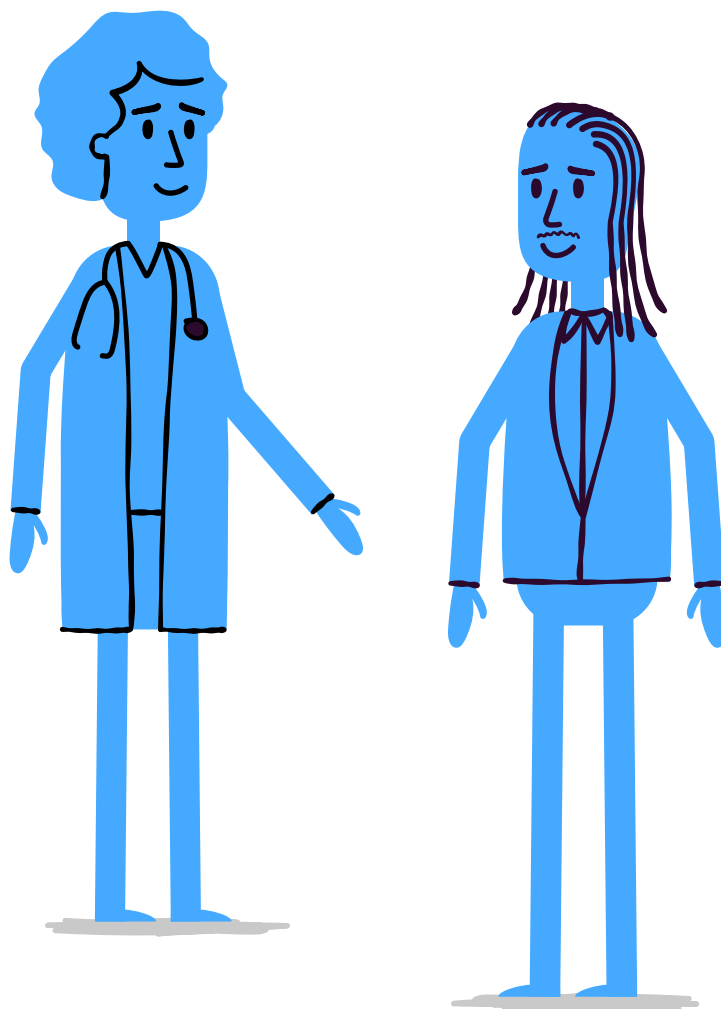
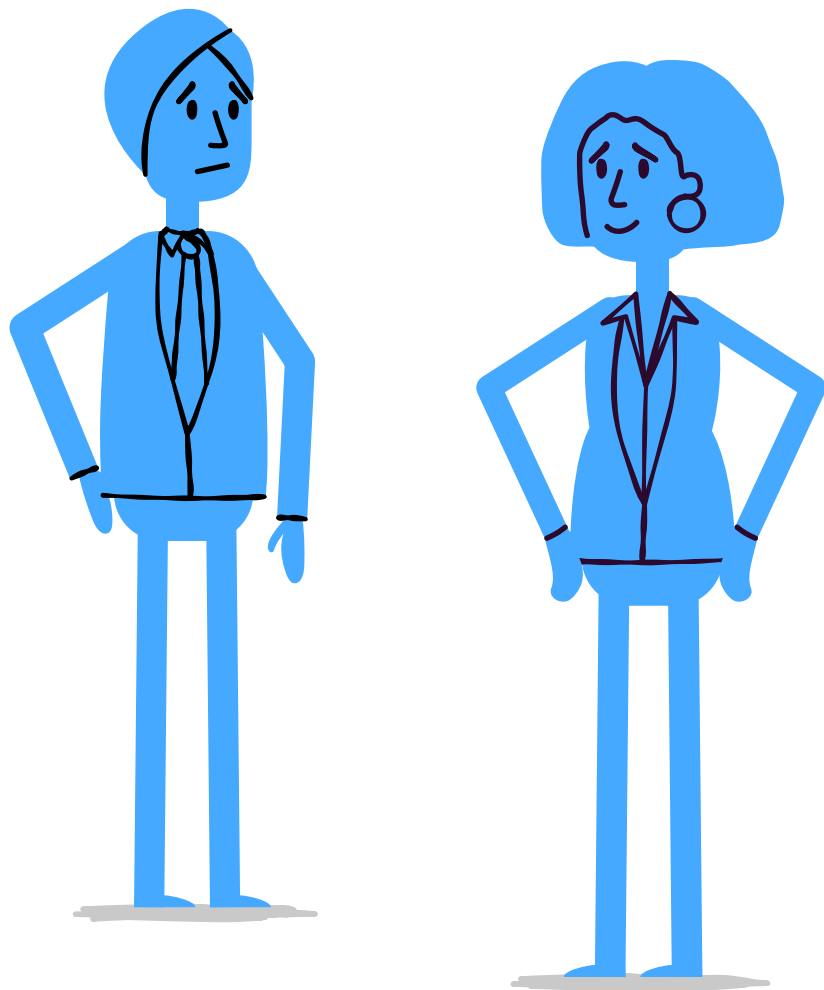


