Inspecting Informing Improving

Healthcare Commission

Spotlight on complaints

A report on second-stage complaints about the NHS in England

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Foreword

In July 2004, the Healthcare Commission became responsible for independently reviewing complaints about the NHS that have not been resolved locally.

This report is the first report of our work in reviewing complaints made by patients or their representatives. It covers the first 16,000 requests for independent review we received between July 2004 and July 2006 and highlights recurring themes and lessons learnt.

The concerns of many patients have focused on the basic elements of healthcare, including communication between clinical staff and patients and their families, standards of care and safety, inefficient or ineffective non-clinical practices, such as administration, booking of appointments and transport, and the attitudes of staff. Unfortunately, these themes have been a reason for complaint against the NHS for a number of years. We have therefore included recommended actions and guidance in this report to help trusts to achieve the improvements needed.

The involvement of the Healthcare Commission has increased the independence with which unresolved complaints are reviewed. However, within the first year of becoming responsible for independent reviews, the number of such reviews requested by patients was more than double the number under the previous system. To enable us to deal effectively with the workload involved, we have both improved our processes for handling complaints and significantly increased the number of staff involved. This is enabling us to provide a speedier service, both for patients and for staff in the NHS who have had a complaint made against them.

The Healthcare Commission's overriding aim is to promote improvements in healthcare. This should eventually reduce the number of complaints made against NHS trusts, including those referred to us for independent review.

Another of our key aims is to encourage trusts to increase the number of cases that they resolve themselves. We therefore call on senior staff within NHS organisations to focus on improving the way they learn from complaints to ensure that the themes highlighted in this report do not continue to cause concern for patients and their families. Complainants want their complaints dealt with as quickly and effectively as possible, not to have to complain again to another body.

The number of complaints that we have been asked to review – and the fact that nearly a third have needed to be referred back to trusts for further action – reveals inadequacies in the way that some trusts deal with complaints. In 2007, we will carry out an in depth audit of the handling of complaints by the NHS. Those trusts that consistently handle complaints poorly will see this reflected in the ratings of their performance which we publish each year.

We have worked to improve the way complaints are handled at local level by developing a guide to good practice on handling complaints, hosting eight national conferences for complaints managers to share the lessons that we have learned, and sharing our findings on the most common complaints.

In addition, with the Health Service Ombudsman, we have developed a proposed new core standard for assessing how well trusts handle complaints. This was undertaken at the request of the Department of Health, in response to the Ombudsman's report, *Making things better? A report on reform of the NHS complaints procedure in England*.[1]

The Healthcare Commission is committed to placing the public at the centre of what we do.

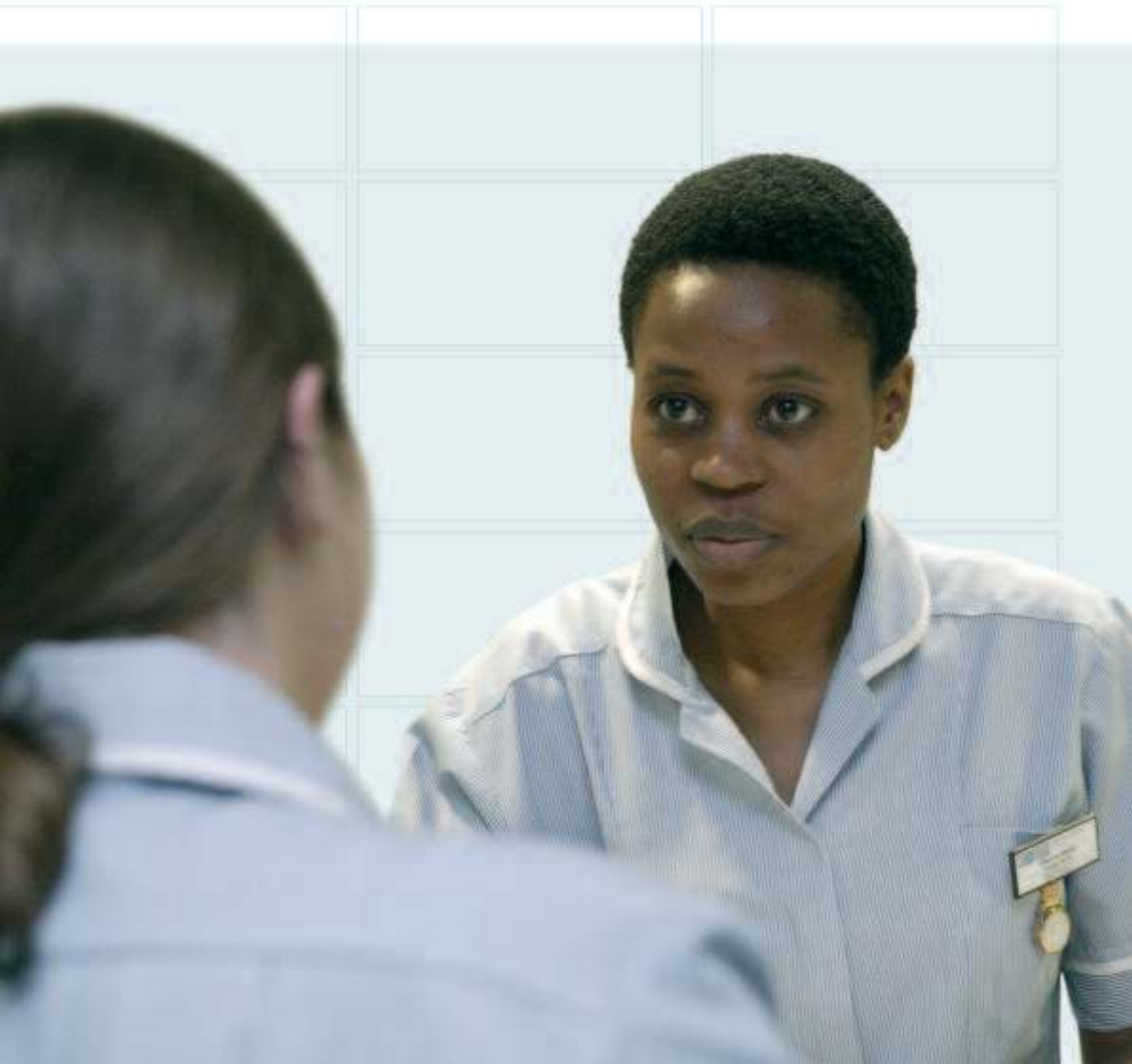
We believe that achieving this aim includes encouraging NHS organisations to pay greater attention to the concerns of patients and the outcomes that they desire, and attempting to resolve complaints at a local level wherever possible. And, most importantly of all, it includes ensuring that they learn from and use the many lessons from patients' complaints to improve their practices.

