A pain to complain

Why it's time to fix the NHS complaints process

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Contents

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Executive summary

Written complaints in the NHS reached a record high in 2024. With public satisfaction with the NHS at record low levels, the way the NHS handles, responds and learns from complaints is vital.

A high quality, responsive NHS complaints process not only provides a key way for services to learn and improve care, it also shows patients that the NHS values their feedback.

When we first reviewed the NHS complaints process over a decade ago, we found major failings and called for reform. To establish if people's confidence or experience has improved, we conducted new research between September and December 2024.

What we found should concern NHS leaders, government and regulators. Low public confidence is preventing people from taking any action after experiencing poor care, meaning that current complaints numbers could just be the tip of the iceberg. There is little evidence that complaints are being systematically used to improve care.

Key findings

Very few patients complain: Almost a quarter (24%) told us they had experienced poor NHS care in the past year. Yet more than half (56%) of people who experienced poor care took no action, and fewer than one in ten (9%) made a formal complaint. This is a significant drop from the four in ten (39%) who said they made a formal complaint when asked a similar question in 2014.

Low confidence stops people acting: Of those who didn't make a complaint after poor care, 34% believed that the NHS wouldn't use their complaint to improve services, 33% thought organisations wouldn't respond effectively, and 30% felt the NHS wouldn't see their concern as 'serious enough'.

A poor complaint experience is common: Over half (56%) of people who made a formal complaint were dissatisfied with both the process and the outcome of their complaint.

Falling investment in support for people complaining: The budget allocated to councils to arrange statutory NHS complaints advocacy for local people has declined by more than 20% over the last decade

People experience long waits for responses. On average, Integrated Care Boards (ICBs) took 54 working days to respond to complaints they handled as commissioners of NHS services. Response times ranged from between 18 and 114 working days.

The NHS is not effectively learning lessons: NHS organisations do not effectively capture the right data about who makes complaints, do not welcome complaints or fail to fully demonstrate learning from complaints. There is little national oversight and accountability over the complaints process.

Key recommendations

Our findings show that the NHS does not consistently welcome, handle, respond or learn from complaints in a patient-centred manner. Action is needed to:

Make the complaints process easier for patients and their families to navigate

- NHS England (NHSE) should require NHS bodies to collect wider data about complainants, such as gender, ethnicity and disability, so that we know who does and does not submit complaints
- The Department of Health and Social Care (DHSC) should set detailed and mandatory standards on NHS 'front-door' information - including on the NHS App - about how people can navigate the complaints process.
- DHSC should commission a comprehensive review of statutory NHS complaints advocacy services.

Monitor and improve the performance of organisations that handle complaints

- DHSC should set mandatory response times for complaints following a baseline exercise on current average response times at all providers and ICBs
- NHS organisations should survey patients after complaint cases are closed to monitor their satisfaction with the process and outcomes.
- NHSE should require all NHS bodies to report on new performance indicators of complaint handling, including the number of re-opened complaints, and the

number of complaints referred to the Parliamentary and Health Services Ombudsman (PHSO).
- NHSE should carry out a performance audit on ICB compliance with the 2009 complaints handling regulations.

Develop a culture of listening to and learning from complaints

- DHSC should strengthen regulations to require NHS bodies to publish their annual complaints reports, rather than 'on request' as currently required.
- DHSC should require providers to better demonstrate learning from complaints through more detailed annual complaints reports.
- DHSC should make the PHSO's NHS Complaints Standards mandatory and clarify which body should lead in monitoring and enforcing them.
- NHSE should assess ICBs' complaints handling in ICB annual assessments.
- The Care Quality Commission (CQC) should improve the regulation of providers' complaints' handling responsibilities by checking this at every new and full assessment.

Introduction

Looking back

In 2014, we published a significant report on people's experience of the health and care complaints systems. *Suffering in Silence* concluded that people found "making complaints overly complex, incredibly frustrating and largely ineffective".[1] This report came a year after the public inquiry into Mid-Staffordshire hospital care, led by Sir Robert Francis KC, reported on a culture in which repeated patient complaints were ignored, delaying the exposure of serious care failings.[2]

Since then, there have been structural changes in complaints handling. In July 2023, England's 42 Integrated Care Boards (ICBs) took on powers from NHSE to handle primary care complaints in cases where patients had exercised their right to go to the commissioner of those services rather than the service directly.

There has also been a 37% increase in the number of complaints the NHS receives, from 174,872 in 2013-14, to more than 240,000 in 2023-24, according to the latest NHS England figures.[3]

This could suggest more people are confident in speaking up, as NHS organisations start adopting NHS Complaints Standards that recommend they welcome and better handle complaints.[4] The non-statutory standards were introduced from late 2022 by the Parliamentary and Health Service Ombudsman after being co-produced with Healthwatch and other bodies.

However, the increase in complaints may also have been driven by poorer quality of care caused by pressures on the NHS, especially since the pandemic. Despite year-on-year increases, the health service may not have learned from complaints and remains in a cycle of repeating the same mistakes. This report adds weight to this case.

Current context

The emerging view from policymakers is that there are serious failings in how NHS organisations listen and respond to patient feedback. In September 2024, an independent investigation into NHS performance by Lord Ara Darzi noted the increase in NHS complaints, as well as rising clinical negligence payouts, and found, "the patient voice is simply not loud enough. There are real problems in responsiveness of services to the people they are intended to serve".[5]

These comments echo the findings of numerous NHS safety inquiries, such as the Ockendon maternity care review, which found 'a lack of compassion' from staff towards parents in responses to their complaints.[6]

Similarly, the recent review of the Care Quality Commission, by Dr Penny Dash, raised concerns about how CQC collects and uses patient experience data to inform regulatory assessments of health and care providers.[7]

A follow-up review, looking at the quality of care more broadly and the role of six national bodies (including Healthwatch England) is currently considering what recommendations to make to government on how complaints data and other patient experiences, 'are effectively used to make improvements in safety'.[8]

Aims of our research

Our research set out to discover:

- if public confidence in using the NHS complaints has increased
- if people know how to take complaints and get support to do so
- if services and commissioners handle complaints well
- if there is adequate national data, oversight and transparency on handling and learning from complaints.

Key themes by chapter

- **Chapter one:** Overall Confidence in the NHS complaints process is low.
- **Chapter two:** People struggle to navigate the NHS complaints process, often without support.
- **Chapter three:** NHS complaints handling is an under-resourced and under-valued function, leading to low or inadequate responses
- **Chapter four:** The NHS does not structurally or culturally support proactive learning from complaints.
- **Chapter five:** We conclude that overall, the NHS does not consistently welcome, handle, respond to or learn from complaints in a patient-centred manner. Legal, national and local changes are required to put this right.

We have set out our recommendations in full on page 42.

Methodology

We adopted a mixed-method approach to our research, consisting of:

Polling

YouGov conducted polling for us in two parts.