# Complaints about multiple service areas or organisations



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# Welcome to this guide

This guide is one of the Good Complaint Handling series. These are designed to help you implement and deliver the expectations in the [NHS Complaint Standards](#).

This guide will help you understand:

- the different types of support available to people who make a complaint about their (or another person's) NHS care and treatment, including:
  - an independent NHS Complaints Advocacy service
  - specialist independent advice and support services
- the aims of these different services and when and how to signpost people to them
- the value of involving an advocate or specialist advice service and how they can help people who are faced with difficult decisions – particularly where there are other processes that may be an alternative to, or run in parallel with, a complaint.

Read this guide alongside the [Model Complaint Handling Procedure](#). You can find guides on related topics on our [website](#).

# What standards and regulations are relevant to this guide?

- The **Complaints Standards** set out expectations to help you deliver good complaint handling in your organisation.
- The **Local Authority Social Services and National Health Service Complaints (England) Regulations 2009** set out what the law says you must do.
- Other relevant guidance includes **Care Quality Commission guidance of duty of candour** and NHS England's **Serious Incident Framework**.

## What the Complaint Standards say

### Positively welcoming complaints

Organisations make sure people know how to access advice and support to make a complaint, including giving details of appropriate independent complaints advocacy and advice providers, any Patient Advice and Liaison Service (PALs), and other support networks.

Organisations make sure staff are able to identify when issues raised in a complaint are likely to be addressed (or are being addressed) via another route, so a co-ordinated approach can be taken. Other possible routes include inquest processes, a local disciplinary process, legal claims or referrals to regulators. Staff know when and how to seek guidance and support from colleagues and are able to provide people with information on where they can get support.

### What the Local Authority Social Services and National Health Service Complaint (England) Regulations 2009 (regulation 3) say

Your organisation 'must make arrangements ... for the handling and consideration of complaints.' The arrangements must ensure that: ... 'complainants are treated with respect and courtesy' ... that they receive 'so far as is reasonably practical – assistance to enable them to understand the procedure ... or advice on where they may obtain such assistance'.

### What other guidance says

#### Duty of candour

The Care Quality Commission's guidance on the duty of candour says that organisations should give people going through the procedure information about 'available impartial advocacy and support services, their local Healthwatch and other relevant support groups, for example Cruse Bereavement Services and Action against Medical Accidents (AvMA).'

#### Serious incident investigations

NHS England's [Serious Incident Framework](#) recommends that organisations should make patients or families involved in investigations aware of sources of independent advice and advocacy, including the national charity Action against Medical Accidents (AvMA).

# What you need to do

This section sets out two different types of advocacy available to your service users or their families or representatives:

- the Independent NHS Complaints Advocacy Service
- specialist independent advice and support.

