, and how we need to mould our new methods of inspection to detect similar problems and take effective action, we do not have the remit to resolve an individual case. As with complaints, we believe there is a regulatory gap in this area and we welcome the Freedom to Speak Up review, including its focus on historic cases.

Through our new approach we will assess the leadership and culture of the organisation in more depth than previously attempted. Staff confidence about raising concerns is an indicator of openness in

an organisation and how it might want to learn and improve.

Some key lines of enquiry and prompts that we ask as part of assessing leadership in a service include:¹²

- z How does the leadership and culture reflect the vision and values, and encourage openness and transparency and promote good quality care?
- z Does the culture encourage candour, openness and honesty?
- z How are staff supported to question practice and how are people who raise concerns, including whistleblowers, protected?
- z Is the value of staff raising concerns recognised by both leaders and staff? Is appropriate action taken as a result of concerns raised?

The following are ratings characteristics at each level, describing leadership in an organisation:

- z **Outstanding:** Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to raise concerns.
- z **Good:** Staff have the confidence to question practice and report concerns about the care offered by colleagues, carers and other professionals.
- z **Requires improvement:** Staff do not always raise concerns or they are not always taken seriously or treated with respect when they do.
- z **Inadequate:** There is bullying, harassment, discrimination or violence. When staff raise concerns they are not treated with respect. The culture is defensive.

Our Intelligent Monitoring includes staff concerns (whistleblowing) raised with CQC. We make extensive use of indicators from the NHS staff survey and the General Medical Council trainee survey, including questions covering feedback, concerns, errors, near misses and incidents, bullying, harassment and abuse, staff sickness and staff turnover.

12. See our guidance for providers for more information www.cqc.org.uk/content/guidance-providers

FOCUS GROUP WITH STAFF WHO HAVE RAISED CONCERNS

In developing our work on staff concerns and whistleblowing, we brought together a group of people with experience of raising concerns in health and social care services. CQC staff met with the group in February and July 2014. We listened to their experiences, discussed the issues and asked how CQC might act to encourage change.

We heard people describe how the organisational response to their concerns was to take the focus away from the actual issues raised and instead focus attention on the person raising concerns. We heard how staff with previously exemplary records were suddenly faced with allegations. Often they found themselves subject to bullying and harassment. We heard about how the stress from this treatment had resulted in sickness and the inability to carry on as normal.

These events helped CQC develop our approach to ensure that the way staff are encouraged to raise concerns – and how issues are investigated and responded to – is integrated as part of our inspection work. The feedback from this group also helped us to understand the links with other cultural issues within the organisation. For example, inspection teams now consider information about bullying from staff surveys. They also look at factors such as staff sickness rates and the priority placed at board level on openness and transparency relating to safety concerns.

Before an inspection of either a homecare agency, hospice or a Shared Lives scheme, CQC carries out a staff survey. We ask if they agree with these statements:

- z “My managers are accessible, approachable and deal effectively with any concerns I raise.”
- z “My managers ask what I think about the service and take my views into account.”

CQC inspections now include specialist professionals who play a key role in helping teams understand whether there are problems with the way staff concerns are handled. We encourage members of staff to raise any concerns with our inspectors.

For example, on hospital inspections we hold focus groups with junior doctors, run by a junior doctor who is on our inspection team, to encourage them to share any concerns. Other staff forums are conducted by a peer on the inspection team and are held with senior doctors, junior nurses and care assistants, senior nurses and administrative staff.

We offer to speak to people who have contacted us to raise concerns directly and confidentially, one-to-one or at a drop-in sessions. We also provide comment cards that people may complete and send to the inspection team, to provide their views about services. We always interview key staff, including HR directors and non-executive directors, and we are able to review a sample of closed investigations.



3. STATE OF COMPLAINTS IN HEALTH AND SOCIAL CARE SERVICES

In their review of NHS complaints, the Rt Hon Ann Clwyd MP and Professor Patricia Hart asked CQC to report on complaints handling in the acute trusts that we inspected in the year following their report.

We have a clearer picture of the state of complaints for NHS trusts than for primary care and adult social care providers.

In acute, mental health and community health services there is far too much poor practice in providers' responsiveness and treatment of people who make complaints. This is backed up by the negative findings from patient surveys.

There is less evidence available on which to judge how well complaints and concerns are handled

in adult social care and primary care. Much more could be done to encourage an open culture where concerns are welcomed, particularly as high numbers of providers in these sectors report that they receive very few or no complaints at all.

Across all sectors, we believe that the new methods we are introducing to look at complaints handling, along with reforms by others such as the Health and Social Care Information Centre, will enable us to present a more complete picture of the state of complaints in the future.

NHS acute, mental health and community health services

Complaints received

NHS acute, mental health and community health services share information about their written complaints with the Health and Social Care Information Centre (HSCIC).¹³

We analysed this data and found that the number of written complaints received by all NHS hospital, mental health and community health services increased every year since 2011/12. This overall increase masks decreases in some areas, including acute inpatient services in 2013/14 and maternity services (TABLE 1 AND FIGURES 3-5).

13. It is mandatory for all NHS hospitals and community health services to return information on complaints to the HSCIC data collections. The response rate from NHS trusts is usually 100%.

DATA SOURCES ANALYSED IN THIS REPORT

- z **Health and Social Care Information Centre – Data on written complaints in the NHS (2011/12 to 2013/14)**
- z **CQC National Customer Service Centre** – concerns received from 1 April 2012 about the quality of care in the providers we regulate.
- z **Published inspection reports** – we reviewed information relating to complaints handling in inspections carried out using our new approach. We looked at 165 adult social care inspection reports, 83 GP practice and out-of-hours service reports, 98 acute NHS hospital reports, seven NHS mental health service reports and eight community health service reports. We carried out qualitative analysis of the text to identify key themes and issues within sectors.
- z **Inspector survey** – we asked inspectors carrying out inspections in adult social care and GP practices between August and October 2014 to complete a survey about complaints handling.
- z **Provider information requests** – before carrying out an inspection, we ask providers for certain information that includes numbers, themes and timeliness of resolution of complaints. We reviewed information returned by 628 adult social care providers inspected during quarter 2 of 2014/15. We drew numbers and themes of complaints and timeliness of resolution from the adult social care information.
- z **User surveys** – in the acute sector, we carried out a survey with the Patients Association of people who had complained in four trusts, inspected in March 2014. Responses were received from 273 people. We also surveyed people using home care agencies and Shared Lives schemes that we were scheduled to inspect in quarter 2 of 2014/15. We received responses from 1,753 people using home care agencies and 38 people using Shared Lives schemes.

TABLE 1: HEALTH AND SOCIAL CARE INFORMATION CENTRE – NHS WRITTEN COMPLAINTS 2011/12 TO 2013/14

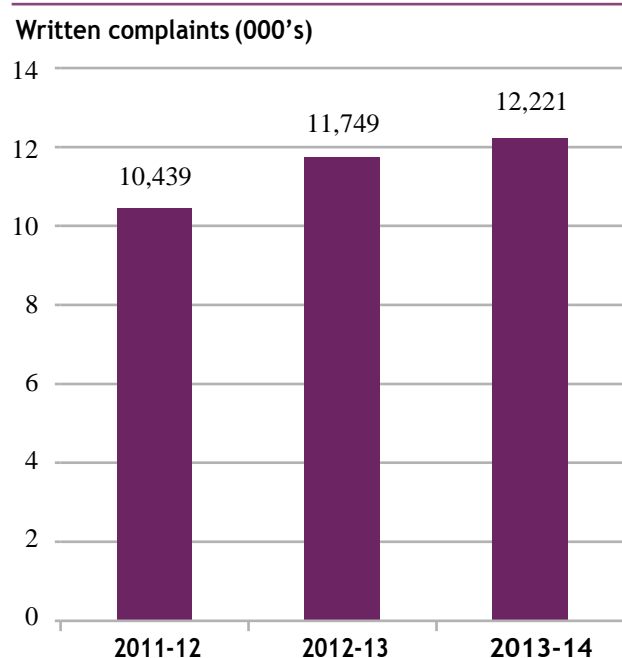
	2011/12	2012/13	2013/14	Change 2012/13 to 2013/14	Percentage change 2012/13 to 2013/14
Hospital acute services: A&E	9,362	9,680	9,919	239	2.5%
Hospital acute services: Inpatient	33,873	34,872	34,422	-450	-1.3%
Hospital acute services: Outpatient	29,559	30,019	31,083	1,064	3.5%
Total acute services	72,794	74,571	75,424	853	1.14%
Community hospital services	1,328	1,315	2,001	686	52.2%
Other community health services	6,407	6,840	6,292	-548	-8.0%
Total community health services	7,735	8,155	8,293	138	1.69%
Mental health services	10,439	11,749	12,221	472	4.0%