Part one: A nationally representative sample of 2,042 adults living in England, between 17-22 October 2024. This asked people if they'd experienced poor NHS care since October 2023 and their general confidence in making complaints.[9]

Part two: A boosted sample, made up of 2,650 adults who had experienced poor NHS care since October 2023, polled 17–29 October 2024, about whether they took any action and experience of the complaints process.[10]

Where relevant, we compared results with the 2014 polling we conducted on the topic.

Freedom of Information requests

We sought data that we believed was held by health and care organisations, but which was not in the public domain. We did this via Freedom of Information requests sent in September 2024. We submitted these to:

- 206 NHS hospital, mental health or community trusts, asking about their budget for Patient Advice and Liaison Services (PALS) and total staff in PALS and complaints teams. We received responses from 166.
- All 42 ICBs, asking about resourcing of complaints handling, response times and if they delegated the remit to another ICB. All but one responded.
- 151 upper-tier local authorities, asking about how much they spent on statutory NHS complaint advocacy services. We received 114 responses.

Roundtables with Healthwatch

In November 2024, we held two roundtables with more than 20 staff from approximately 17 local Healthwatch services. These focused on patient feedback on complaints, local complaints processes, and their role in providing NHS complaints advocacy if their organisation also delivered this service.

An analysis of Healthwatch feedback on complaints

In October 2024, we analysed over 200 pieces of feedback on people's experiences of the NHS complaints process shared by local Healthwatch services. We use some of these stories in this report.

1) Low confidence in the complaints process

Making a complaint is a legal right for patients enshrined in the NHS Constitution.[11] Introduced in 2009, the constitution pledges to listen and learn from complaints and drive improvements to patient care.

Your right to make a complaint

The NHS Constitution states that: *'You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.'*

The NHS also pledges to ensure:

- you're treated with courtesy and receive support throughout the process
- your future care is not 'adversely' affected by making a complaint
- you get an explanation and apology 'delivered with sensitivity and recognition of the trauma you have experienced' if mistakes or harm occur
- you will know that lessons will be learned to help avoid similar incidents
- the NHS body uses complaints to learns lessons and to improve services.

However, the legitimacy and usefulness of the complaints process depends on certain factors. People need to feel confident to use it and trust they will be heard. However, they also need to believe that services will put things right and prevent similar mistakes or experiences from happening in the future.

Among the general population, **less than half (48%) of the 2,042 people we questioned in part one of our polling said they would feel confident making a complaint** if they were to experience poor care, and more than one-quarter (27%) said they would not feel confident to make a complaint.

This is a concern considering how many people receive poor care across services. **Nearly one-quarter (24%) of the 2,024 people polled had had an experience of poor NHS care in the past 12 months.** This would equate to 10.7 million adults when applied across the current population.[12] It is double the 12% of people we polled in 2014, who had had either an experience of poor NHS or poor social care in the last two years.[13]

In our latest research, certain groups reported experiencing poorer care compared to others:

- Women: 28% reported a poor experience, compared to 19% of men.
- Disabled individuals: 35% experienced a poor level of care, while only 19% of those who were not disabled felt the same.
- Current or former unpaid carers: 35% had a negative experience compared to 20% of individuals who were not carers.

Action taken when people experience poor care

To understand in more detail what actions people take if they feel let down by the NHS, YouGov boosted the initial polling sample to reach 2,650 people who'd experienced poor care in the past year. Their responses shows a reluctance to take any action at all - just as in 2014 - let alone pursue a formal complaint.

Action taken by those who experienced poor care[14]	**2024**	**2014**
Didn't take any action	56%	61%
Gave feedback to the service	30%	n/a
Made a formal complaint	9%	39%

Fewer than one in 10 people in our latest poll chose to make a complaint. In 2014, the figure was higher – although that included 26% who'd made a complaint once, and 13% who'd made a complaint twice, within the last two years, about either NHS or adult social care services. In contrast, our 2024 poll focused solely on NHS complaints made within the past year.

Feedback we received in our roundtables with local Healthwatch and complaints advocacy staff shows that people often feel torn about speaking up:

> "When people are wanting to give some sort of feedback…the word complaint almost puts them off. People love the NHS. People know they're [NHS staff] doing the best they can. So therefore, they don't say anything because it's a very formal process and the routes in just to give feedback are not clear enough.

And because it's quite a formal process, it then becomes quite unrepresentative. It's quite a complex process and it tends then to be the people who feel able to do that that do it" – Roundtable participant.

Why people choose not to make a complaint

To understand where people's lack of confidence stems from, we asked those who did not make a complaint after receiving poor care why they chose not to. The table below shows the options they selected and compares with similar 2014 polling questions where these were asked.

Reason for not making a complaint	Percentage of respondents 2024	Percentage of responses 2014[15]
I didn't think my complaint would be used by the NHS to improve services	34%	49%
I didn't feel confident that the NHS would respond to my complaint effectively	33%	n/a
I didn't believe the NHS would think my complaint was serious enough	30%	16%
I was scared that complaining would affect my ongoing treatment from the NHS	20%	26%
I didn't know who to contact	19%	23%
I felt that giving feedback would be sufficient	13%	n/a
The complaint process seemed too complicated for me	8%	13%
I didn't feel confident in writing a good complaint letter	5%	n/a
I felt legal action would be more effective	2%	n/a

The top deterrent for people making complaints relates to a lack of confidence in how they will be used. **One-third of people (33%) did not believe that NHS organisations would use the complaint to improve services or give them an effective response**, and 30% didn't think the NHS would regard their complaint as 'serious enough'.

One in five people (20%) were concerned about the personal impact on their care, a slight improvement on the 2014 percentage of 26%. However, this remains a worrying statistic given that Care Quality Commission guidance requires providers to assure complainants their care won't be affected:

CQC guidance to NHS bodies on complaints handling

> 'Complainants must not be discriminated against or victimised. In particular, people's care and treatment must not be affected if they make a complaint, or if somebody complains on their behalf'.[16]

How confidence varies between different groups of people

We also wanted to determine whether some groups were more likely to speak up after receiving poor care than others, as an indicator of different levels of confidence in the complaints process. Our polling showed groups who were less likely to take further action on poor care were:

- Women (58% wouldn't take further action compared to 52% of men)
- People who aren't working (58% compared to 54% of those who are working)
- People with low educational attainment (60% compared to 53% with medium educational attainment)

This suggests that NHS organisations may need to do more to support these groups with practical changes using simpler language for the complaint process and fostering a culture that welcomes complaints from everyone.

Lack of demographic data on who makes complaints

NHSE mandates providers and commissioners provide only the following information about complainants: the person's age and whether the person making the complaint is the patient, a parent, guardian, or their carer. This requirement for primary care providers is recent, implemented only from 2023-24.

Yet **there is no systematic collection, recording and analysis of full demographic and protected characteristics of complainants, such as gender, ethnicity and disability**, to identify whether these groups face any inequalities of access to the process or may be more likely to experience poor care.