## The Independent NHS Complaints Advocacy Service

The Independent NHS Complaints Advocacy Service is a free, independent, impartial service funded by local authorities. It is designed to guide anyone wanting to complain about their (or another person's) NHS care and treatment through the process of complaining to the appropriate NHS organisation.

Everyone in your organisation who has a public-facing role needs to be aware of who your local Independent NHS Complaints Advocacy provider is. That way, they can quickly signpost anyone who wants to make a complaint to help and support, if they need it. If you're not sure who your provider is, check with your local authority or Healthwatch.



Try to establish a relationship with your local Independent NHS Complaints Advocacy Service team. It is a valuable source of information about the needs of your service users and the local population.

They can also help you understand what their service offers, as services can vary from area to area. This will help you:



make sure you provide correct information about the advocacy service to anyone wanting to make a complaint



refer people who want to make a complaint for advocacy support directly, where appropriate



secure early resolution of complaints by making sure people making a complaint are guided through the process and fully understand their options



help people who want to make a complaint to access advocacy rapidly, so they are supported as early in the process as possible.



shape local arrangements for advocacy, including working with commissioners.



### **Tips: Share details**

- Share the advocacy service's contact details in posters and information leaflets about your own complaints service.
  - Also share leaflets about the service, or links to the service, in your letters. This makes it clear that the service is independent and separate from your organisation.
  - Independent NHS Complaints Advocacy providers can also signpost and cross-refer to other helpful advocacy and specialist support services.
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The Independent NHS Complaints Advocacy Service can support anyone who needs to navigate the complaints process. There are no specific eligibility criteria. Wherever possible, they will facilitate self-advocacy in line with the empowering model of advocacy.

Most advocates with the Independent NHS Complaints Advocacy service have the relevant advocacy qualification, and all are required to work in line with the Advocacy CharterC. This ensures that they have a full understanding of the NHS complaints process.

They are also trained to support people with specific needs or protected characteristics and are able to work alongside other organisations where needed.

### **Why involve advocates in the process?**

An independent advocate with the NHS Complaints Advocacy service can provide support at any stage of a complaint, including at the very beginning. If they are involved early, it is more likely that the complaint is productive and easy to understand.

The advocate will also:

- make sure that the complaint is directed to the right part of the NHS (this can sometimes be difficult to identify)
  - explain the NHS complaint journey to the person making the complaint and help them understand what you are doing to investigate
  - act as mediator between the person making the complaint and you
  - support them until the process is finished, including support with the Parliamentary and Health Services Ombudsman (PHSO) procedures if needed.
- 



**Tip:** Some organisations also enlist advocacy organisations to provide independent facilitation to their patient experience and patient participation groups.

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## Specialist independent advice and support

When someone complains, they may be faced with difficult decisions – particularly if there are other processes that may offer an alternative to a complaint or could run alongside it. This is common if the incident that gave rise to the complaint involves suspected avoidable harm or complex clinical issues.



When someone makes a complaint about this type of situation, make sure you recognise their wider needs. They may need more specialist independent advice and support.

Complaints in which people may benefit from more specialist independent advice services include those where:

- if harm has occurred and there is a need for an independent view on the clinical aspects
- if litigation is being considered or has started
- if there will be an inquest (or the family wants one)
- if there has been a patient safety incident, so the organisation must put the duty of candour or a serious incident investigation in motion
- if the person making the complaint wants the organisation to investigate potential fitness-to-practice issues involving health professionals
- if the person making the complaint wants to raise patient safety concerns to regulators or commissioners of services
- if there are concerns about private treatment that is believed to have caused harm.

As well as providing details of the local advocacy provider you may need to signpost to further support. For example:

**If the complaint has any of the features listed above** provide the details of the national charity [Action against Medical Accidents \(AvMA\)](#).

**If someone has experienced trauma or bereavement**, they may also need counselling or mental health support, arranged either by your organisation or sourced independently.

**If someone is facing financial hardship** they may also need practical advice on benefits or other financial matters, as well as support with their complaint.



You need to provide details of how people can access all these forms of support.