FIGURE 3: ACUTE SERVICES 2011/12 TO 2013/14



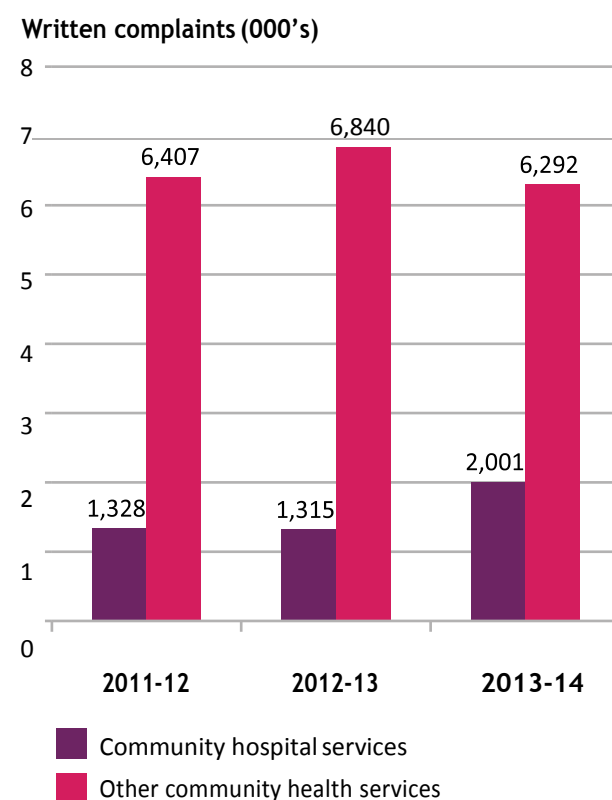
Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

FIGURE 4: MENTAL HEALTH SERVICES 2011/12 TO 2013/14



Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

FIGURE 5: COMMUNITY HEALTH SERVICES 2011/12 TO 2013/14



Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

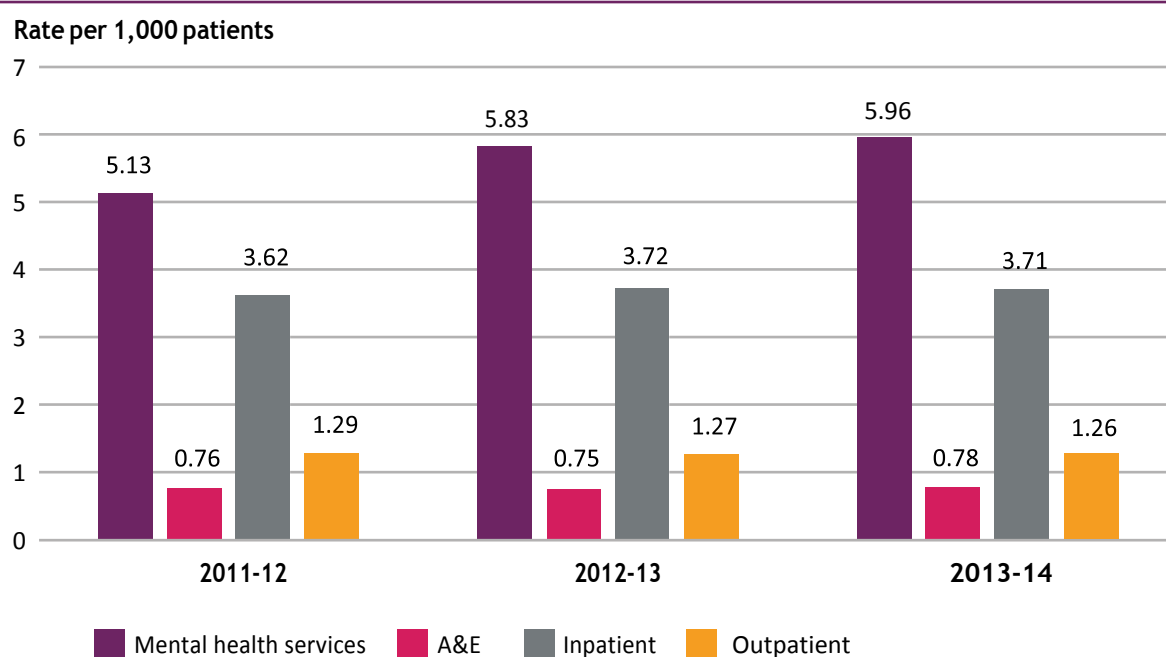
When considered against estimates of increased activity over the last three years, the rate of complaints per 1,000 patients has changed little in acute services, although it does appear to be increasing in mental health services (**TABLE 2 AND FIGURE 6**).¹⁴

14. The estimates of activity are drawn from the total counts of unique patients recorded across Hospital Episode Statistics (HES) and the Mental Health Minimum Dataset (MHMDs). The total count of unique patients does not take account of multiple attendances or length of inpatient stay, both of which may have a bearing on the likelihood of raising a complaint. Different rates may be produced if a different estimate of activity is used.

TABLE 2: RATE OF COMPLAINTS 2011/12 TO 2013/14

	2011/12	2012/13	2013/14
	Rate per 1,000 patients	Rate per 1,000 patients	Rate per 1,000 patients
Mental health services	5.13	5.83	5.96
Hospital acute services:			
A&E	0.76	0.75	0.78
Inpatient	3.62	3.72	3.71
Outpatient	1.29	1.27	1.26

FIGURE 6: RATE OF COMPLAINTS 2011/12 TO 2013/14



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

There is variation in acute and mental health services between the organisations receiving the lowest numbers of complaints and those receiving the most complaints, even when activity levels are taken into account (TABLE 3 AND FIGURES 7-8).

This variation is not necessarily linked to differences in the quality of care. As we have already noted,

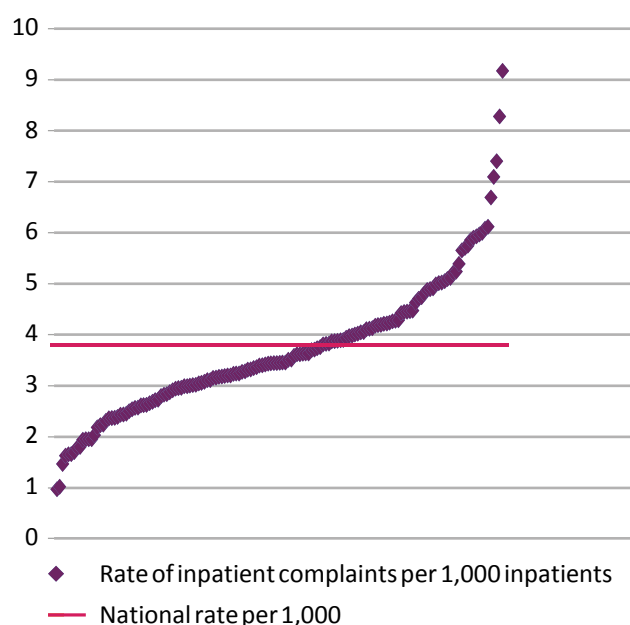
an organisation that actively encourages and seeks feedback and proactively promotes its complaints process is likely to receive higher volumes of complaints than an organisation with a more defensive approach. Higher numbers and rates of complaints should not automatically be seen as a negative, but should prompt further investigation.