Even the limited demographic data currently collected is not fully transparent. NHS England does not report the age and status of complainants in the national summary of the annual complaints statistics. This represents a missed opportunity, for example, to map the age of complainants against the age groups that most use the NHS overall.

Our analysis of files within the NHSE annual statistics, showed that most primary care complaints were made by people aged 20-59, while the biggest age group for NHS trusts, was 26-55-year-olds. It's important to note that age group data collection methods varied between primary and secondary care.

First steps needed to increase confidence in the complaints process

How can we encourage the more people who experience poor care to act?

Increasing public confidence in how the NHS handles complaints will require improvements to all aspects of the process – including awareness, support and navigation, complaint handling, and the culture of the NHS, which we explore and make recommendations about further on in this report.

To build confidence in the NHS, it is crucial to take some important initial steps. The NHS should clearly communicate that it welcomes all types of feedback and reassure people that coming forward won't affect their care.

The NHS also needs to fully understand who is making complaints so it can establish any inequalities in the experiences of those receiving poor care, as well as any barriers people may face to making a complaint.

Recommendation one

NHS England should require NHS bodies to collect wider data about complainants, such as gender, ethnicity and disability, to understand trends and identify any inequalities in who feels able to raise concerns about poor care

2) A confusing process to navigate

The NHS complaints process should be easy for people to understand and use. Support should be available when people do not feel confident navigating the process.

These stand out as key features of legal regulations and recommended best practice from the Parliamentary and Health Services Ombudsman:

Requirements for NHS bodies to promote and support people on complaints

- Complainants should receive 'so far as is reasonably practical, assistance to enable them to understand the procedure in relation to complaints; or advice on where they may obtain such assistance'.[17]
- 'Information and guidance about how to complain must be available and accessible to everyone who uses the service. It should be available in appropriate languages and formats to meet the needs of the people using the service.'
- 'Providers must tell people how to complain, offer support and provide the level of support needed to help them make a complaint. This may be through advocates, interpreter services and other support identified or requested'.[18]
- 'Organisations must make sure people know how to get advice and support when they make a complaint. This includes giving details of appropriate independent complaints advocacy and advice providers, any Patient Advice and Liaison service (PALs), and other support networks'.[19]

Despite these requirements, our polling showed that one in five people (19%) who had experienced poor care in the past year, didn't know who to contact to make a complaint.

This also emerged as a key theme of discussion in our roundtables, in relation to giving any kind of feedback.

> "People don't necessarily want to make a formal complaint about the NHS. They want to give feedback, but it's not clear how they can do either." – Roundtable participant

Participants identified particular problems in trying to raise concerns in primary care:

> "Practice managers are behind a wall of receptionists, it's actually really hard to then go and talk to that practice manager about that receptionist who's been really rude to you. And that just crops up again and again. People find that really tricky." – Roundtable participant

> "I've just analysed around 500 experiences of GP services and the recurring theme is very much that they can't get hold of the practice manager. They'll write to them or try and get an email address for them, but they seem to be this elusive figure. And they don't respond either. It needs to be a lot easier to make primary care complaints" Roundtable participant

How the complaints process is supposed to work

To help people navigate the process, the NHS is expected to explain the following steps for raising a formal complaint:

1. Speak up at the time with the staff member, a manager or the Patient Advice and Liaison Service. A PALS team exists in most hospital, community and mental health trusts.
2. If the concern isn't resolved quickly, to your satisfaction, or very serious, you can make a formal complaint. You can make a formal complaint either directly to the NHS service or to the body that commissions that service. The commissioner is usually one of 42 ICBs. You may wish to complain to an ICB if you're uncomfortable dealing directly with the NHS service.
3. You can get free, independent support from a local NHS complaints advocacy service.
4. The NHS body or ICB must acknowledge your complaint within three days. They must also investigate it and provide a written response. If you're satisfied with the response, this part of the process, called local resolution, ends.
5. If you're unhappy with the response, you can ask the Parliamentary and Health Services Ombudsman (PHSO) to investigate. The PHSO only fully investigates the

cases it considers the most serious. It is an independent and neutral body that establishes if the NHS has acted properly or fairly, or needs to put things right.

In some instances, NHS organisations use an integrated team to jointly handle or deal with any patient queries, feedback, concerns or formal complaints. There may be good reasons for this, as explored in the next chapter, but evidence from our roundtable discussions suggests this can confuse patients.

The role of advocacy services in supporting people

Since 2003, NHS complaints advocacy services have been set up (first nationally, and now at a local level) to provide free and independent support to people who want to make an NHS complaint.

They play a vital role in helping people understand what they can and can't make a complaint about, and what kind of outcome they can expect. They also advise whether making a complaint is the correct route for an individual or if they should, for example, instead report serious concerns about an individual clinician to a professional regulator, such as the General Medical Council.

Advocates can speak up on the person's behalf if the person feels unable to deal with the service directly or needs support because of disabilities or communication needs.

Advocacy service support ranges from providing self-help guides and template letters to initial phone discussions or full support throughout the complaint.

Pressures on advocacy services

Our polling shows that **only 21% of people (11 out of 78 people) who sought help with making a complaint received it from an advocate**, suggesting that complaints advocacy services are often not well publicised or utilised.

Our desktop research also revealed that advocacy services face severe resource challenges, with more than a 20% real-terms decline in funding.

Independent advocacy services are funded through the annual Local Reform and Community Voice Grant to all 153 upper-tier local authorities. Since 2013, these councils have been responsible for commissioning a local NHS complaints advocacy service for people in their area.

Despite a growth in the number of people complaining about NHS services and clear indicators that healthcare access and quality may be deteriorating, the national allocation for advocacy of £15.11m has remained the same since 2019-20. Adjusted for inflation, these allocations represent a real-terms decrease of more than 20% as our table below shows .

Year	LRCV complaints allocation (cash terms)	LRCV complaints allocation (in April 2024 prices)	% change since base year (2015-16) in real terms
2015-16	£14,200,000	£18,953,008	0
2016-17	£14,410,000	£19,107,255	0.81%
2017-18	£14,620,000	£18,879,156	-0.39%
2018-19	£14,840,000	£18,699,854	-1.33%
2019-20	£15,110,000	£18,705,069	-1.31%
2020-21	£15,110,000	£18,547,296	-2.14%
2021-22	£15,110,000	£18,079,362	-4.61%
2022-23	£15,110,000	£16,571,585	-12.56%
2023-24	£15,110,000	£15,110,000	-20.28%

The national allocation for advocacy is provided via the Local Reform and Community Voices (LRCV) grant, allocated by the Department of Health and Social Care. This funding is not ringfenced at a local level. To understand how much local authorities have spent on advocacy services over the past five years, we submitted Freedom of Information requests to 151 local authorities.

In responses received from 114 councils, 41 gave us a specific figure on spending for NHS complaints advocacy. **In 2023-24, these 41 councils spent only, on average, £54,568 on a local service for an NHS complaints advocacy service**. This sum would fund a limited Independent Complaints Advocacy Service (ICAS) service of around two full-time-equivalent advocates, before any other running costs.