# Case studies

## Case study 1: The value of involving advocacy and advice services

### What was the complaint about?

Josephine\* died in hospital because of a nosebleed, which caused choking. Her daughter, Shelley\*, made a complaint because she felt that her mother's treatment had been inappropriate.

Shelley was not informed about advocacy until she received the response to her complaint. Information about advocacy was provided at the end of the letter, and incorrectly signposted her to the previous service provider. The complaint response letter did not answer all the points Shelley had raised, and she and the family felt ongoing distress about the way Josephine had died.

### How did the advocate help?

Having seen the organisation on television, Shelley got in touch with Action against Medical Accidents (AvMA). The organisation explained its role and her various options, and she realised that litigation was not a route the family wanted to take. AvMA signposted Shelley to her local provider explained how they could help.

Shelley and her local advocate worked together to raise her outstanding concerns with the hospital. The advocate helped Shelley identify what she wanted to happen as a result of the complaint, and to articulate her views to the consultant in charge of her mother's care.

### What was the outcome?

A full investigation was carried out, resulting in the case being referred to the Nursing and Midwifery Council and a fitness-to-practice investigation. The advocate also signposted Shelley to the local bereavement support service, to address her feelings of guilt about the way her mother had died.

Advocacy empowered Shelley and her family to navigate a complicated process and to reach a resolution that gave them the closure they needed on a very distressing process.



## What are the lessons from this case study?



When anyone wants to make a complaint, signpost them to their local NHS Complaints Advocacy service as early as possible.



Where harm or death has taken place, make the person aware of specialist advice and advocacy services such as Action against Medical Accidents (AvMA).



If someone who is making a complaint appears distressed, consider signposting to a local or national counselling or specialist mental health support service.



All advocacy and specialist advice providers are equipped to signpost and cross-refer to each other.

\*Not their real names

## Case study 2: The value of involving advocacy and advice services

### What was the complaint about?

Ravi\* wanted to make a complaint when his treatment was stopped after a clinical consultant said he had been verbally aggressive. Ravi has a diagnosis of paranoid schizophrenia. He also has a learning disability that prevents him from being able to read and write.

### How did specialist support help?

The trust signposted Ravi to his local advocacy provider. With the advocate's support, Ravi submitted a letter of complaint and was offered a local resolution meeting (LRM) within a short period of time.

On the day, Ravi and his advocate were called into the meeting room and introduced to the staff members present. Because Ravi cannot read or write, his advocate asked for the meeting to be recorded so it was accessible to him. The trust agreed. Ravi was able to get all his points across during the meeting and felt listened to.

### What was the outcome?

A long time had passed since Ravi's last appointment. Appointments of this nature can take months – and sometimes, years – to get. However, following the meeting, he was given an emergency appointment in a fortnight's time. Ravi was very happy and considered this a great result.

He disclosed that the meeting had given him a purpose to leave the house, and that it was only the second time he had done so in six months. If the meeting had been delayed, this would have been detrimental to his overall mental and physical wellbeing. If Ravi had attended without the advocate, he may have become frustrated and unable to communicate his concerns and what impact the situation had on him.

## What are the lessons from this case study?



When someone makes a complaint, signpost them to the correct advocacy provider at the start of the process.



Advocate support can enable someone to articulate their feelings and wishes more clearly and effectively, despite communication difficulties.



Preparing a focused complaint letter can provoke a swift response to the client's needs and enable the organisation to deal more quickly with the complaint. In Ravi's case, this resulted in a positive outcome and avoided further missed treatment and a prolonged complaint process.

\*Not his real name

## Case study 3: The value of involving advocacy and advice services

### What was the complaint about?

Darius\* attended the Accident & Emergency department following a cycling accident. He was discharged with suspected bruised ribs but died that evening at home from a bleeding spleen.

Darius's parents were told what had happened. They had concerns about the treatment he had received but were unsure what to do or whether they wanted to make a complaint. They discussed this with the hospital, and staff gave them the AvMA leaflet on the duty of candour. Because it seemed that its actions may have resulted in their son's death, the hospital launched an investigation under the duty of candour regulations.