Professor Sir Ian Kennedy
Chair

Anna Walker CB
Chief Executive

Introduction

The NHS provides around 380 million treatments through its services each year. The majority of patients are satisfied with the quality of the healthcare that they receive. However, around 100,000 formal complaints are made each year by people who have concerns about the treatment that they have received.



If a patient or a representative believes that something has gone wrong during treatment, they can make a complaint to their local healthcare provider in the NHS. Depending on the type of healthcare involved, this provider could be an NHS trust, a GP, a dentist, a high street chemist or optician, or a private treatment centre providing care to NHS patients. The provider then investigates and responds to the complaint, which in more than 90% of cases will resolve their concerns. It will often strengthen the relationship between the patient and their clinician as well.

Prior to July 2004, if a complaint could not be resolved at a local level, the NHS was responsible for reviewing the case. However, a national evaluation of the NHS complaints procedure in 1999 showed that the public thought that the process was not sufficiently independent, was applied inconsistently and took too long. As a result, the Department of Health launched a new three-stage system, which introduced a second stage to be carried out independently by the Healthcare Commission. If patients or their representatives remain unsatisfied with the outcome of this independent review, they may ask the Health Service Ombudsman to carry out an independent investigation of their complaint.

The overall aim of the new system is to encourage better local resolution of complaints and to produce a process for review that is independent of the NHS. Another key aim is to ensure that healthcare organisations learn from the concerns of patients and improve the way in which they work to prevent similar complaints in the future.

The first two years: July 2004 – July 2006

- 16,130 requests for review received
- 10,950 reviews completed
- 5,180 reviews open

The safety of clinical practices is the most common issue highlighted in the cases that we have dealt with to date. Another major source of concern is poor communication between staff and patients or their family, particularly following a death, or about the treatment of relatives. We also receive large numbers of complaints about poor clinical care, records being lost or unavailable at appointments, the removal of patients from GP lists and access to dental treatment in the NHS. Concerns over waiting times, access to services, cleanliness and the coordination of care make up almost 30% of the complaints that we receive.

Since the Healthcare Commission took on the role of independent reviewer in 2004, far more complaints have been referred for independent review than were referred for appeal under the previous system. We have received around 8,000 requests per year, compared with around 3,200 per year under the previous system. But the number of complaints made to healthcare providers in the NHS has remained roughly the same since 2002. This significant increase in second-stage complaints could in part reflect patients'

confidence in the impartiality of reviews carried out by an independent organisation.

The very large number of requests for reviews that we have received has meant that many patients have had to wait longer for their cases to be reviewed than was anticipated when the new system was developed. Yet despite these delays, we have received positive feedback from those who referred their complaints to us. An analysis of feedback from nearly 2,000 respondents showed that 71% found our review to be fair, independent and helpful.

This report does not cover patients' complaints against independent healthcare providers. The way in which we handle these complaints differs from that for complaints made against NHS trusts. More information about our role in relation to complaints about the independent sector is available on our website at **www.healthcarecommission.org.uk**.

The role of the Healthcare Commission

The role of the Healthcare Commission in the complaints procedure is to find out why a complaint about the NHS has not been resolved locally and to identify what action needs to be taken to achieve a resolution. In some cases, because of the issues raised by a complainant and the circumstances involved, we may also investigate the substance of the complaint ourselves and make recommendations for how the case might be resolved or suggest ways in which organisations can improve their services to prevent similar complaints in the future.