TABLE 3: RATE OF COMPLAINTS TO NHS TRUSTS 2013/14¹⁵

	Acute A&E complaints	Acute inpatient complaints	Acute outpatient complaints	Mental health complaints
Maximum rate of complaints per 1,000 patients	3.05	9.17	3.76	14.63
Minimum rate of complaints per 1,000 patients	0.13	0.98	0.16	1.97
Average rate of complaints per 1,000 patients ¹⁶	0.86	3.73	1.35	6.33

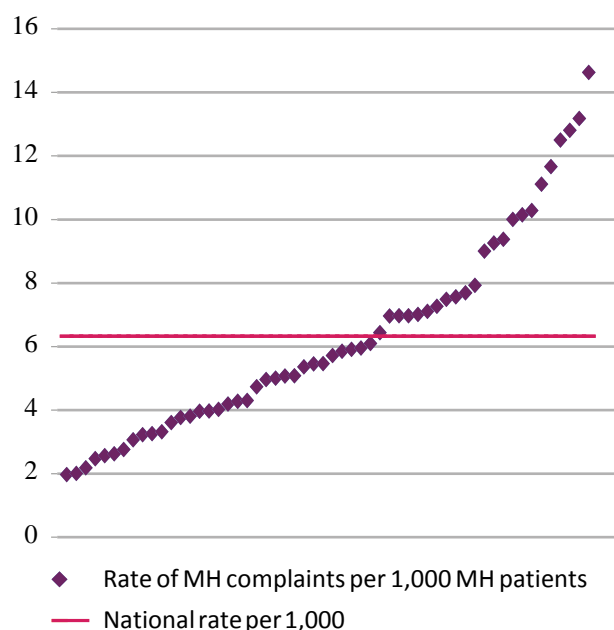
CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

FIGURE 7: RATE OF INPATIENT COMPLAINTS



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

FIGURE 8: RATE OF MENTAL HEALTH COMPLAINTS



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

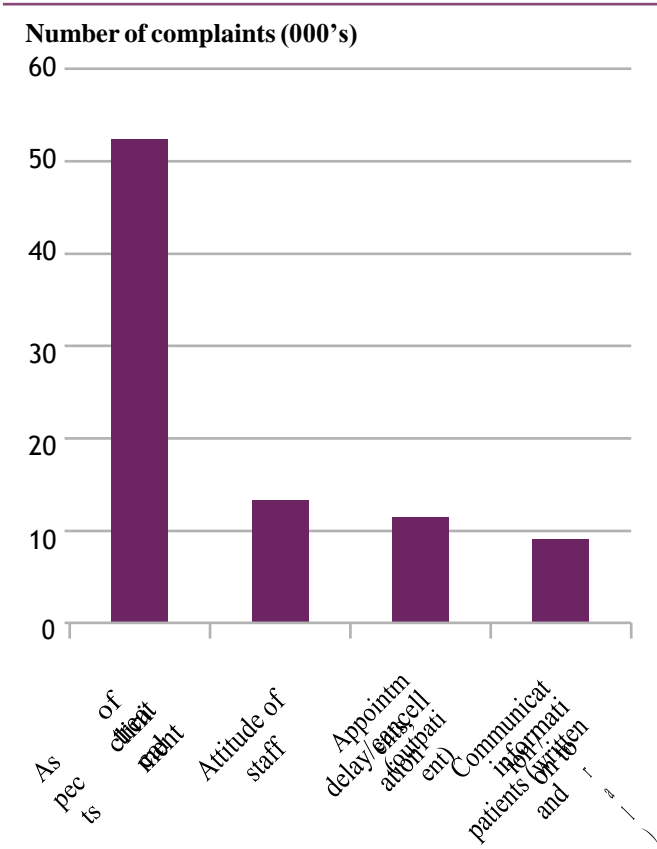
15. NHS acute trusts with known HES data quality issues have been excluded from these calculations.

16. The average figures presented in this table only relate to acute NHS trusts and mental health NHS trusts; the figures presented in the previous table relate to any organisation that received complaints regarding NHS A&E, inpatient, outpatient or mental health services.

Data from the HSCIC has informed this report and it has shown that over the last three years the main four themes of complaints across all NHS hospital and community health services are unchanged (FIGURE 9).

In November 2014 a Parliamentary and Health Service Ombudsman report showed that, in the first two quarters of 2014/15, 28% of its investigations into complaints about NHS acute trusts were about reported inadequate apologies or personal remedies. This has doubled from the 14% in 2013/14.

FIGURE 9: MOST COMMON SUBJECTS OF WRITTEN COMPLAINTS IN NHS HOSPITAL AND COMMUNITY HEALTH SERVICES 2013/14



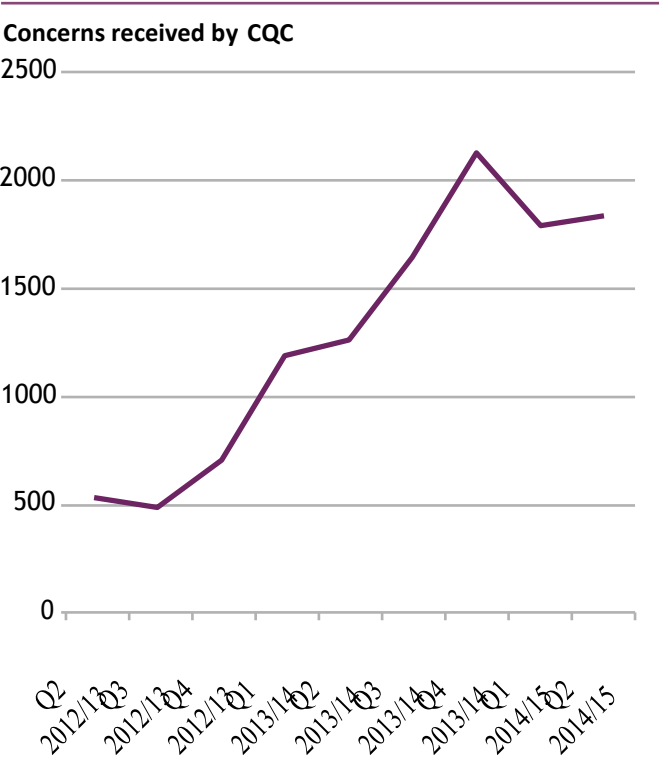
Health and Social Care Information Centre data on NHS written complaints 2013/14

Four issues have remained in the Ombudsman’s top five list of the most mentioned reasons for complaining about NHS trusts over the past 18 months:

- z Clinical care and treatment
- z Communication
 - z Diagnosis (including delay, failure to diagnose and misdiagnosis)
- z Attitude of staff.

As part of our new approach, we are encouraging people to share their experience of care with us, because this information helps us to understand the quality of providers. We have seen large increases in the numbers of concerns shared with our National Customer Service Centre (FIGURE 10). (See the start of chapter 2 for a description of the system.)

FIGURE 10: CONCERNS RECEIVED BY CQC – NHS TRUSTS Q2 2012/13 TO Q2 2014/15



Information from CQC National Customer Service Centre 2012/13 to 2014/15 – represents concerns received regarding a total of 1,307 NHS services

The marked increase in concerns raised with CQC from all sectors began around the end of 2012, when we were consulting on a new strategy and making significant changes to our organisational leadership, including beginning the recruitment of the new Chief Inspectors. We cannot be sure what has caused this increase but we know the public's awareness of CQC is increasing. In May 2014, 55% of people had heard of CQC compared to 22% in 2012.