### How did specialist support help?

Darius's parents contacted AvMA, which assigned them a caseworker to support them at a meeting to discuss the duty of candour investigation. The trust explained what had happened, to the best of its knowledge, and promised to share the results of the investigation when it was completed.

After discussion with the parents, the caseworker asked if they had informed the coroner about the death and it transpired they had not. The trust did this and the coroner decided to hold an inquest.

Initially, the trust thought that it could not share its investigation report with Darius's parents until after the inquest was held. However, after talking to their caseworker, the parents challenged this and the trust agreed to share the report with the family as soon as it was ready.

### **What was the outcome?**

The caseworker reviewed the investigation report with the parents. AvMA recommended that the parents should have legal representation at the inquest and arranged for a barrister to attend on a pro bono basis. The inquest concluded with a 'prevention of future deaths' letter being issued to the trust.

The family decided not to take legal action or make a formal complaint but remained concerned about the actions of one doctor in particular. The AvMA caseworker helped them make a referral to the GMC, which agreed to investigate.

### **What are the lessons from this case study?**



Organisations need to take concerns seriously, whether or not a complaint is made.



Making patients and families aware of specialist independent advice services such as AvMA can help them play an active role in investigations and inform decisions about which processes to follow.



Involving an advice service can help an organisation to manage a difficult situation appropriately. This can help the person complaining to feel that a fair process was followed, which may avoid their need to make a complaint or take legal action.

\*Not his real name

# Practical tools

When to refer and who to: Advocacy, Advice & Support Overview (see below).

## Useful contacts:

### Independent NHS Complaints Advocacy

Organisation commissioned by local authorities. To find your local service, search online for 'local authority + NHS complaints advocacy' or contact your local Healthwatch.

### Action against Medical Accidents (AvMA)

Independent charity providing specialist advice on clinical complaints involving harm, patient safety investigations, fitness to practise referrals, inquests, private healthcare complaints and legal action, including referral to specialist solicitors where appropriate.

Website: [www.avma.org.uk](http://www.avma.org.uk)

Helpline: 0845 123 2352 (Mon-Fri 10am-3.30pm)

### The Patients Association

Charity for all patients, regardless of health condition. The helpline offers free, confidential information and signposting about the complaints process, while the website provides information leaflets on topics including how to complain.

Helpline: 0800 3457115 or [helpline@patients-association.org.uk](mailto:helpline@patients-association.org.uk)



#### Find out more

See The duty of candour and what it means for patients and their families  
[www.avma.org.uk/wp-content/uploads/Duty-of-candour.pdf](http://www.avma.org.uk/wp-content/uploads/Duty-of-candour.pdf)

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## Advocacy, advice and support: When to refer and who to

Use this tool to signpost people to further advice and support if they need it.

Advocacy, advice and support overview				
	Independent NHS Complaints Advocacy	Action against Medical Accidents	Mental healthservices (including bereavement)	Debt, finance and benefits advice
<b>Support provided</b>	Impartial guidance throughout complaints process	Specialist medico-legal advice and guidance	Support to process and manage trauma related to the complaint	Support to navigate debt, benefits and financial hardship
<b>Referral pathways</b>	Engage with local authority to identify appropriate provider	Refer directly via (contacts)	Signpost to your local IAPT and/ or bereavement support services for triage and assessment	Engage with local authority to identify appropriate provider
When to refer				
When someone is making, or considering making, a complaint about NHS-funded service.	ü			
When someone is involved in a serious incident investigation		ü		
When a duty of candour process is being followed		ü		
When harm has occurred, and an independent view is needed		ü	ü	
When litigation is being considered, or has started		ü		ü
When someone has experienced trauma or harm			ü	
When someone has died			X	X
When there is an inquest, or one has been requested		X		
When there are concerns about patient safety or fitness to practice		X		
When there are concerns about private treatment		X		

If you would like this document in a different format, such as Daisy or large print, please contact us.

**Let's make  
complaints  
count!**