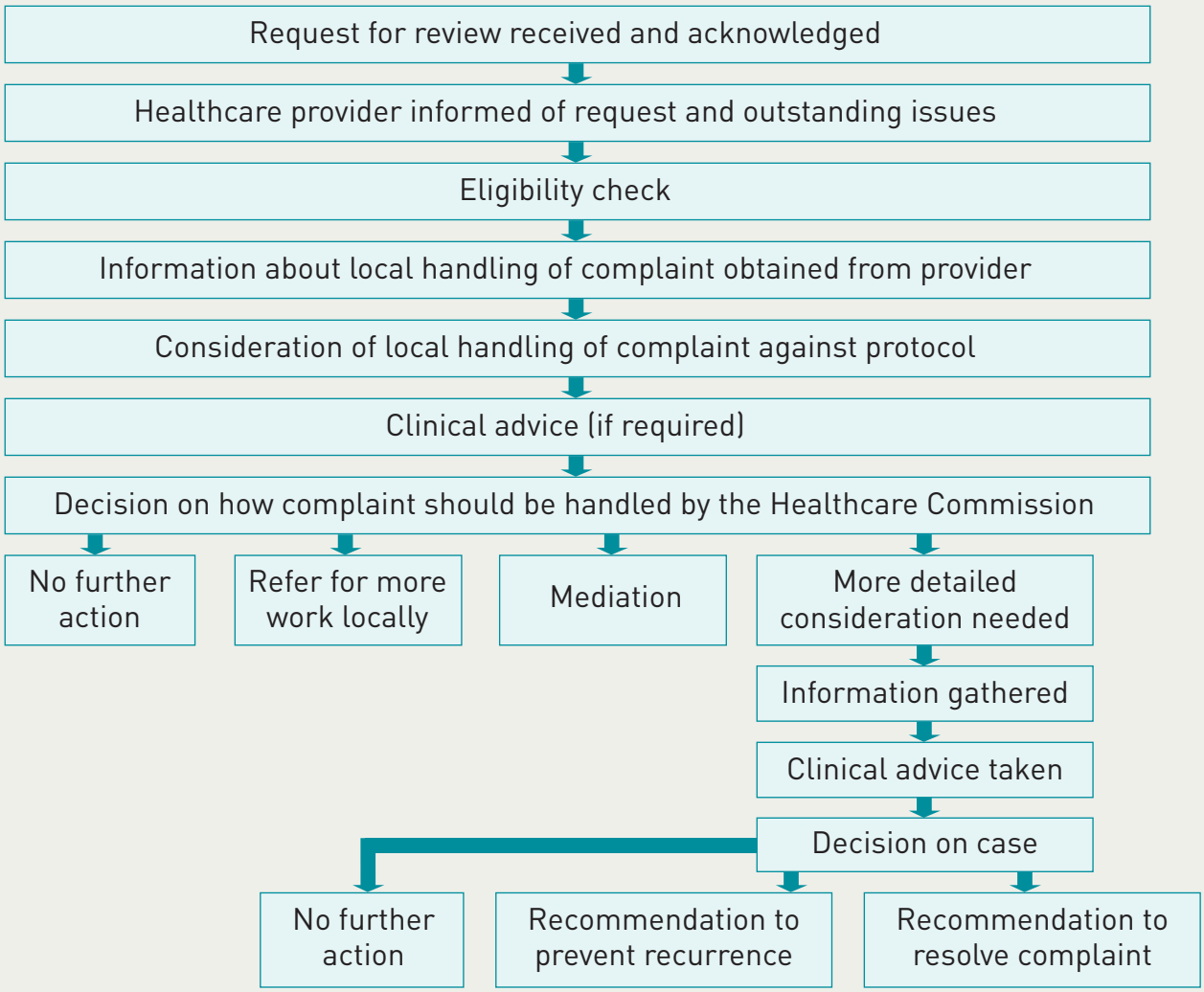
And we are committed to supporting NHS organisations to improve the way complaints are resolved locally.

Typically, we deal with complaints or requests for independent review made by:

- patients or their representatives
- people affected by decisions made by NHS bodies (such as decisions about the funding of treatment)
- people excluded from the local complaints process due to time limits
- people who have not had a response to their complaint locally

Figure 1 sets out our process for independently reviewing complaints about the NHS. We aim to acknowledge all complaints within two working days of receipt and to have completed 65% of reviews within eight weeks. We also aim to close 95% of cases within 12 months, which is comparable with the Ombudsman's target to complete 90% of investigations within 12 months.[2] These timeframes have been determined in consultation with other public sector complaints bodies to ensure that they are appropriate and realistic, given the number and complexity of cases that we receive.

Figure 1: The process for reviewing second stage complaints about the NHS

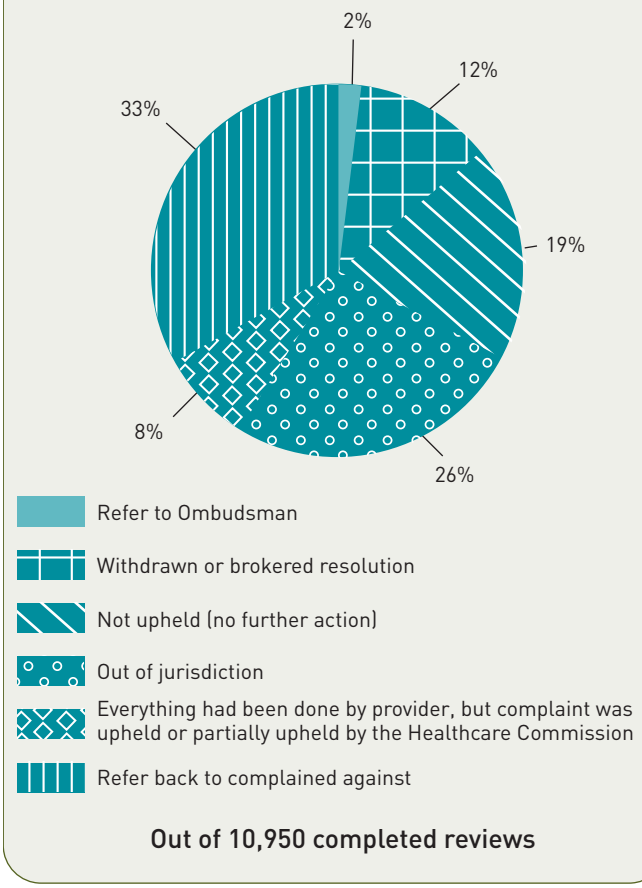


The Healthcare Commission can make a range of decisions at the conclusion of an independent review, including:

- referring the review back to the provider – this would occur when there are still steps that can be taken locally to resolve a complaint
- deciding to investigate further ourselves – this would usually occur where we have doubts about the accuracy of the provider's response to the complaint, or the robustness of its investigation or learning from the incident
- referring to another part of the Commission – this could occur when we spot a pattern of complaints suggesting that a serious failure in services is not being addressed locally and is compromising the safety of patients
- taking no further action – this would usually occur when the provider has responded fully to the complaint after a thorough investigation, and has taken any necessary steps to prevent a situation from re-occurring
- referring directly to the Ombudsman – there are a number of situations in which this might occur. For example, when a case raises issues which span the jurisdiction of two Ombudsmen, such as cases involving health and social care (which can be dealt with by the Health Service Ombudsman and the Local Government Ombudsman) or where issues of retrospective continuing care funding are raised

Figure 2 shows that most (33%) of cases are referred back to the provider for further action. A significant number of requests submitted to us also fall outside our remit, because the complaint was not raised locally (26%) or was not upheld (19%).

