Public Service Ombudsman

Strengthening patient voice in the NHS

November 2026

Introduction

The patient's voice is essential to improving NHS services.

In October 2026, the Public Service Ombudsman brought together organisations from within government, the NHS and the voluntary sector and senior leaders with a role in improving patient experience and patient safety. This roundtable focused on how the patient voice can be better heard, acted on and reflected in NHS structures and services in England.

The NHS collects a lot of feedback. But it does not always bring together or act on the information, insight and personal experiences that patients share, including through complaints.

The 10 Year Health Plan and the creation of a new Director of Public Experience role provide an opportunity to change this. Services should be designed around patients' needs. Listening and responding well can create a more open culture, better engagement between the patient and the clinician, and strengthen trust in the NHS.

We explored three connected aspects of the patient voice:

- how patients are heard in healthcare settings
- how organisations respond when concerns are raised
- how the wider NHS uses patient experience to design and improve services.

This report does not attribute comments to individuals or identify participating organisations, except where we quote published reports.

It is intended to provide a balanced account of the discussion and a practical basis for influencing policy, practice and priorities.

How patients are heard in their own care: open, empathetic and effective communication

What we heard

Communications form the most common theme in healthcare complaints brought to the Public Service Ombudsman. It is important to put this in the context of the millions of interactions the NHS handles every day. From those complaints, we can see that clear, compassionate and accessible communication should be treated as critical to patient safety and given ongoing priority in professional education and everyday practice.

At the roundtable, we heard views which expanded on this position. We heard that in a recent survey by the Patient's Association nearly 70% of patients said they were not asked what was important to them during their NHS care. Roundtable participants noted that the NHS typically works best in 'broadcast mode' but is not always set up as well for two-way communication.

Participants were clear that there are many brilliant and compassionate clinicians in the NHS who listen and communicate empathetically. But the view was expressed that we could do more to train and support clinicians in listening and communication skills, and that medical education could put more focus on listening to patients' views and their stories.

Participants also reflected on the unique value of listening carefully to patient voices. It can be hard to spot, diagnose and act on service failings from **within** an organisation, particularly an organisation that is under pressure, as the NHS undoubtedly is. The culture of a given organisation is often itself a barrier to being able to absorb and act on feedback. Patient experiences, which give insight into an organisation but crucially come from **outside that organisation**, offer one way out of this.

What needs to happen

Our report on communication in end of life care shows what can happen when communication breaks down. Poor communication can increase distress, damage trust and reduce opportunities to resolve concerns early. The report recommends making good communication a central part of the Modern Service Framework for Palliative and End of Life Care and the Single Patient Record. While the report focuses on end of life care, its lessons apply across health services.

The Public Service Ombudsman also believes that healthcare professionals need specific training and support to deal well with concerns, complaints and challenges from patients. This

is particularly important at the start of their careers. We have developed a pilot with medical schools that we hope will help students develop these skills. Together, we are producing a range of resources that focus on patient safety, communication and compassionate care.

Incorporating these skills into the training our clinical staff receive could help create lasting change across the NHS. It could also help staff identify and resolve concerns before they become formal complaints.

How organisations respond when concerns are raised: candour, complaints and learning

What we heard

Participants noted that complaints processes were not always easy to access and there was often low confidence from complainants and families that systems would change as a result. We heard that staff managing complaints need to be given power to deal with the issues they are seeing. Complaint staff can still be seen as having a somewhat low status within some NHS organisations. From the clinician perspective, we heard that complaint information must be considered in the context of other feedback, including positive comments.

The group reflected on the importance of the statutory duty of candour in setting out a clear response when harms or potential harms have occurred. However, implementation of the duty of candour has been inconsistent. A view was expressed that this was in some part because the duty was created without enough focus on how it would be implemented in practice.

We know that the NHS is not homogenous and, in Ombudsman visits to NHS trusts around the country, we have spoken to many leadership teams who have invested heavily, and with good results, in building a patient-centred organisational culture. However, at the roundtable we heard some participants describe fear and uncertainty in some NHS workplaces, where leadership had put in place policies stressing the importance of openness but the organisational culture did not support their implementation.

There was strong agreement that getting candour right comes from the top. Leaders must create a culture in which staff feel safe to speak up, take responsibility for mistakes and be honest with patients and families

The group discussed the pending Department of Health and Social Care review of the operation, compliance and enforcement of the statutory duty of candour in the NHS. That discussion was set in the context of the Public Office Accountability Bill, which is anticipated to receive Royal Assent in 2027.

Changes in the policy landscape provide an opportunity to look again at how the duty of candour is operating in the NHS and to address the underlying cultural issues which can lead to defensive and dishonest behaviour. Participants also pointed out that, as most people will not have heard of the phrase ‘duty of candour’, it will be important that we use plain, clear English as technical language may introduce confusion.