However, most local authorities who responded (57) gave only a figure for jointly funded contracts they commissioned that combined NHS complaints advocacy, other statutory advocacy services (such as Independent Mental Health Advocacy for people facing compulsory treatment in hospital) and/or statutory Healthwatch services.

A further 14 responses from councils were too ambiguous to be analysed.

While there may be simplicity for councils and economies of scale for providers in jointly commissioning different types of advocacy, a lack of transparency makes it challenging to determine if:

- All the money the Government allocates is being spent,
- The needs of varying advocacy services clients are being met, and if
- Taxpayers are getting good value for money.

Rationing of advocacy services

Our roundtables revealed that advocacy providers were responding to strained finances by avoiding active promotion of their service and rationing full support to more vulnerable clients, such as disabled people.

> "Money's been taken out of those services over the years. They're poorly funded services. Our city has a really diverse population, quite a lot need help to go through the complaints process to articulate themselves. People often really need somebody at [complaints resolution] meetings, but that's much less available now." -Roundtable participant

While rationing can be understood as a necessary response to the growing mismatch between how many people require support and the resources available, it also points to a lack of a consistent advocacy offer. This is also a hidden problem, as local authorities are not required to nationally report on how many people are supported by advocacy in their area each year, although they may share figures locally at statutory health and wellbeing boards or health oversight scrutiny committees.

A support service difficult to find and lacking oversight

We also heard that the advocacy provision market is increasingly complex, making it difficult for NHS organisations to keep providers' details up to date.

From 2003 to 2012, the Government commissioned a national Independent Complaints Advocacy Service (ICAS). ICAS was delivered by three providers throughout England, all of whom use the same branding.

However, when advocacy commissioning was transferred to local authorities in 2013, ICAS branding was no longer required, and contracts opened up to more organisations.

Today, there are dozens of advocacy providers, ranging from large organisations operating in multiple areas to small grassroots services that may have only a single contract. Some local Healthwatch providers have also been chosen to run complaints advocacy contracts as a companion to their main service. Contracts in some areas are frequently retendered, leading to a high provider turnover rate.

This situation can make it harder for patients to find an advocate. We heard that some NHS trusts do not provide details of NHS complaints advocacy to people raising concerns, or the information is incorrect.

There is no central online search tool for the public to find which organisation provides NHS complaints advocacy in their area. There is also no national body with the remit to support and promote best practices among advocacy providers. This is despite there being a precedent for this, with Healthwatch England supporting all 153 council-commissioned local Healthwatch services.

Recommendation two

The Department of Health and Social Care should set detailed and mandatory standards on NHS 'front-door' information to help the public better navigate the complaints process. Information should include:

- the named responsible staff member or department, contact details, and hours of operation
- statements that welcome complaints as a learning tool for the NHS
- options for giving feedback, raising concerns, or making a formal complaint
- your right to, and contact details for, statutory NHS complaints advocacy

- your right to make a complaint to your Integrated Care Board (as commissioner of the service) instead of the service directly, and contact details for the ICB
- your right to communication help if you have a sensory or learning disability
- contact details for your Healthwatch to share feedback with a body independent of the NHS.

Promotion of this information should include:

- A new section on the NHS App setting out complaints rights and the process
- Waiting room and reception posters and leaflets
- Information online

Recommendation three:

The Department of Health and Social Care should commission a comprehensive review into statutory NHS complaints advocacy, considering its visibility, funding, quality, and ability to reach those who need support.

This would be the first national review since local authorities took responsibility for commissioning advocacy services in 2013 and would help provide transparency over current arrangements, value for money and whether better national oversight or support is required.

3) Delayed or poor complaints handling

People are entitled to complain either directly to the provider or the commissioner of the NHS service where the poor care occurred. These 'responsible' bodies must handle complaints according to 2009 regulations.

Key obligations to you by NHS bodies that handle complaints

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 stipulate that NHS bodies must:

- Have a designated complaints manager.
- Accept your complaint, whether made verbally, in writing or electronically.
- Acknowledge your complaint within three days.
- Offer you an initial discussion about how the NHS will investigate your complaint and explain how long this is likely to take.
- Advise you where you can get help to make a complaint.
- Investigate your complaint in a way to 'resolve it speedily and efficiently'.
- Keep you updated about their progress and write to you if they don't complete the investigation within six months, with a likely finish date.
- Send you a written response on completion and tell you of your right to go to the PHSO if you're not satisfied.

Our evidence suggests that these bodies often fall short with this remit.

Main problems experienced by people

Our polling and roundtables reveal problems with the timeliness, empathy and overall response to complaints.

Delays in investigations and responses

In our polling, we found that **43% of people who had made a formal complaint about the poor care they had received had waited more than six months for the outcome of their complaint** at the time the polling took place.

Roundtable participants said it was one of the main concerns about the process reported to them by people making complaints.

"Our local acute trust now has said it's going to take 60 days to respond to a complaint when it used to be 40. But they've just recently taken 16 months to reply to a complaint, so the delays are just massive in the system." – Roundtable participant

"I need help and support with my complaint against the A&E department. I have been in touch with PALs, but they are struggling to get a response from senior members of their A&E team. It's been three months now, and I'm concerned they are kicking the can down the street, meanwhile memories will be getting less sharp." - Story shared by Healthwatch Gloucestershire

Current regulations state organisations must acknowledge the complaint within three days but don't prescribe maximum response times.

However, the regulations state that organisations must write to complainants if they have not responded within six months, and explain the reason why and when they might expect a response.

In our Freedom of Information requests, we inquired with all Integrated Care Boards about whether they have a target response time for complaints. Our aim was to determine how many of them have adopted the 40-working-day target since July 2023. This target is the same one used by NHS England when it previously managed primary care complaints, and it continues to apply to complaints about the specialised services it commissions.[20]

Of the 41 ICBs who responded, four told us they don't have a target response time. The remaining ICBs had a mix, with the most common being 25 or 40 working days. One set a target response time of 85 working days.

When we asked how they performed against these targets, 20 ICBs said they recorded this data, on average, ICBs responded to complaints in 54 working days, but there was a wide range of performance - from 18 to 114 working days.[21]

These waiting times vary from standards in other parts of the United Kingdom. In Wales[22] and Scotland,[23] NHS organisations are expected to resolve and respond

to informal concerns within 10 working days, or within 20 working days for 'stage 2 complaints'.

We heard mixed views from advocates and organisations about the appetite for new mandatory response times. Some people were worried about organisations 'working to the clock' at the expense of thorough and effective investigations. But others thought improvements in response times wouldn't happen without compulsory targets.

Previously, we have found support from the public for such targets. **More than half of the people (55%) we polled last year about a range of theoretical new patient rights, said they would want to have any formal NHS complaint they made investigated and responded to within 28 days.**[24]

A first step to improving the timeliness of responses would be transparency about the current average response times by all bodies and how many write to complainants if investigations exceed six months. This could help identify variations between all providers, different types of services, and ICBs and spur improvement in performance.