Figure 2: Outcomes from independent reviews of complaints about the NHS



Out of 10,950 completed reviews

"I felt it my duty to complain, little realising that this matter of complaint was prevalent throughout the UK, and not just a matter for our local hospital. It is of comfort to know that there is a real concern about this matter, and everyone is endeavouring to solve the problems."

Feedback from patient on complaint about acute services

Demand for independent reviews of complaints

The Healthcare Commission has seen an unprecedented demand for its services as an independent reviewer of complaints.

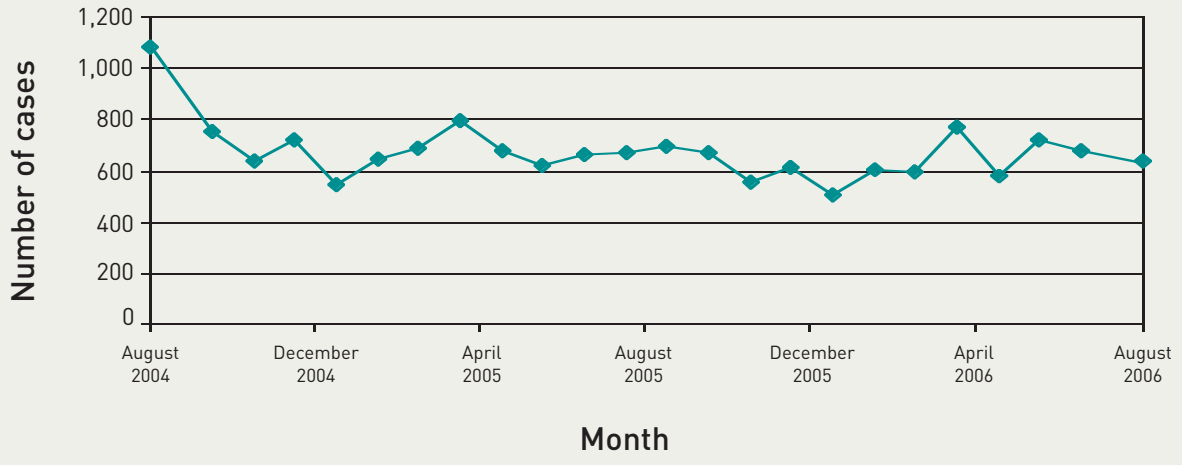
Since 2004, the number of requests for independent review has almost trebled – 8,500 received in the first year of operation, and 7,600 received in the second year – while the number of complaints about healthcare nationally has stayed the same.

Due to delays in the process of legislation for the new three-stage system, a significant number of complaints were lodged before we could begin work. In fact, by August 2004, we had received more than 1,000 requests for independent review – this figure far exceeded expectations (see figure 3).

The Healthcare Commission has taken a number of steps in the first two years to address the increased demand for independent reviews and to improve the quality of service we provide. For example:

- we have increased the number of staff dealing with cases from 21 to more than 150 – the team now accounts for almost 20% of the Healthcare Commission's staff and has a budget of around £10 million each year
- we have streamlined our internal processes to make them more efficient
- a new team has been set up to check the eligibility of cases for independent review and to carry out assessments of risk earlier in the process – this has helped to prevent cases which are not eligible for review waiting unnecessarily for an outcome
- we are keeping people better informed of the progress of their review
- we are working with providers to improve the way they handle complaints and to prevent complaints arising in the first instance

Figure 3: Number of complaints received since 2004



These measures have started to increase the rate at which reviews are completed. We now complete between 750 and 800 cases each month and, in the past six months, we have consistently closed more reviews than we have received. Figure 4 shows an increase in the number of complaints closed each month since September 2005, particularly over the summer of 2005, when a small team was brought in to tackle some of the oldest cases.

Unfortunately, despite the increased resources and refinements to our process, people have had to wait longer than we would like for their case to be reviewed. However, by the end of November 2006, the number of cases waiting for review had fallen from around 2,000 at its peak to less than 500 – with none of these cases waiting longer than six months for the review to start.

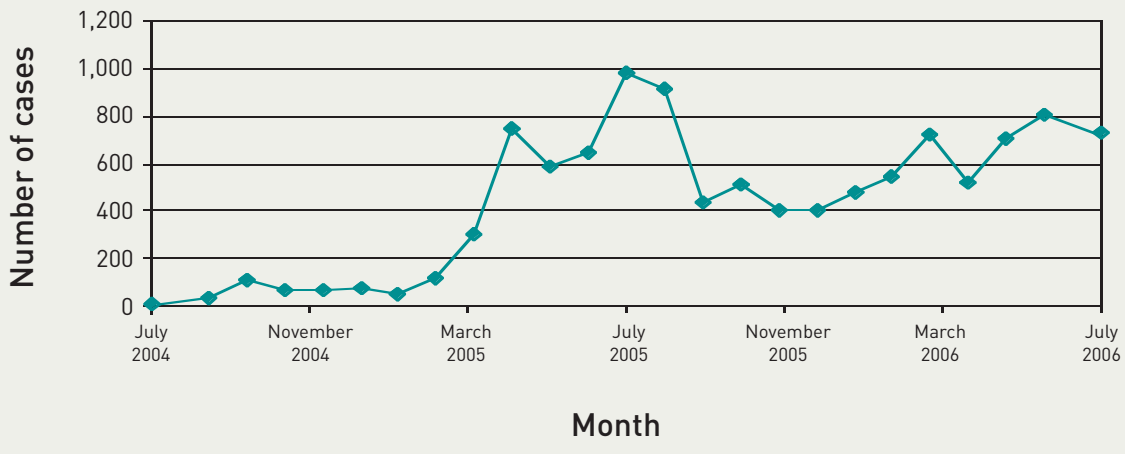
With almost 70% of cases received in June 2006 closed and reviews of the remaining cases under way, we are confident that our target to close 95% of cases within 12 months will be routinely met from Summer 2007.