Complaints handling

We analysed a number of data sources to understand how well NHS providers are handling complaints and concerns.

Qualitative analysis of published inspection reports using our new approach showed variable practice in complaints handling (from knowledge and awareness of how to complain to providers learning lessons from complaints), although overall there was more evidence of good practice than poor.

Most poor practice reported by inspectors related to providers' responsiveness and treatment of people who complain (FIGURE 11).¹⁷

The majority of positive practice was found where providers were learning lessons from complaints and demonstrating the actions taken as a result of complaints.

We analysed a sample of qualitative data from a number of sources that collect feedback from

people who use health and care services, regarding care received across NHS services between 2011 and 2014 (including our own 'Share your experience' web form).¹⁸ This type of feedback tends to be skewed negatively as people are more likely to report negative experiences than come forward to report acceptable or good experiences of care.

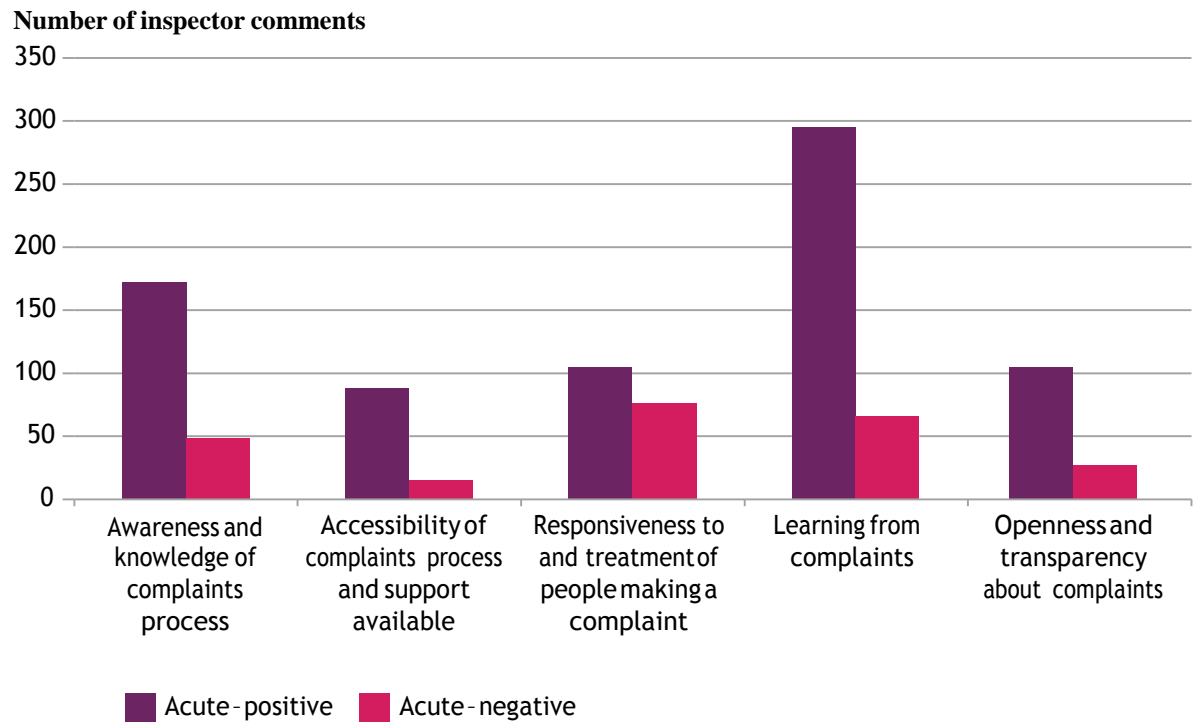
Key areas of concern across acute, mental health and community services include issues with the timeliness of investigations of complaints and people feeling that their concerns were not taken seriously or adequately addressed (FIGURE 12).

We carried out a survey with the Patients Association of 237 people who had complained in four NHS acute trusts, inspected in March 2014. It showed that people felt the experience of complaining had been difficult (FIGURE 13).

17. We reviewed inspection reports from our new approach for 98 acute NHS locations, from which 998 comments from CQC inspectors about complaints handling were analysed; seven inspection reports for mental health providers, from which 44 comments were analysed; and eight inspection reports for community health providers, from which 25 comments were analysed. The taxonomy that we have used to categorise inspectors' comments has been applied retrospectively to the inspection reports. At the time of undertaking these inspections, inspectors were not working to the detailed methodology around complaints handling that has since been rolled out, and may not therefore have reported on all aspects of complaints handling that they do now.

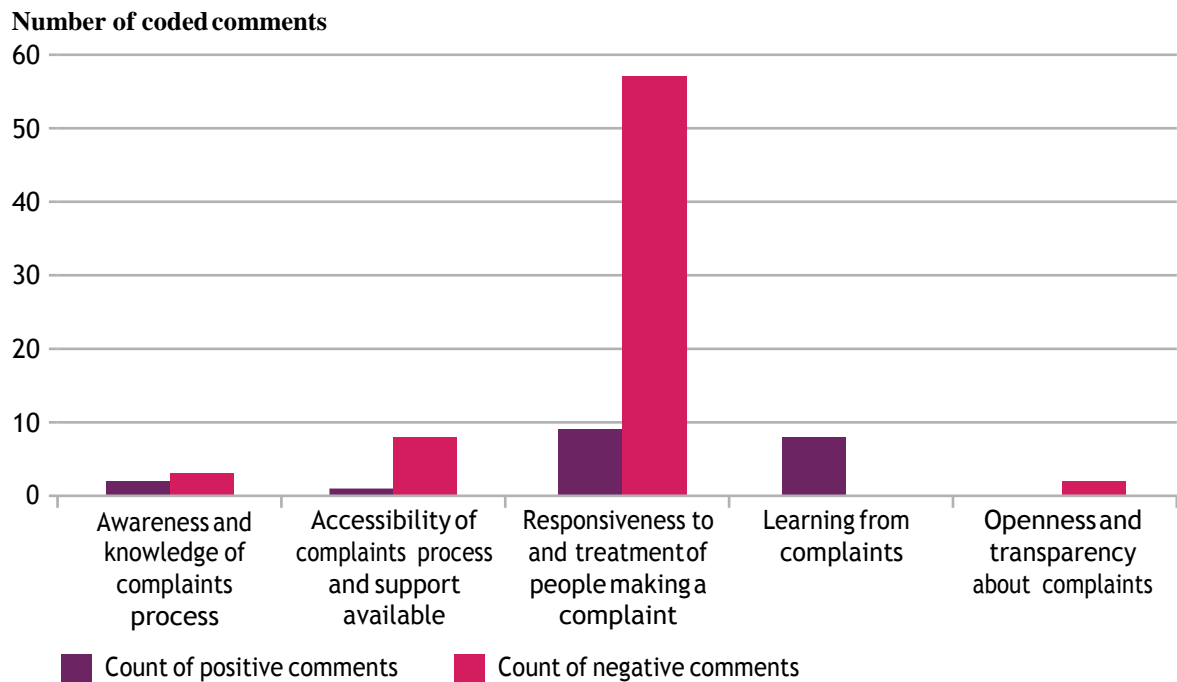
18. This data was categorised against the regulation relating to complaints handling in our outgoing ('old approach') framework. We reviewed 113 comments about NHS acute services, 48 about NHS mental health services and 11 about NHS community health. We only reviewed a sample of comments for acute services. The total number of available comments for mental health and community health services was low.