Confusion about complaints involving more than one organisation

Another concern raised in the roundtables related to people feeling like they were being passed from one organisation to another when their complaint related to care that involved a process across NHS or NHS and care boundaries – such as a GP referral to a hospital going missing, or a person being discharged from hospital without social care support in place or follow-up GP care.

> "The system feels very disjointed to a person who wants to complain. It's really difficult to identify when you've been using multiple services as to whom you're supposed to be complaining. You end up being passed on from service to service."." – Roundtable participant

Despite regulations making clear that organisations involved in multiple-provider complaints must agree on a lead organisation to coordinate the response and for all parties to share information, enabling a joined-up response, we heard that people are often told to contact each organisation individually.

Dismissive or ineffective responses

Our polling found that **more than half of people (56%) who had made a complaint were dissatisfied with the outcome**. Views shared with local Healthwatch suggest that people feel NHS organisations are highly defensive or lack empathy in their responses.

> "I would use the words they 'hedged their bets' and slid away from issues. They came out with an apology for how I felt rather than having dealt with the issues. There was an assumption made that I was wrong about some things which implied I was lying" – Story shared with Healthwatch Plymouth

> "It's very pointless making a complaint as it's brushed off, even in the event of damaging a patient's health, the hospital still brushes it off and takes so long to reply it makes it not worth it unless a patient is able to afford legal help to tackle the hospital's negligence." – Story shared with Healthwatch Wiltshire.

In our poll, we asked respondents who made a complaint to tell us what kind of outcome they received (see table, below). **The proportion of people in 2024 who said they received an apology (19%) was much lower than in 2014, when 49% said they received an apology**.[25] This is despite the PHSO's complaints standards urging NHS staff to 'give meaningful and sincere apologies and explanations that openly reflect the impact on the people concerned', if mistakes have occurred.

Organisations must also adhere to a 'Duty of Candour', which was introduced in 2014 to require full explanations and apologies to people in the event of serious safety incidents.[26] The government ordered a review into this duty last year, to explore 'failures to comply with the duty' and has yet to report on its findings.

People who made complaints told us the most common response was receiving a written or verbal explanation.

Complaint outcomes	Percentage
I'm still waiting on the outcome of my complaint	28%
I received a written or verbal explanation from the NHS about what happened	26%
I received a written or verbal apology from the NHS	19%
The NHS agreed to make changes to help prevent similar experiences in future	15%
The NHS said they didn't uphold my complaint	12%
The NHS agreed to speed up an action about my care	11%
The NHS offered to relook at my care	10%
The NHS agreed to issue a payment or refund of NHS charges related to my care (for example, dental charges)	6%
Don't know/can't remember	8%

During our roundtables, concerns were raised about the language used in complaint outcomes, such as whether the NHS judged a complaint as being 'upheld' or not.

> "You could change the language in terms of the outcomes of the responses. Why aren't we talking about 'learning points identified' or something like that? Why is somebody sitting and making a judgement about whether this complaint is valid or not?" - Roundtable participant

Challenges by setting

Alongside people's general problems with complaints handling, we heard about specific challenges related to the type of body that dealt with the concerns.

NHS trusts

Most of our roundtable participants said that NHS hospital trusts generally handled complaints better than primary care services like GPs or dentists, usually because they had a dedicated complaints team. However, this team's

function could sometimes be confused with the remit of Patient Advice and Liaison Services.

When the PALS and complaints teams are merged, the public may find it unclear when their issue is considered a 'concern' that can be resolved informally, and when it is classified as a 'complaint' that requires a full investigation according to the 2009 regulations.

> "Caller originally contacted PALS about delays to hospital cancer treatment. PALS tried to get a response from the relevant people and couldn't, so suggested the caller make a proper complaint to the hospital. The caller did this, and the hospital said it was their aim to respond by a date over three months after the original complaint.
>
> "[The patient] Told us they have followed up consistently via email and is getting nothing back at all. Caller said they feel powerless and completely stonewalled by the complaints process. Caller said PALS were initially really helpful and were chasing on their behalf, but more recently caller has copied them into emails and they haven't gotten back." – Story shared by Healthwatch Barnet

To establish how handling of patients' concerns is valued and resourced, we asked all NHS trusts, via Freedom of Information requests, how many full-time equivalent staff they allocated to PALS and complaints functions.

We sent a Freedom of Information request to 206 trusts, and 166 trusts provided us with some data.

Of the 127 trusts that provided data on their PALS budget for 2019-20 and 2023/4, average spending rose from £228,251 to £302,003, a modest real-terms increase.

On average, trusts had 5.36 FTE staff working in PALS in 2023-24 (compared with 4.8 in March 2019) and 4.4 FTE staff working on complaints in March 2024 (compared with 4.66 in March 2019).

Although both budgets and staffing numbers have increased, some advocates and local Healthwatch told us this is inadequate to deal with the volume and complexity of complaints and to meet the expected standards.

Primary care

Issues with primary care complaints stood out as a key concern in our roundtable discussions. Unlike in trusts – which have PALS or complaints teams working separately from front-line staff - in settings like GP surgeries complaints go directly through a practice manager, in close and regular contact with clinicians.

We heard that people may feel less confident that the investigation will be fair and balanced, putting people off making any complaints.

> "Patient submitted a complaint…regarding what he feels is discriminatory behaviour by a member of healthcare staff. He has since found out that the individual who the complaint against is investigating it. He does not see how this is fair or will result in an impartial outcome. He no longer wants the individual to be involved in his healthcare, but she seems to be the only one that supports patients with long term conditions." - Story shared by Healthwatch East Sussex

NHS figures show that 45% of dental practices and 120 GP practices (2%) that returned complaints data reported not receiving any complaints at all in 2023-4.[27] Stakeholders involved in healthcare regulation told us the absence of complaints is a potential red flag, suggesting the organisation does not promote or welcome complaints or people have difficulty navigating its process.

Integrated Care Boards

If people feel uncomfortable making a complaint directly to an NHS service, such as a GP surgery, they have the right to ask the service commissioner to handle it. In most cases, the ICB will be the commissioner. ICBs took over primary care complaints handling from NHS England in July 2023.

However, our research shows that not all ICBs appear to fully understand or meet their duties under the complaints regulations. **One ICB told us that it did not 'have a complaints handling function of its own'** and instead facilitates contact

between residents and providers to manage the process, in response to our Freedom of Information request. Another six ICBs said in their responses that they referred complaints back to providers or required people to go to their provider first before getting involved.

Analysis of publicly available data also shows that last year, two ICBs submitted no primary care complaints data to NHS England.[28] A further six reported they had received less than 30 complaints related to their role as a commissioner of primary care services.[29]

Like NHS trusts, ICBs do not appear to devote significant resources to complaint handling. Of those ICBs which shared financial data with us, £258,151 was the average amount spent on complaints handling.