Key issues raised by complainants

Independent reviews have been requested from all parts of the country and from all types of providers – reflecting the diversity of modern healthcare.

Acute and foundation trusts account for more than half of complaints submitted for independent reviews (see figure 5). However, we have also dealt with cases involving independent sector treatment

Figure 4: Number of cases closed each month



centres, private providers who treat NHS patients, prison healthcare establishments, general practices, PCTs, pharmacists and opticians.

Despite the variety of sources from which independent reviews are derived, there are a number of common themes in what people tell us they want as a result of making a complaint, the subject of complaints, and also in terms of what has gone wrong at the local level to prevent a resolution.

Figure 5: Breakdown of complaints received for independent review, by type of trust

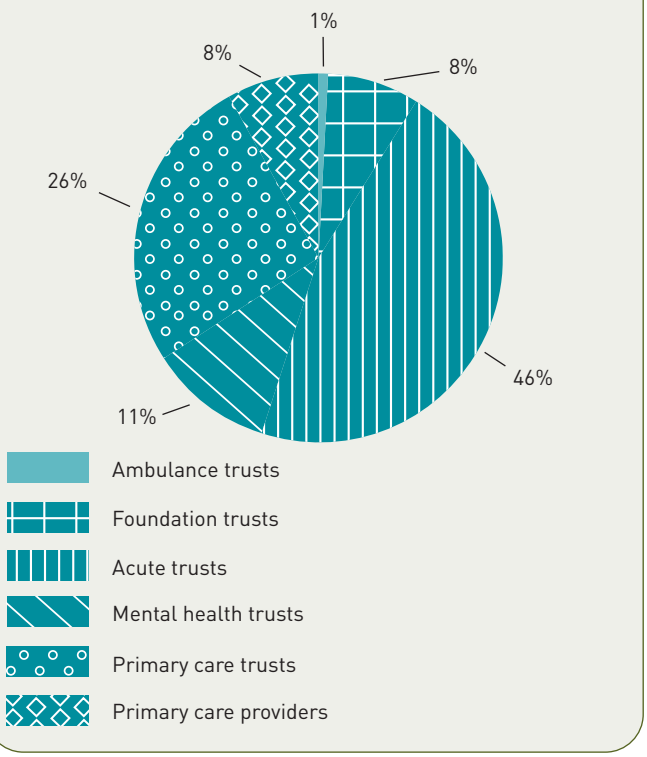
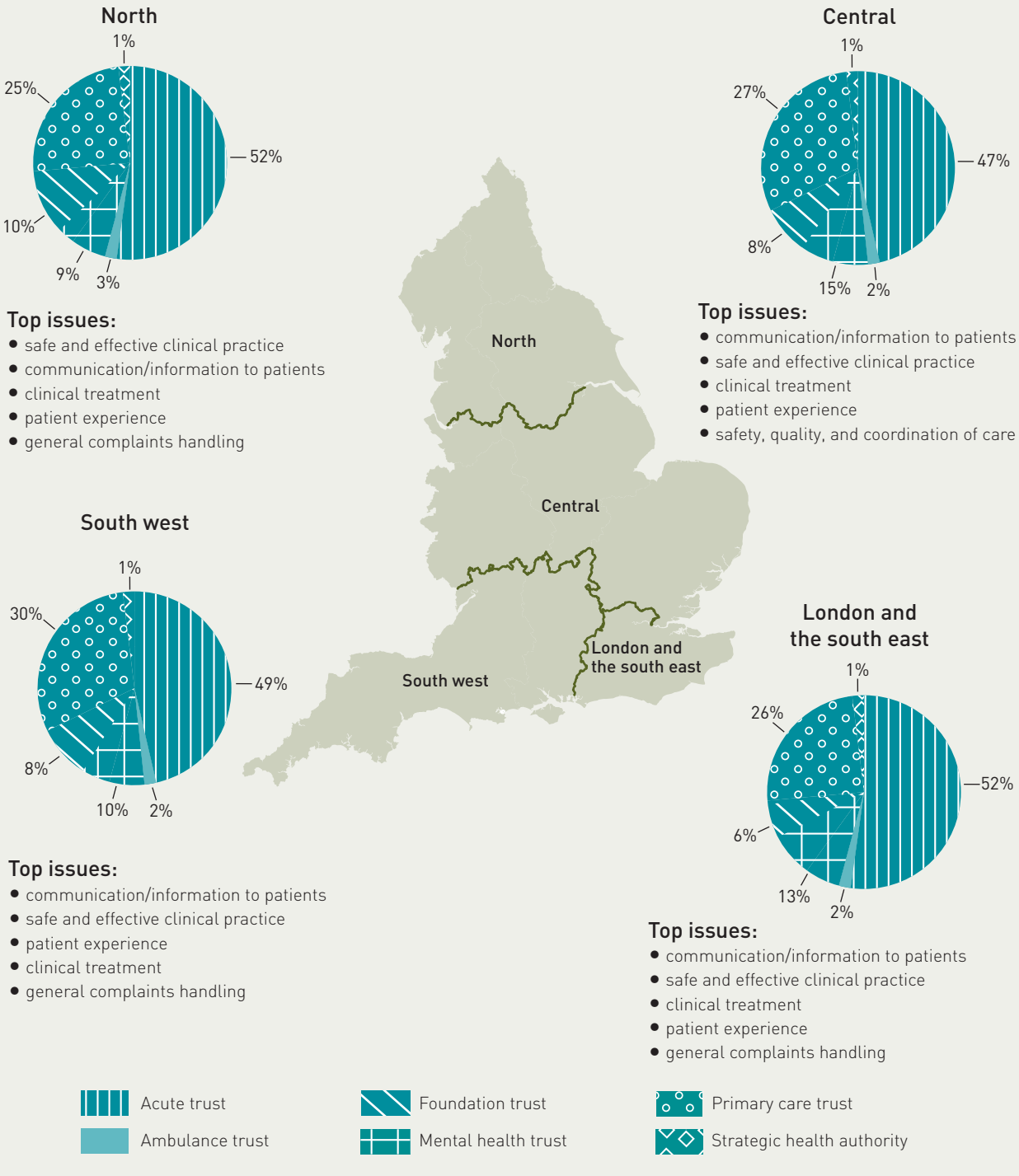