FIGURE 11: NHS INSPECTION REPORTS – COMPLAINTS HANDLING THEMES



CQC inspection reports

FIGURE 12: ACUTE 'USER VOICE' FEEDBACK REGARDING COMPLAINTS HANDLING



We found that people were concerned that complaints could impact on current or future care and were often unhappy with the speed of the complaints handling process. Both of these findings were echoed in online surveys conducted by Healthwatch England in 2014.¹⁹

Our analysis only shows some of the findings from the Patient’s Association and Healthwatch surveys. These surveys highlighted other issues around complaints handling. Full findings from the Healthwatch survey, conducted by YouGov: www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf.

Nationally, responses to CQC’s 2013 inpatient survey showed only one in four people recalled having seen or being given information explaining how to complain to the hospital about care received. Across most trusts there was limited variation in responses to

19. Healthwatch England conducted two online surveys in 2014 to understand people’s experience of raising complaints about health and social care, one hosted on their own website and another hosted on their behalf by YouGov. Both surveys found that fear of negative repercussions on care was a common reason for not complaining (60% of 85 respondents in Healthwatch England survey and one in four people (26%) in YouGov survey). The surveys also found dissatisfaction over the speed of complaints handling (71% of 211 respondents to Healthwatch England’s survey and 60% of 182 responses to the YouGov survey www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf)

this question (FIGURE 14). However, there are a small number of trusts, mostly acute specialist trusts, that performed much better than others.

Responses to the NHS staff survey showed that staff responded positively when asked if their organisation acted on concerns raised by people using services (FIGURE 15).

FIGURE 13: CQC AND PATIENTS ASSOCIATION SURVEY OF COMPLAINANTS, MARCH 2014

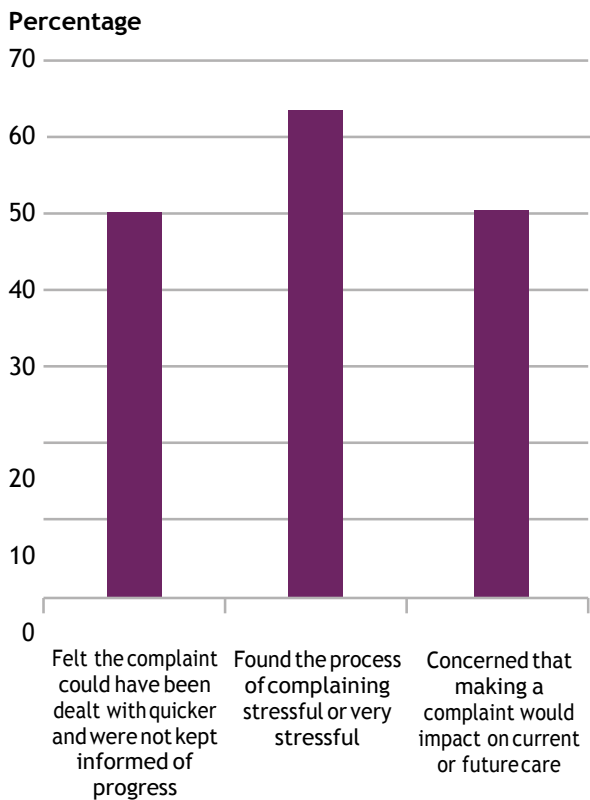
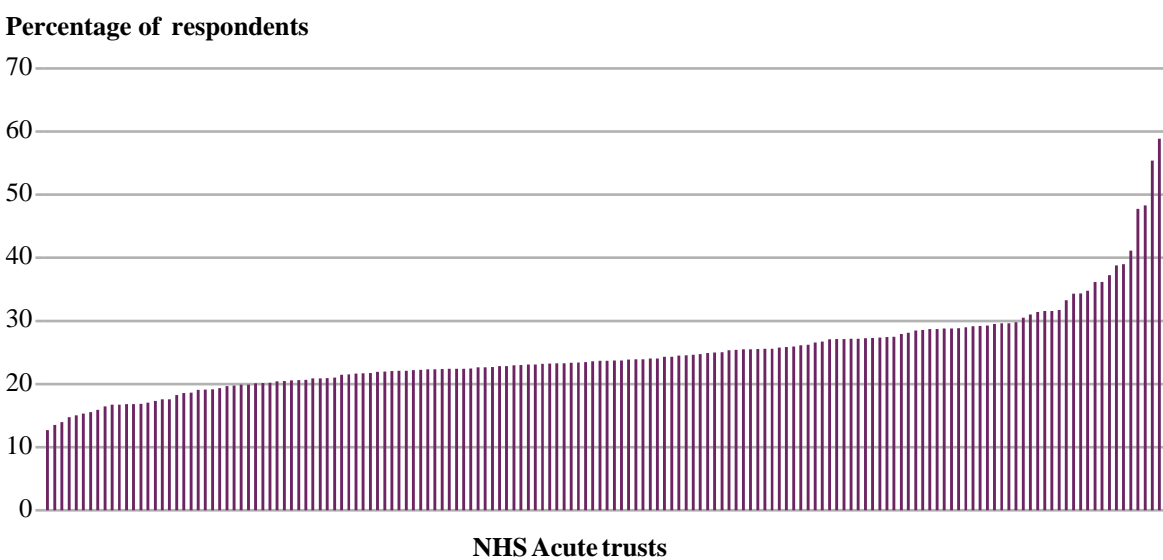
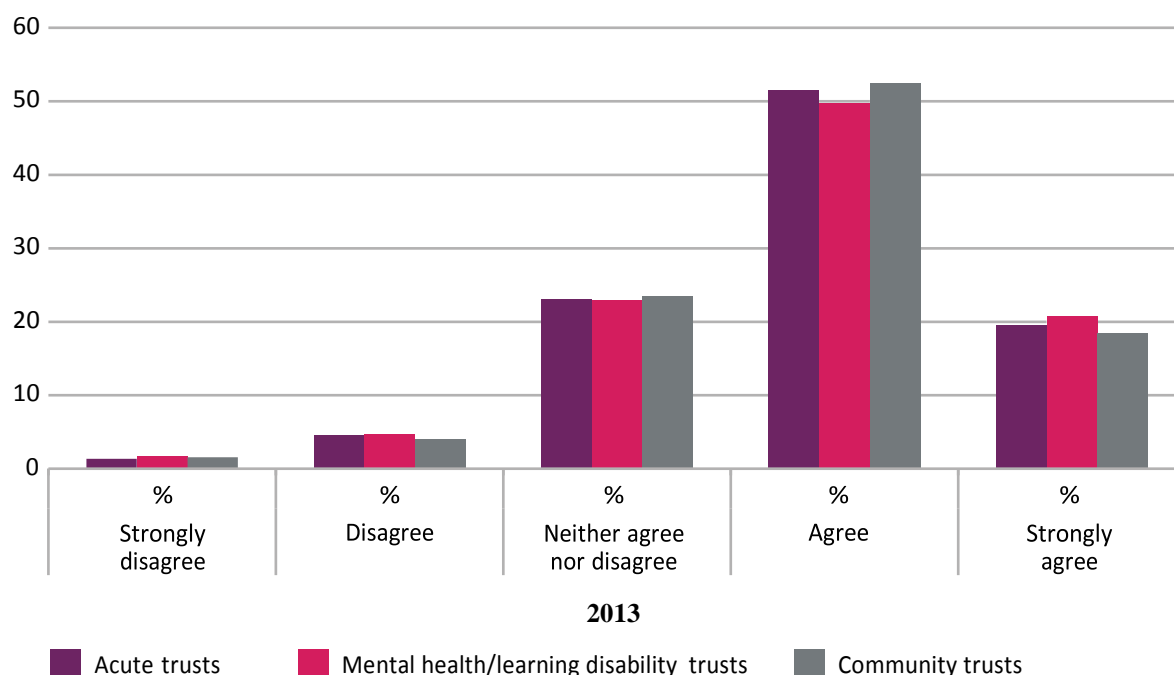


FIGURE 14: 2013 ACUTE INPATIENT SURVEY – WEIGHTED PERCENTAGE OF RESPONDENTS THAT SAID THEY SAW OR WERE GIVEN INFORMATION EXPLAINING HOW TO COMPLAIN



All trusts, CQC inpatient survey 2013/14

FIGURE 15: NHS STAFF SURVEY – MY ORGANISATION ACTS ON CONCERNS RAISED BY PATIENTS/SERVICE USERS



NHS staff surveys 2013

There is a discrepancy between the views of staff and the experience of people who have made complaints. This needs further investigation. More thorough methods of reviewing complaints handling are now a part of CQC's inspection process and we will soon have a more accurate picture of the state of complaints handling.