On average, these ICBs spent just over 1% of their running cost allowance on complaints handling[30]. ICBs employed an average of 5.0 full-time equivalent staff to handle complaints.

In 2023, NHS England set out an expectation that ICBs reduce their core running costs by at least 30% in real terms by 2025/6. There is a risk that complaints handling, and patient experience budgets are further squeezed because of this change.[31]

In addition, we found that just over half of all ICBs (22) delegated their primary care complaints handling function to a complaints hub run by another ICB. For example, in the East Midlands, all primary care complaints are managed by Nottingham and Nottinghamshire ICB. In the South East, they are handled by Frimley ICB. In the South West, Somerset ICB takes care of these complaints, while Birmingham and Solihull ICB oversees them in the West Midlands.

This might make sense from a resource perspective, but it requires even better information for the public to understand which body to contact. It may leave complainants feeling detached from what they had thought would be a localised process.

> "The ICS themselves outsourcing their complaint services means that there's kind of just a lack of understanding and appreciation of what local people are facing. And again, there seems to be a lack of sharing

sort of learning opportunities from complaints because they're outsourcing." - Roundtable participant

The Parliamentary and Health Service Ombudsman (PHSO)

As the final stage in the complaints process, the PHSO offers people the opportunity for a neutral body to investigate the complaint if the person is dissatisfied with how it was handled initially.

Roundtable participants raised concerns about inconsistency between NHS organisations and the PHSO over how soon people should submit a complaint. The 2009 regulations state that this should normally be within 12 months of the incident, or later if the complainant only became aware of the issue then. Some organisations will also use discretion to accept later complaints if the incident led to a bereavement, harm or illness that has delayed the person going through the process.

However, **NHS complaints advocates described cases of the PHSO not accepting final-stage complaints more than 12 months after the incident happened, even if there were delays by the local NHS body**.

Advocates also raised concerns about long waiting times at the PHSO. These are confirmed by the Ombudsman's website, which states 'current wait times are up to seven months for complaints about the NHS'.[32]

Efforts to improve complaints handling

In response to previous reports, the PHSO, NHSE and others have taken steps to improve the process.

According to its latest annual report, the PHSO has trained 563 NHS staff, to date, from more than 150 different organisations on its model complaints standards. The PHSO is also trying to mitigate delays by only accepting the 'most serious complaints' and using alternatives to full investigations, such as mediation. The PHSO adds that it also has the discretion to waive the 12-month limit if there are delays at a local level.

On dental complaints, NHS England's chief dental officer's team worked with Healthwatch England and other bodies last year to audit information in the public domain about how to make complaints. This found inconsistencies or missing information in the material publicised by different bodies, and work is

underway to agree on standard wording for the public that is used at dental practices, by ICBs and NHS organisations, and online.

However, overall, there is little evidence of systematic monitoring of complaint handling. No national data is collected on key performance indicators that might suggest poor handling by either providers or commissioners – such as the number of outstanding complaints after six months or the number accepted for investigation by the PHSO when people are dissatisfied with local resolution.

The failure of a minority of ICBs to accept their responsibility, under the 2009 regulations, to handle complaints submitted by the public as commissioners of those services is also concerning. ICBs also hold a general oversight role on the performance of all providers in their area, but will be unable to set an example to assure themselves of good complaints handling at GP surgeries and other organisations, if they do not themselves handle complaints well.

There is also a lack of transparency over the timeliness of complaints responses and more efforts are required to train more staff on better handling, especially in primary care.

Recommendation four:

DHSC should set mandatory response times for complaints (as is done in other parts of the UK), following a baseline exercise by NHSE to establish current average response times at all providers and ICBs, and considering whether differing times should apply depending on complexity.

Recommendation six:

NHS England should require all NHS bodies to report on new performance indicators for handling complaints. These should include the number of complaints re-opened after initial resolution and the number of complaints referred to the Parliamentary and Health Service Ombudsman.

Recommendation seven:

NHS England should carry out a performance audit on ICB compliance with the 2009 complaints handling regulations to gain assurance that ICBs are promoting the process correctly to the public and meeting their duties to investigate complaints.

4) A lack of learning & insight on complaints

In addition to navigation and handling problems, there is concern that the NHS does not seem systematically or culturally geared towards learning from issues raised by patients.

At the local level, this culture leaves people feeling providers are just 'processing' complaints, rather than analysing what these concerns reveal about services so they know where to target improvements:

> "Our hospital trust's approach to complaints is really transactional. They have one target which they've set themselves: have they responded to 75% of complaints within 25 days? It doesn't matter how they've responded. Therefore, all the reporting within the organisation is related to the process. Not around the outcomes and learning." - Roundtable participant

For others, the procedures feel inherently unfair because they see them as allowing the NHS to 'mark its own homework':

> "They are investigating themselves, so how can that be impartial when the person that you've complained about is the actual person that's doing the complaint? So it's not really until it gets to the Ombudsman that you can then say, well, actually you're now going to get an independent review." - Roundtable participant

People are also unsure where true accountability lies in checking whether providers have implemented what they promised in their responses to complainants.

There should be more openness and transparency about the learning. That's one of the biggest things that people say to us. 'Well, I see that you're going to do this and you're going to do that, but who's going to follow it up? Who's going to be looking at that in the six months' time?' Even when the Ombudsman says [to providers] 'you need to do this, this and this'. There's nobody coming behind the Ombudsman and saying in six months' time, did you do that [checking to ensure the provider acted]?" -Roundtable participant

A confusing landscape of guidance and oversight

Central to these problems is a landscape of multiple bodies holding various or overlapping responsibilities on complaints.

For example, the expectations on trusts to learn from complaints, are described in varied ways by different bodies, including:

- Legal regulations overseen by DHSC. These require trusts to provide annual complaints' reports, containing numbers and themes of complaints. Reports should also summarise 'any matters where action has been or is to be taken to improve services as a consequence of those complaints'.
- CQC guidance on its legal remit to check providers' complaints handling. This states that 'providers should monitor complaints over time, looking for trends and areas of risk that may be addressed' and 'maintain a record of all complaints, outcomes and actions taken in response to complaints'.
- The PHSO's national complaints standards. These call for trusts to 'have appropriate governance structures in place so that senior staff regularly review information that arises from complaints and are held accountable for using the learning to improve services'.
- An NHSE toolkit (produced in 2015 before the introduction of Integrated Care Boards). This encourages (but does not mandate) providers to reference complaints learning in board reports, to survey complainants about the experience of going through the process, to publicise learning to patients and to share anonymised patient stories with commissioners so they can be disseminated more widely for learning.[33]

However, the regulations on annual complaints reports state that they only need to be available 'on request'. Local Healthwatch staff told us that such reports are either not routinely published by NHS trusts or contain only numbers of complaints received and few examples of learning. **As little as 12% of trusts were meeting their statutory reporting obligations on complaints**, according to an analysis of the information at 149 NHS trusts, carried out by us in 2020.[34] **Just under 40% were publishing any learning from complaints**. In most cases, this was high-level descriptions of non-specific 'improvements made'.