Figure 6 (over page) shows how many independent reviews are carried out by region, and highlights the top five issues raised by complainants in these regions. Some of these issues are explored in more depth in the following section on common themes.

The top 10 issues raised in complaints reviewed by the Healthcare Commission were:

1. safety of clinical practices (22%)
2. poor communication by providers and not enough information for patients (16%)
3. ineffective clinical practices and administrative procedures (5%)
4. poor handling of complaints (5%)
5. discharge and coordination of care (4%)
6. a lack of dignity and respect (4%)
7. poor attitudes of staff (4%)
8. failure to follow agreed procedures relating to consent (4%)
9. poor environments for patients, including unhygienic premises (3%)
10. a lack of access to personal clinical records and disputes about personal clinical records (3%)

Figure 6: Breakdown of independent reviews in trusts, by region



Common themes

In this section, we highlight some of the common themes from our independent reviews along with the recommendations we have made which have helped to resolve particular complaints or drive improvement in services for patients. The figures in this section are based on the first 16,000 requests for review we received.

Safety

Approximately 22% of cases we have reviewed raised issues of safety. These complaints frequently related to a particular aspect of a patient's care and treatment and the response of the healthcare provider when things went wrong. For example:

- a mix up involving patients of the same surname during an immunisation clinic in a general practice resulted in a child being given the wrong injection – 11% of cases involving children involved problems with immunisations

- when a poorly managed post partum (after a woman gives birth) haemorrhage in a large acute trust put a patient's life at risk, we recommended the staff involved were retrained and levels of staffing re-examined – the trust agreed to implement our recommendations

- our investigation of the infection and injury of a patient in a dental clinic found that staff failed to follow required procedures or record treatments appropriately. We recommended that the clinician concerned be referred to the National Clinical Assessment Service or to a local assessment scheme for evaluation – this action was considered in approximately 20% of cases involving dental services

- an elderly patient in a community hospital was injured trying to move from their bed to a nearby chair – we recommended that the trust audit the way falls were assessed at a local level to ensure that staff were responding to the changing needs of patients, rather than relying on the assessment undertaken upon admission

These types of cases involve the highest level of risk for patients. Our reviews therefore also aim to identify whether they are indicative of a wider pattern of problems. In a recent example, a complaint about the transfer of patients from ambulances to an A&E department highlighted the delays being experienced by seriously ill patients in a trust.

Where we have such concerns, we call on our regional teams or our serious service failure team to take action under the Commission's wider regulatory functions. However, we have been reassured to find that, in many of the most serious cases, trusts have been using processes for dealing with 'serious untoward incidents' to identify lessons and improve the way they work. On the other hand, it is disappointing to find that this action is sometime not shared with the patients or family involved.

Care surrounding the death of a patient

Many of the cases we received were concerned with the care provided to dying patients and the relationships between healthcare staff and family members following a patient's death. This is a particularly common theme in cases involving acute trusts.

In many cases, families have received contradictory or confusing information from the different staff caring for their relative. Or, when they have compared the information they have received following a death, they have found discrepancies in what they have been told.

In other cases, relatives sometimes felt that they were unprepared for the death of a patient or had no time to arrange for family members to be present. We often found that misunderstandings between staff and a patient's family arose as a result of ambiguous language used in consultations, such as the use of the terms 'critical' or 'serious', to describe a patient's condition. The use of clinical terms can also confuse or upset patients and their families – see *Bereavement services for relatives* on page 19.

Reviewing cases where basic clinical records, such as weight charts, fluid balance or nutrition charts, have not been kept and clinical observations not recorded has been particularly difficult. To family members, this lack of information suggests that their relative was not monitored, fed or cared for appropriately.

We have repeatedly recommended that healthcare providers review and audit their policies relating to record keeping and make sure that they are being implemented and adhered to by staff. Agreeing one point of contact with family members may also help to prevent such concerns.

The Department of Health's guidance booklet, *When a patient dies: advice about developing bereavement services in the NHS*[3], should be used as a benchmark for developing services for dying patients and their relatives. We have also used this guidance as part of our reviews, to assess whether patients and families have received the support they need.

Keeping records

Although only a small number of cases relate specifically to issues of record keeping, complainants regularly raise concerns about record keeping alongside other issues. These concerns echo the issues raised for many years by the Health Service Ombudsman, despite detailed guidance from all professional bodies in England about what they expect of their members in this regard.

In many cases, poor records, particularly about what had been communicated to the patient and their family, made it difficult for us to resolve cases. From our perspective, if something has not been recorded there is no evidence that it occurred. We recommend regularly that trusts carry out an audit of compliance with policies on record keeping at a local level. We have, on occasion, also recommended that clinicians who are particularly poor at keeping patient records be referred to their relevant professional bodies.

Where a patient or family member objected to the comments made by a clinician in their record, the simple addition of a note acknowledging this objection was often enough to resolve the complaint. Where comments have caused unintended offence, an apology by a clinician has also helped to resolve the complaint. However, it is disappointing that apologies are not being offered earlier, before a case reaches the Healthcare Commission.