We also reviewed 2013/14 data supplied by the Parliamentary and Health Service Ombudsman on the proportion of complaints they investigated that were partially or fully upheld. Nationally, 43% of complaints investigated by the Ombudsman regarding care in acute trusts were fully or partially upheld. In NHS mental health trusts this figure was 36% and in NHS community trusts it was 30%. However, the data also showed great variability between organisations in the proportion of complaints being upheld. Organisations that have high rates of complaints being upheld by the Ombudsman may have inadequacies in their complaints handling processes.

Adult social care and primary care services

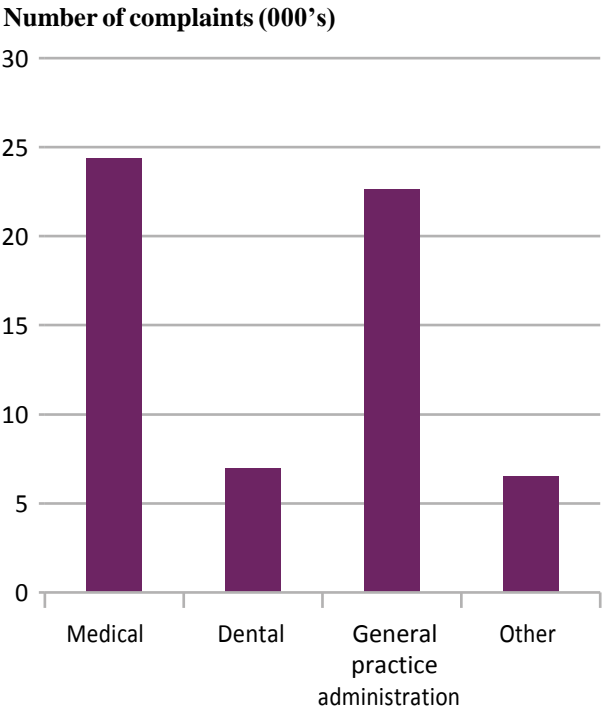
Complaints received

Many complaints in adult social care are about funding and assessment of care, which are local authority issues where CQC has no remit. However, we want to find out about concerns that relate to the care people receive.

Returning data to the Health and Social Care Information Centre regarding the number of written complaints received is mandatory. However, many GP practices and out-of-hours services are not returning this information, so the reported figures are an under-representation (**FIGURE 16**).

The response rate of GP practices to the Health and Social Care Information Centre data collection in 2013/14 was 77%. The return for NHS trusts was near to 100%. In 2013/14, the total reported number of written complaints received across general practice and dental practice was 60,564.

FIGURE 16: GENERAL AND DENTAL PRACTICE – WRITTEN COMPLAINTS 2013/14



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

Many organisations in adult social care and primary care settings report low numbers of complaints. Around 40% of the adult social care providers that we inspected in quarter 2 of 2014/15, and

requested complaints information from, said they had not received any written complaints in the previous 12 months (TABLE 4).²⁰ We also asked adult social care providers inspected in quarter 3 for additional information about the themes of complaints they receive. Replies revealed three major themes of complaints: staffing and care, laundry, and communication.

Almost 30% of GP and dental practices that returned data to the HSCIC had not received any written complaints in the previous 12 months.

The number of concerns received by CQC regarding adult social care services has increased since the beginning of 2012/13, but this has been at a slower rate than for NHS services (FIGURE 17).

We have seen a large increase in concerns we receive about primary care, but some of the increase will be because CQC’s regulation of the sector is fairly new (FIGURE 18).

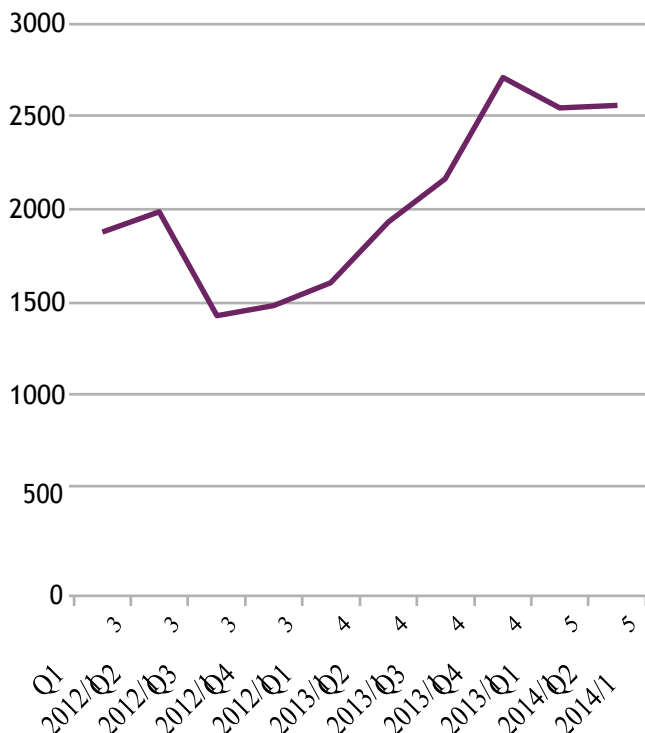
20. As part of CQC’s new approach to inspections, information is requested directly from health and adult social care providers that are scheduled to be inspected. This helps guide the inspection and inform our findings. There are concerns over the accuracy of the information that has been returned to date and CQC is seeking solutions to ensure that future returns are more robust.

TABLE 4: RETURNS FROM PROVIDER INFORMATION REQUESTS (PIRS) IN QUARTER 2, 2014/15

Service type	PIRs with zero complaints	%	PIRs with complaints	%	Total PIR returns	Total number of complaints in PIRs
Community	75	40	114	60	189	984
Hospice	7	37	12	63	19	53
Residential	165	40	247	60	412	1112
Shared Lives	4	50	4	50	8	4
Total	251	40	377	60	628	2153

FIGURE 17: CONCERNS RECEIVED BY CQC – ADULT SOCIAL CARE SERVICES 2012/13 TO Q2 2014/15

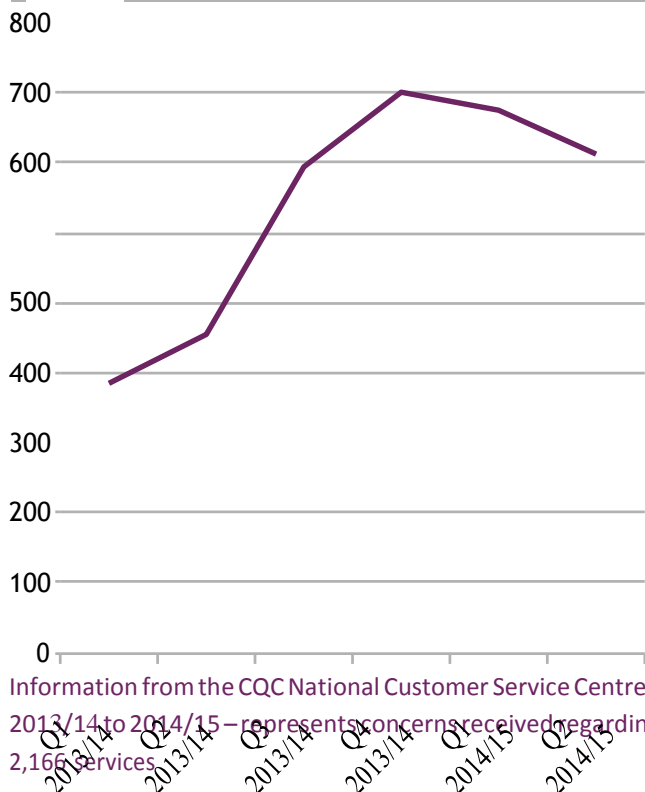
Concerns received by CQC



Information from the CQC National Customer Service Centre 2012/13 to 2014/15 – represents concerns received regarding 10,315 services

FIGURE 18: CONCERNS RECEIVED BY CQC – PRIMARY CARE SERVICES 2013/14 TO Q2 2014/15

Concerns received by CQC



Information from the CQC National Customer Service Centre 2013/14 to 2014/15 – represents concerns received regarding 2,166 services

Complaints handling

We analysed a number of data sources to understand how well providers are handling complaints and concerns.