PHSO standards urge trusts to have appropriate governance over complaints, but these standards are not mandatory and the Ombudsman doesn't have a remit to monitor and enforce compliance. While the PHSO would like the standards to be compulsory, it is not seeking the same powers as a complaints standards authority that ombudsman services have in Scotland and Wales. The PHSO believes responsibility for compliance of standards would be best placed with a health regulator, such as the CQC.

However, **CQC assessments of providers do not examine whether they are meeting regulation 16, on complaints handling, in every case**.

When this CQC regulation came into effect in 2014, the CQC said in its report, Complaints Matter, 'all our new inspection reports will describe complaints handling'.[35] During inspections, it said it would review a sample of complaints, talk to patients about complaints handling and gather intelligence from bodies such as the PHSO, local authorities, Healthwatch and NHS complaints advocacy services.

However, the CQC's shift from inspections to a new single assessment framework in 2022 has changed how often complaints handling is checked. Under the new framework, CQC teams can choose from 34 quality statements to check how providers deliver safe, effective, caring, responsive and well-led services.[36]

Only one of the 34 quality statements specifically references complaints handling, and this statement was considered in only 13% of all assessments carried out between 4 December 2023 and 30 July 2024, according to an analysis of figures published as part of the independent review of the CQC.

The regulator says CQC regulation 17, on good governance, and other quality standards may also lead to assessments looking at complaints. It is currently reviewing its single assessment framework as part of improvements to its

regulatory approach and expects to undertake extensive internal and external engagement to inform further changes.

Meanwhile, NHSE does not explicitly examine complaints handling when it assesses the performance of ICBs in annual assessments, according to the NHSE Oversight Framework,[37] and it is unclear how ICBs are monitoring complaint handling by providers.

Problems with regulation, oversight, and the NHS culture on learning from mistakes persist, according to recent opinions expressed by barrister Sir Robert Francis KC, a former chair of Healthwatch England. He has recently stated that many of the changes he recommended to the complaints process in 2013, as chair of the Mid-Staffordshire public inquiry, have not been implemented.

Sir Robert said it was still common for people to experience 'silence' and delays in responses to complaints. He added that the transparency of learning from complaints also fell short: minimum reporting requirements didn't provide "sufficient detail for the outsider to understand what the problems are in a particular trust and that tends to be because the shield of confidentiality is abused" by providers avoided publishing anonymised case studies on complaints and how they'd dealt with them.

> "...I believe there is a public interest in knowing as much as you can properly put into the public domain about a complaint and... most of the time you will be able to do that without identifying either the patient or the members of staff involved.....because that's the most important thing, not that there has been a complaint, it is what has been done to make sure it doesn't happen again". -Sir Robert Francis KC, former chair of the mid-Staffordshire Public Inquiry and former chair, Healthwatch England

Further culture change, more detailed regulations, better transparency, and leadership are required to embed complaints as a valuable learning tool across the NHS, and provide assurance to the public, commissioners, and government.

Recommendation eight:

DHSC should strengthen regulations that require NHS bodies to compile and make annual complaints reports available on request, to make publication of these reports mandatory.

Recommendation nine:

DHSC should require providers to demonstrate better learning from complaints through more detailed annual complaints reports that include case studies and complainant surveys, any changes to service delivery, policies or staff training, and any escalations to national safety bodies or regulators, as well as better demographic and response time data.

Recommendation ten:

DHSC should make the PHSO's NHS Complaints Standards mandatory, clarify which body should lead on monitoring and enforcing these, identify NHS staff training gaps, and champion the value of complaints.

Recommendation eleven:

NHSE should assess ICBs' complaints handling in ICB annual assessments. This should be enabled through amendments to the NHS Oversight Framework, which should require ICBs to demonstrate good handling and learning of complaints received by them, as well as how they monitor and seek to improve complaints handling by local providers.

Recommendation twelve:

The Care Quality Commission should enhance the regulation of how providers handle complaints by assessing this aspect during each new and

full assessment. Particular attention should be given to compliance with Regulation 16 in primary care. Additionally, the Commission should summarise best practices and any issues related to complaints handling identified during assessments in its annual State of Care report.

5) Conclusions and recommendations

Our research has highlighted the structural and cultural gaps in the NHS complaints process and how these affect people's confidence in raising concerns or making complaints if they experience poor care.

Below, we summarise the key features required to deliver a truly people-centred complaints process and our recommendations for change would enable this.

We hope that all those responsible for safe, high-quality healthcare – from the Secretary of State for Health and Social Care down to individual practice managers – will use our findings to address persistent failings we have seen despite multiple public inquiries.

The upcoming 10-year Health Plan and independent review into patient safety offer opportunities to embed a culture of listening. We must treat feedback, concerns and complaints as – in the words of Sir Robert Francis KC - 'gold nuggets' that drive improvements to care.

Delivering a patient-centred complaints process

Key features	Current requirements	Gaps	Summary of recommendations (*indicates would require legal changes)
Understanding who makes complaints and who feels confident or able to do so.	Age of complainant and status (e.g. patient, relative or carer) must be submitted annually by trusts, GP surgeries and dental practices, and ICBs, for publication by NHS England.	Gender, ethnicity, disability and other protected characteristics of complainants are not mandated to be collected or published.	1. NHS England should require NHS bodies to collect wider demographic data about complainants to understand trends and identify any inequalities in who feels able to raise concerns about poor care.*
Public awareness and knowledge of how to navigate the process.	NHS bodies must publicise the process and provide information on how to get assistance with making a complaint, according to the regulations.	Variable, inconsistent or lack of any information on NHS websites, in reception or waiting rooms, or on the NHS App.	2. DHSC should set detailed and mandatory standards on NHS 'front-door' information (including on the NHS App) to help the public better navigate the complaints process.*
People can get independent support from statutory NHS complaints advocates if needed.	Local authorities must commission a local NHS complaints advocacy service to provide free support to people.	Little transparency over funding of advocacy services and total people supported. Variable promotion and no national database of all advocacy services.	3. DHSC should commission a comprehensive review into statutory NHS complaints advocacy that considers their visibility, funding, quality and ability to reach those that need support.

Key features	Current requirements	Gaps	Summary of recommendations (*indicates would require legal changes)
		No national body for advocacy.	
Timely complaints responses.	NHS organisations must acknowledge a complaint within three days, offer a discussion on the likely timeframe and write to complainants if they have not responded within six months, to say why and when the response is due.	No data on the number of complaints acknowledged within three days or still open at six months. No data on any average target response times set by individual NHS bodies or actual response times achieved.	4. DHSC should set mandatory response times for complaints following a baseline exercise on current average response times at all providers and ICBs.*
Effective complaints handling and responses.	NHS bodies must 'efficiently' and 'properly' investigate complaints, treat complainants with 'respect and courtesy' and keep them informed of progress. Commissioners of services must accept and handle complaints from people who choose not to make a complaint directly to the service.	No requirement on NHS bodies to systematically seek and publish information on complainants' satisfaction with the process. No mandatory metrics for NHS bodies on the quality of complaints handling. A minority of ICBs aren't handling	5. NHS bodies should carry out post-complaint surveys of complainants to measure their satisfaction with the process and outcome. 6. NHS England should require all NHS bodies to report on new performance indicators of complaint handling, such as the number of complaints referred to the Parliamentary and Health Service Ombudsman.