In a number of cases (around 3%) involving GPs, we found that patients' records had been misplaced. The transfer of records to PCTs or other GPs was frequently a source of these problems, as was the archiving of records of deceased patients.

Bereavement services for relatives

After a long illness, in the course of which he was suspected of having tuberculosis, A's husband died in hospital. A subsequently complained that, following a post mortem examination, his body was sent to the undertaker in a plastic body bag to prevent the risk of infection. When she asked the undertaker to open the bag so that she could see her husband one last time and dress him in appropriate clothing, he refused.

The trust failed to resolve A's complaint, so she raised her concerns with the Healthcare Commission.

We found that the facts of the case were not really in dispute by either party. We also established that, many months after the events in question, the trust still did not have a formal policy for bereavement (although it confirmed that it had set up a working group to devise one).

We recommended that the trust:

- review its timetable for developing a policy for bereavement and allocate additional resources to its bereavement review group, if necessary, to speed up implementation of this policy
- ensure that its policy for bereavement contains explicit guidance on what information should be given to relatives about the practicalities of dealing with bodies that pose an infection risk, with particular reference to the process for viewing and clothing such bodies
- consider introducing a mechanism with which relatives can ask mortuary staff to dress bodies that pose an infection risk, if they believe that the undertakers may be reluctant to do so
- develop written information on the practicalities of bereavement for relatives to take away and read

The trust has implemented our recommendations.

Nursing

Around 7% of complaints referred to the Healthcare Commission related specifically to nursing issues. Issues about nurses and nursing care were also raised as part of many other complaints, or were linked with wider concerns.

Issues relating to the management of falls, record keeping, attitudes of staff and the dignity of a patient were common. However, concerns about nutrition were most prevalent – found in approximately 25% of the cases we reviewed in this area. In particular, complainants were concerned with:

- poor standards of service and the poor quality of food
- a lack of help for patients who needed assistance with their dietary needs
- patients not being given appropriate food – for example, some patients were given pureed food for long periods of time without an appropriate assessment to determine whether they still needed this type of meal
- patients being given food which they could not eat, only for it to be taken away untouched without alternatives being offered
- patients only being fed when family members were there to help

Other regulators and healthcare researchers have also identified many of these themes in their work, particularly around the care of the elderly. They are basic nursing issues, which we would expect the nursing profession to address to ensure the most vulnerable patients are safeguarded.

Worryingly, 6% of cases highlighted issues with continence, bladder and bowel care. In particular, we found that the reasons for incontinence were not investigated, needs were inadequately assessed, referrals to specialist continence advisers were delayed, and poor management of catheters. A further 11% of cases raised concerns about the management of pressure ulcers – we found that guidance by the National Institute for Health and Clinical Excellence (NICE)[4] was not followed, pressure relieving aids not provided quickly enough, and poor records of the care provided to patients.

A lack of planning was another common theme in cases relating to nursing care. For example, in some departments, care plans were not completed or were not regularly reviewed or updated. This was a particularly worrying theme in complaints about the assessment of falls. In some instances, we found that measures to prevent falls were inappropriate because assessments were not updated to take account of the changing needs of the patient.

The *Essence of Care*[5], launched by the Department of Health in February 2001, provides a tool to help healthcare organisations to "take a patient-focused and structured approach to sharing and comparing practice". Many of the themes identified throughout our reviews of nursing care relate to core elements of *Essence of Care*.[5] In these instances, we have recommended that NHS trusts benchmark services against the requirements of *Essence of Care*. We have also raised a number of issues with the Royal College of Nursing. These will be followed up with its members.

In the long term, we are exploring ways in which to include *Essence of Care* as part of our annual assessment of the performance of the NHS.

Discharge from hospital and the coordination of services

Approximately 5% of cases related to the discharge of patients from hospital or the coordination of care or services between providers. Sometimes, these cases were about the lack of notice given to families prior to the discharge of a relative from hospital. Other cases were more serious involving, for example, the discharge of vulnerable patients (including children and the elderly) without any support or at inappropriate times of the day or night. In these instances, we have recommended that trusts review their arrangements for discharge against the requirements of *Discharge from hospital; pathway, process and practice*[6], in order to reflect the principles of best practice set out in this document.

A lack of communication between services, particularly mental health services (see *Top five issues in complaints about mental health services*), was often an issue. Some cases raised concerns about the coordination of health and social services, particularly at times of crisis for the patient. Patients also frequently told us that they experienced problems gaining access to some services, especially community psychiatric nursing services and services for children with autistic spectrum disorders. One family told us that they waited three years for an appointment with a relevant specialist.

The use of techniques to restrain patients was another common issue in complaints about mental health services. Complainants often reported that they were injured while being restrained or felt that the use of restraint was unnecessary.

Top five issues in complaints about mental health services

1. Difficulty or delay in accessing services
2. Poor attitudes of staff
3. Problems with medication (refusal of patient to take medications or concerns about prescription)
4. Detention under the Mental Health Act 1983 and the availability of places of safety
5. Use of techniques for restraint

"I would like to thank you personally for the sterling job that you have carried out as my case is not an easy one, and you have very tactfully and diplomatically expressed some contentious points. I am extremely grateful that you have raised the four points that you have, as human rights are all too frequently overlooked in mental health. Once again, thank you for your careful considerations in this matter."

Feedback from patient on complaint about mental health services

Arrangements for discharging patients from hospital (case one)

A 91 year old patient, B, was admitted to hospital with pneumonia. She was the primary carer for her husband, who has arthritis and is blind. After a week, she was discharged at short notice. Her family was concerned that she was made to leave her bed and sit around for hours waiting to be discharged, and that her mobility was still limited. B also had difficulties with the drugs she needed when she left hospital. Her family cared for her but after four days she had to be re-admitted to hospital following an emergency call from her GP.