Qualitative analysis of published inspection reports (using CQC's new approach in adult social care providers, GP practices and out-of-hours services) showed high levels of positive practice at all stages of the journey of making a complaint (FIGURE 19).²¹

To provide additional evidence for this report, we asked inspectors to complete a survey about complaints handling in the services they inspected

between August and October 2014.²² Many adult social care and GP practice inspectors felt that they did not have enough evidence to answer the questions, often because the locations inspected had received no or very low numbers of complaints.

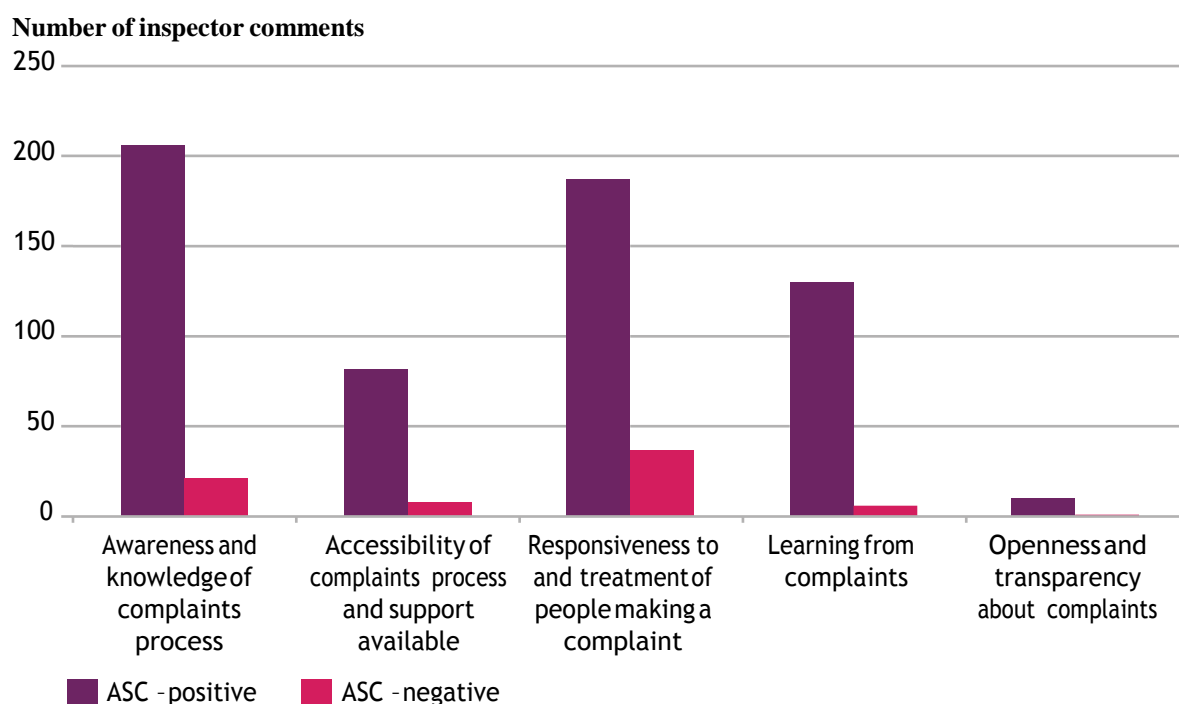
Where inspectors could provide an answer, it was generally positive about how providers were

handling complaints. However, the responses did indicate variation in the provision and awareness of advocacy and support to assist people who wanted to complain. There was also variability in ensuring that a complaints process was accessible to vulnerable groups and children. Inspectors also found variation in what information services

provide about complaints processes. In GP practices, inspectors showed that people do not always know how to make a complaint.

21. We reviewed inspection reports from CQC's new approach for 165 adult social care locations, from which 688 comments about complaints handling were analysed. We reviewed reports for 59 primary medical service locations and 24 out of hours services, from which a total of 479 comments about complaints handling were analysed. The taxonomy that we have used to categorise inspector's comments has been applied retrospectively to the inspection reports. At the time of undertaking these inspections, inspectors were not working to the detailed methodology around complaints handling that has since been rolled out, and may not therefore have reported on all aspects of complaints handling that they do now.

22. Just under 100 responses were received. Responses related to 54 adult social care providers and 35 providers of primary medical services. Inspectors of five NHS acute hospitals, one NHS ambulance trust and one independent hospital also provided responses. However, these have not been included in analysis due to the low numbers.

FIGURE 19: ADULT SOCIAL CARE INSPECTION REPORTS – COMPLAINTS HANDLING THEMES**CQC inspection reports**

In a CQC survey, a large majority of people who use home care services (that were due to be inspected in quarter 2 of 2014/15) reported that they knew how to raise concerns. They were very positive about the actions of care agencies in response to any

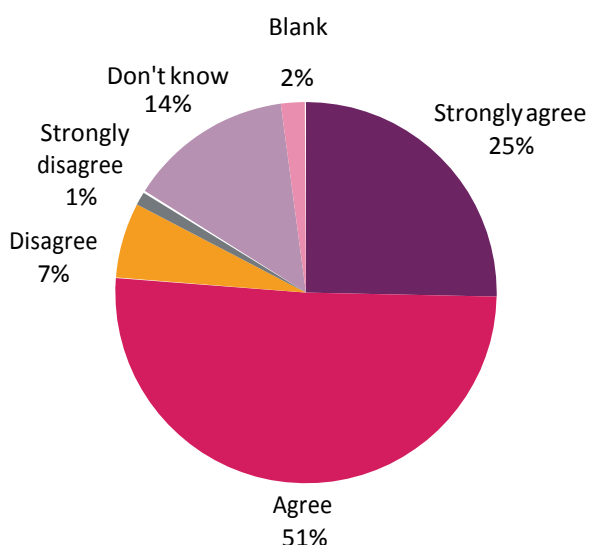
complaints made. More than 75% of those people said they knew how to make a complaint and over 70% said that care agencies and staff responded well to complaints or concerns raised (TABLE 5 AND FIGURES 20-21).