What needs to happen

The early experience of Martha's Rule may offer useful lessons for the implementation of a policy intended to shift culture. Its introduction has been supported by efforts to make patients and families aware of the rule by helping them to understand their rights and making sure NHS staff understand the policy.

The NHS Complaint Standards are also an effective tool. They support complaints teams to communicate openly, honestly and with empathy when people raise concerns, providing a guiding set of principles and accompanying guidance.

Finally, the duty of candour has been in place in the NHS since 2014. Lessons learned in the NHS should inform work to create more open cultures across all public services which will fall within the scope of the Public Office (Accountability) Bill.

As the Public Service Ombudsman, we are considering our role in this. We are currently assessing our casework evidence on breaches of candour and considering how our insight can be valuable to improving cultures of candour in the NHS and wider public service.

Patient voice in NHS systems and service design

What we heard

The best way to make sure that the NHS listens to and acts on patient experience is to build in learning from complaints and feedback mechanisms into NHS structures.

Since our roundtable was held, Government has announced that Healthwatch England and local Healthwatch offices will be retained. This is positive news. However, the discussion at our roundtable suggested that more must be done to make the best use of insight on patient experience. Most importantly, it must use this insight to improve how services are designed and delivered.

Roundtable participants strongly supported involving patients in decisions about NHS services. Patients should have a meaningful role in decisions about priorities, funding and how services are designed. We know that the best Integrated Care Boards (ICBs) are already doing this, consulting widely with local authorities, mayoral representatives and patient groups. But this is not happening consistently and it cannot be overlooked as the 25 ICBs form.

We heard examples of good practice, including programme boards jointly chaired with charities. Participants also wanted stronger expectations of policymakers to consult patients before making changes. There was a strong view that co-production would help but would not move forward without robust governance and accountability.

What needs to happen

The planned review of the NHS complaints process is an important opportunity to improve how the NHS learns from complaints. It should help create a culture in which services listen to patients and act on what they hear.

The NHS England review of NHS feedback systems is also important. Information from local Healthwatch services, complaints and other feedback should be brought together. This should give the NHS a clearer picture of patients' needs, expectations and experiences.

Collecting information is not enough. The NHS needs clear ways to learn from it and turn that learning into action at every level. Patients should be involved through consultation and co-production so that services are designed around the people who use them.

From discussion to action

We ended the roundtable sharing participants' ideas on some of the practical changes that they felt would most move the dial on effective patient voice in the NHS. We recorded these as follows.

- A requirement for health organisations creating new policy, procedure or protocol to include the role of patient experience in its production. This could be akin to the development of equality impact assessments that are now required across government.
- Making it mandatory for NHS organisations to publish information annually about how they have used complaints to deliver specific changes.
- Mandating a board-level patient experience champion at each trust, with a standing agenda item at board meetings.
- Including patient and family experience within the measures used to assess service performance, including appropriate patient-reported experience and outcome measures.
- Making patient experience data a clear measure of success in the design and roll-out of new technology, including digital access, patient-facing applications and shared records.
- Timely publication and practical implementation of recommendations arising from the review of the statutory duty of candour in health.
- Embedding the NHS Complaint Standards within regulatory assessment and future reform of NHS complaints regulations.
- Upskilling PALS (Patient Advice and Liaison Service) and complaint handling teams in better use of data and framing their work as a core part of patient safety, learning and improvement activity, not as an administrative function.
- Bringing together complaint data, patient feedback surveys and other patient voice intelligence at system level to inform commissioning, service design and improvement priorities.

The role of the Public Service Ombudsman

The Public Service Ombudsman's five-year strategy sets out our ambitions to achieve impact beyond resolving individual complaints. We use evidence and insight from our casework to identify systemic problems and help public services to improve.

Complaints can provide evidence that helps the NHS understand where change is needed and informs how services are designed, commissioned and improved. Our report, Improving access to ADHD and autism services: commissioning with confidence, is one recent example of how insight from complaints can be used to support wider change.

The number of complaints that feature a failure to listen to the patient voice tells us that we collectively need to:

- position good communication and listening as essential to patient safety, trust and early resolution, rather than as optional aspects of service quality
- embed meaningful patient involvement in NHS decision-making, commissioning, service design, evaluation and technological change
- clarify accountability for understanding and responding to patient experience at national, system and provider levels
- support a culture of candour, openness and continuous improvement across health services.

We are currently working with NHS England's Strategic Commissioning Development Programme with the aim of strengthening the ability of ICBs to learn from complaints.

We are considering future focus areas and ways that we can work with wider NHS systems to make sure the stories of those who complain to the Ombudsman lead to lasting improvements in services.

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