Key features	Current requirements	Gaps	Summary of recommendations (*indicates would require legal changes)
		complaints as commissioners or promoting this option to the public.	7. NHS England should carry out a performance audit on ICB compliance with the 2009 complaints handling regulations to gain assurance that ICBs are promoting the process correctly to the public and meeting their duties to investigate complaints.
The NHS learns from complaints, and demonstrates this learning to patients, the public, commissioners and the government.	Trusts must provide annual complaint reports 'on request', containing numbers and themes of complaints and summaries of any action to improve services. Providers should track complaints' trends over time, address any risks and record their actions. Trusts should 'have appropriate governance' so senior staff 'are held accountable for using the learning to improve services'.	Little evidence of regular publication of annual complaints reports. Complaints reports are of variable quality, sometimes with limited information. The CQC does not check complaints handling at every assessment of providers. PHSO standards on complaint handling are not mandatory.	8. DHSC should strengthen regulations to require NHS bodies to publish their annual complaints reports, and not just 'on request' as currently. 9. DHSC should require providers to better demonstrate learning from complaints through more detailed annual complaints reports. 10. DHSC should make the PHSO's NHS Complaints Standards mandatory, clarifying which body should lead on monitoring and enforcing these.* 11. NHSE should assess ICBs' complaints handling in ICB annual assessments.

Key features	Current requirements	Gaps	Summary of recommendations (*indicates would require legal changes)
			12. The CQC should improve regulation of providers' complaints' handling responsibilities by checking this at every new and full assessment.

Endnotes

[1] Suffering in Silence, Healthwatch England, 2014.
[2] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary, www.gov.uk, 2013.
[3] Data on written complaints in the NHS, 2023-24, NHS Digital, 2024.
[4] NHS Complaints Standards: Summary of Expectations, Parliamentary and Health Service Ombudsman, December 2022.
[5] Independent Investigation of the NHS in England, Lord Ara Darzi, 2024.
[6] Ockenden review: summary of findings, conclusions and essential actions, Department of Health and Social Care, 2022.
[7] Review into the operational effectiveness of the Care Quality Commission, Dr Penelope Dash, 2024.
[8] Review of patient safety across the health and care landscape: terms of reference, DHSC, 2024.
[9] Part 1 of polling by YouGov for Healthwatch England, 2024.
[10] Part 2 of polling by YouGov for Healthwatch England, 2024.
[11] The NHS Constitution for England, Department of Health and Social Care.
[12] Calculated based on UK Census 2021 figures for number of adults aged 18 or over living in England.
[13] 2014 poll of 1,676 adults conducted for Healthwatch England by YouGov asked about poor NHS or social care experienced in past two years. 12% said they had personally experienced poor care, a further 18% had witnessed poor care in a relative or friend, giving a net poor experience of 28%.
[14] 2024 base for action taken: 2650 adults. Question was: You mentioned that you had a poor experience of NHS healthcare in the last year. What action, if any, did you take as a result of the poor care you experienced? Please select all that apply.
2014 base for action taken: 461 adults. You mentioned that in the past two years (i.e. since mid-August 2012), you have experienced poor care, or witnessed a relative, friend or partner receiving poor care from a health or social care service…Did you make a complaint about the poor care that you experienced, or witnessed? (Please select the option that BEST applies). 13% stated that they had made a complaint on more than one occasion in the last 2 years and 26% said they had done so on one occasion in the last two years.
[15] 2014 base for reasons why people didn't make a complaint: 311 adults. Question asked: "For the following question, if you have experienced poor care, or witnessed a relative, friend or partner receiving poor care from a health or social care service more than once in the past two years, please think about the most recent example…Which, if any, of the following are reasons why you did not make a complaint?"(Please select all that apply). 2024 base for reasons why people didn't make a complaint: 2420 adults. Question asked: "Why didn't you choose to make a formal complaint about the poor care you received? Please select all that apply.
[16] Regulation 16: Receiving and acting on complaints, Care Quality Commission.
[17] The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 .
[18] Health and Social Care Act 2008 (Regulated activities) Regulations 2014: Regulation 16, www.cqc.co.uk.
[19] [19] NHS Complaints Standards: Summary of Expectations, Parliamentary and Health Service Ombudsman, December 2022.
[20] NHS England complaints policy, NHS England, 2024.
[21] ICBs presented data on average response times in both working days and calendar days. Healthwatch England converted calendar day calculations into working days by multiplying calendar days by 250/366 (0.685) to reflect the percentage of working days in the year 2023/4.
[22] Complaints Standards Authority – Wales Guidance for Public Service Providers on Implementing the Concerns and Complaints Policy, Public Services Ombudsman for Wales

[23] The NHS Scotland Public Facing Model Complaints Handling Procedure, Scottish Public Services Ombudsman.
[24] Looking beyond the NHS Constitution to a meaningful Patient Promise, Healthwatch England, 2024
[25] Base for 2024 questions on outcome of complaint, satisfaction with outcome and overall experience: 229 people who had made a formal complaint. 2024 outcome of complaint question was worded: What was the outcome of your complaint? Please select all that apply.
Base for 2014 question on outcome of complaint: 182 All English Adults who have experienced poor care, or witnessed their relative, friend or partner receiving poor care from a health or social care service in the past two years and have made a complaint.
2014 question on outcome of complaint: Still thinking about the most recent complaint you have made about poor care from a health or social care service in the past 2 years… To what extent do you agree or disagree with each of the following statements? (Please select one option on each row) I received an apology. Answer is Net: All Agree.
[26] Regulation 20, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, legislation.gov.uk.
[27] Data on written complaints in the NHS, 2023-24, NHS Digital, 2024
[28] Data on written complaints in the NHS, 2023-24, NHS Digital, 2024
[29] Data on written complaints in the NHS, 2023-24, NHS Digital, 2024
[30] Calculation based on analysis of FOI data and NHS England, Running Cost Allowance, 2023/4 to 2025/6, 2023.
[31] NHS England, Integrated care board running cost allowances: efficiency requirements, 2023.
[32] https://www.ombudsman.org.uk/service-update, accessed 13 January 2025.
[33] Assurance of Good Complaints Handling for Acute and Community Care – A toolkit for commissioners, NHS England, 2015.
[34] Shifting the mindset: A closer look at hospital complaints, Healthwatch England, 2020
[35] Complaints Matter, Care Quality Commission, 2014.
[36] Assessment framework, Care Quality Commission, (guidance, last updated 2025).
[37] NHS Oversight Framework, NHS England, 2022.

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