TABLE 5: ADULT SOCIAL CARE SURVEY RESULTS 2014 – PEOPLE USING HOME CARE AGENCY SERVICES

	I know how to make a complaint about the care agency		The care agency and its staff respond well to any complaints or concerns I raise	
Strongly Agree	444	25%	444	25%
Agree	893	51%	818	47%
Disagree	112	6%	118	7%
Strongly Disagree	23	1%	34	2%
Don't know	244	14%	302	17%
blank	37	2%	37	2%
Total	1753		1753	

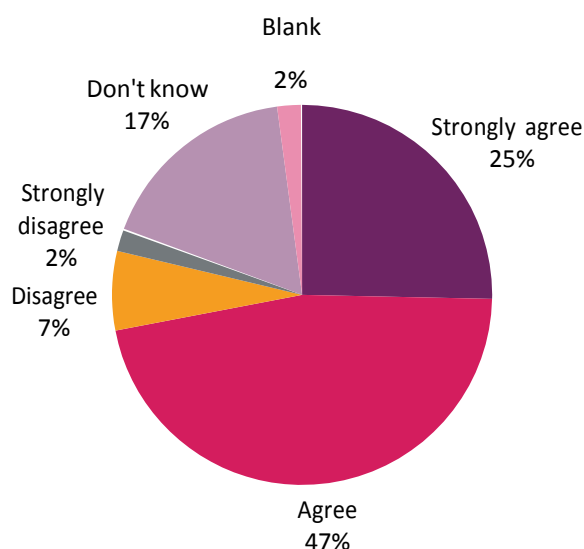
CQC survey of 133 home care agency services 2014

FIGURE 20: ADULT SOCIAL CARE SURVEY – “I KNOW HOW TO MAKE A COMPLAINT ABOUT THE CARE AGENCY”



CQC survey of 133 home care agency services 2014

FIGURE 21: ADULT SOCIAL CARE SURVEY – “THE CARE AGENCY AND ITS STAFF RESPOND WELL TO ANY COMPLAINTS OR CONCERNS I RAISE”



CQC survey of 133 home care agency services 2014

We analysed a sample of qualitative data from a number of sources that collect people’s feedback, including CQC’s own ‘Share your experience’ web form, between 2011 and 2014 (**FIGURE 22**).²³

Importantly, this type of feedback is less reliable for informing a true picture. A negative slant is likely because people are more likely to report bad experiences than acceptable or good care. As in acute and mental health services, feedback highlighted issues with the timeliness of

investigations of complaints and responses. People felt that their concerns were not taken seriously or adequately addressed.

There are a number of potential interpretations of this data. The fact that a large number of adult social care

and primary care providers did not report receiving any written complaints suggests that more could be done to encourage feedback and build a culture in which concerns are welcomed as opportunities to improve. The positive picture from our inspection reports and our user survey in adult social care may

reflect the fact that in many locations we inspected, there were few complaints or none at all.

However, feedback from websites and other sources highlights that there are issues with the handling of complaints in these sectors. Combined with our survey that showed inspectors often had insufficient evidence to answer questions, we believe that the partial picture we are able to pull together is not accurately capturing how well providers encourage, listen to and respond to complaints and concerns in adult social care and primary care.

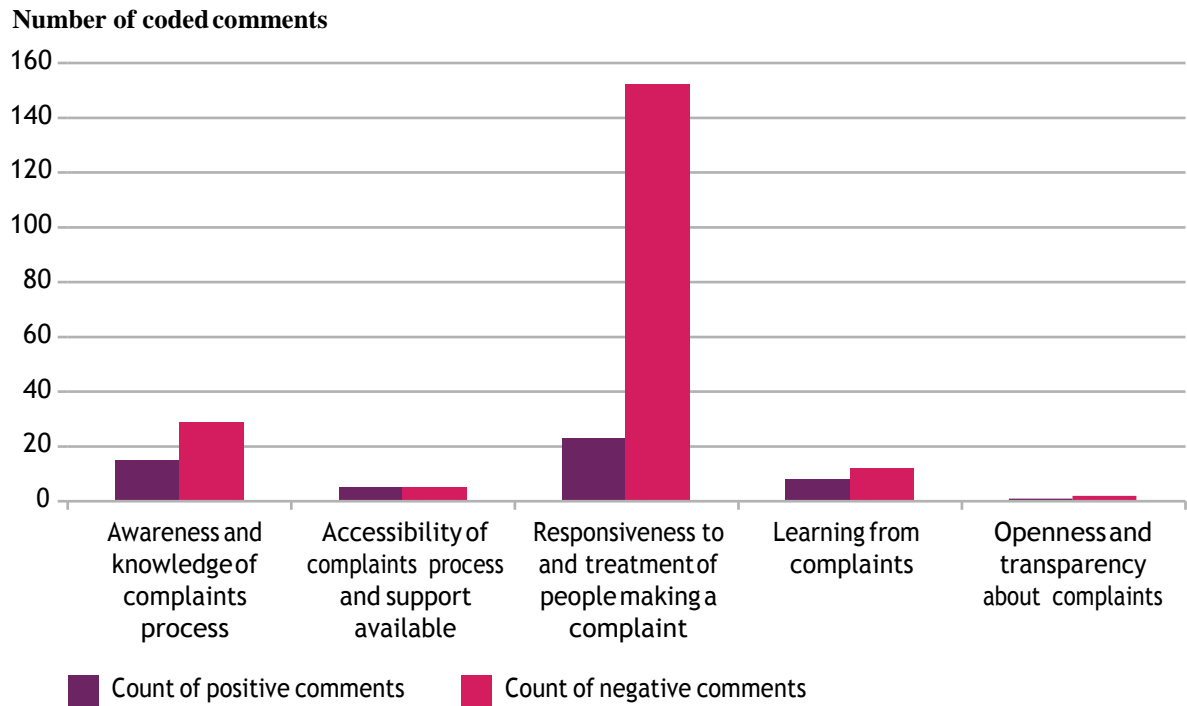
We believe that the more thorough methods of reviewing complaints handling that we are now rolling out will help inspectors to gain robust evidence of the state of complaints. We will continue to review inspection findings and refine our methods if necessary.

23. This data was categorised against the regulation relating to complaints handling in our outgoing (‘old approach’) regulatory framework. We reviewed 243 comments about adult social care and 25 comments about primary care. We only reviewed a sample of comments for adult social care. The total number of available comments for primary care organisations was low.

CQC understands that the next stage of reform to the HSCIC data collection will focus on improving response rates and quality of primary care returns, and will consider the extension of the collection

to adult social care. Improving the data available in these sectors will be crucial to presenting a true picture of the state of complaints and we hope these reforms will be implemented as a priority.

FIGURE 22: ADULT SOCIAL CARE PROVIDERS - ‘USER VOICE’ FEEDBACK ON COMPLAINTS HANDLING



4. CONCLUSION

This report paints a partial picture of the state of complaints in health and social care services, but one in which some things are clear. There is wide variation in the way complaints are handled and much more could be done to encourage an open culture where concerns are welcomed and

learned from. While most providers have complaints processes in place, people's experiences of the system are not consistently good.

This must change. Services should encourage and embrace complaints. They are valuable because every concern is an opportunity to improve. Making this cultural shift will require everyone involved in health and social care to stop seeing complaints as a negative. As long as we do, there is an incentive for services to be less open about seeking feedback.

CQC has a big role to play in supporting this change. We have set out what we expect from providers when it comes to encouraging, listening to and responding to complaints, and how we will look at this through our inspections. We have aligned our approach with the universal expectations of good complaints handling set out by the ombudsmen

and Healthwatch England, to ensure that there is a single shared vision.

We will take action on services that do not take complaints seriously. From now on, all our inspection reports will include a description of

how complaints and concerns are handled. We will recognise and celebrate good practice and set out where improvements need to be made.

As we hold providers to a higher standard, we know we need to deliver that same standard ourselves.

We are working to make it easier for people to share their experiences with us, to use that information effectively in our regulation, and to report back to people on what action we have taken. We know this should create a virtuous circle where more people share information with us, and our regulation becomes more effective.

We will continue to work with the Department of Health, the ombudsmen, patients' organisations, Healthwatch England and NHS England to make it easier for people to raise concerns. And we

will continue to test and develop our inspection approach to complaints handling.

This report demonstrates why complaints matter – to people who use services, to organisations providing services and to CQC. Every concern is an opportunity to improve. Complaints may signal a problem, but this information can help save lives and learning from concerns will help improve the quality of care for other people.



How to contact us

Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at: **Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA**



Follow us on Twitter: **@CareQualityComm**

Please contact us if you would like a summary of this document in another language or format.

CQC-269-122014