The family made a complaint to the trust, who suggested a meeting. This did not take place until seven months later, partly due to the failure of the trust to respond to the family's letters about 'bed blocking' – this was what they thought was behind B's quick discharge from hospital.

At the meeting, the trust admitted that they had failed to follow correct procedures when discharging B. The consultant still maintained that the patient was fit to be discharged, but admitted that there was no consideration of recuperative care or B's social circumstances.

When the Healthcare Commission reviewed the complaint, we found that the assessment of B was inadequate. Her discharge from hospital had not been discussed in advance with her family, even though the trust's procedures stated that 24 hours notice should be given, and there was no consideration of her circumstances as a carer.

We referred the matter back to the trust and asked it to improve its procedures for discharging patients and to inform B's family of the outcome. The trust introduced a more robust discharge policy and provided training to staff in these new procedures. It introduced a new single access point, which now holds information about the availability of all beds in the hospital so that patients can be allocated a bed appropriately. The trust also set up a working group to review and agree a new information booklet for patients about leaving hospital.

The trust met B's family again, with a representative from the Independent Complaints Advocacy Service (ICAS). The Chief Executive also wrote to B to apologise for the distress caused, acknowledging that the arrangements for her discharge from hospital did not take account of her social needs.

B's son wrote to the Healthcare Commission stating that the review had "resulted in an unequivocal apology... and clear statement of intent to produce a booklet, which will go a very long way to avoid a repetition of the problems we had. If this document meets expectation, we can finally draw a line under the whole unfortunate episode. Thank you again for your help and support".

Arrangements for discharging patients from hospital (case two)

C, who had a depressive illness, was taken to the A&E department of a large hospital after she took an overdose of drugs. She became very distressed and staff called the locum (temporary) psychiatrist who was on call. He said he could not assess C, due to her behaviour, and suggested that she may need to be sectioned under the Mental Health Act 1983 (the Act). This information distressed C further, and the police were called. As the trust had no local 'place of safety', C was taken to the police station where she remained. She was assessed later that day by two consultant psychiatrists, who decided that she should be detained under the Act.

We considered the trust's policy for assessing people under the Act. We found that the policy defined a police station as an option for a place of safety, which meant that staff had correctly followed the policy. However, we recognised that the use of a police station in such circumstances was not ideal and found the delay before C's assessment unacceptable.

A number of other issues were also highlighted, including the lack of coordination of staff and departments involved in the matter and the lack of documentation. The situation was further complicated by the failure of staff to contact C's own psychiatrist or community psychiatric nurse for background.

We recommended that the trust:

- review the way it communicated information about patients from A&E to psychiatrists who are on call
- as a measure of best practice, ensure that staff complete a detailed account of such events in separate psychiatric records, and regularly audit this procedure, and emphasise good record keeping as part of the induction of locum staff
- ensures it complies with standards for the commencement of assessment, and considers undertaking an audit of compliance with the standards relating to assessments carried out in police custody
- ensures it makes a reasonable effort to contact a patient's psychiatrist or community psychiatric nurse before they are detained under the Act, and that this is documented

The provider is implementing these recommendations.

Cleanliness and healthcare associated infection

Around 5% of cases related to the cleanliness of hospitals or infections acquired in hospital, such as MRSA or *Clostridium Difficile*. Often patients kept very detailed diaries of their experience in hospital. Some of the issues highlighted by patients were:

- the failure of staff to follow procedures displayed in wards and treatment areas
- quarantine arrangements not being clearly signposted
- visitors not being challenged if they fail to follow procedures

We have been closely examining the steps being taken by these hospitals to improve measures for controlling infection, based on national guidance from the Department of Health.[7] We are also carrying out a wider programme of work to improve the control of infection in the NHS. For example, all acute trusts in the NHS have made a formal commitment to implement *Saving Lives*[8], a programme which provides tools and techniques to help reduce rates of infection. (A similar programme, *Essential steps*[9], applies to other types of trusts.) When reviewing complaints, we consider whether these procedures have been properly applied.

In December 2005, we also made a number of recommendations for under-performing trusts based on the findings of 100 unannounced inspections of hospitals in the NHS and independent sector.[10] And the recent introduction of the *Code of Practice for the Prevention and Control of Healthcare Associated Infection*, set out in the Health Act 2000, gives us new powers to issue notices if a trust fails to meet the requirements of the code.

Linked to the issue of infection control, and raised in around 50 cases, were concerns about how the death of a patient with MRSA or *Clostridium Difficile* was recorded. In many instances, the healthcare provider failed to explain fully how death certificates were completed or the rationale behind records in patients' notes. We returned many of these cases to the provider for further clarification.

Top five issues raised in complaints about acute services

1. Safety
2. Communication/information to patients
3. Clinical treatment
4. Complaints handling
5. Patient experience (including cleanliness)

Use of restraint

D was a patient in a psychiatric intensive care unit. She complained that, on one occasion, staff had physically restrained her and, in doing so, had nipped and punched her. She said this caused bruises on her arms, back and chest, and provided photographs as evidence. The trust said that staff had acted appropriately, in line with recognised techniques and with minimal force. Also, a medical examination after the restraint did not find any recent bruising.

D asked the Healthcare Commission to review her complaint. We initially asked the trust to clarify how staff had restrained D – the trust simply stated that safe restraining techniques had been used. We reviewed the trust's records of the incident and found insufficient detail about how D was restrained. A case manager and an independent clinical adviser visited the unit and interviewed nine members of staff, including those who had been involved in restraining D.

We concluded that the restraint had not been carried out in a safe environment. Staff had not contacted the switchboard to request assistance when they restrained D, which meant that the trolley with emergency equipment was not taken to the incident. We were also concerned that D was not examined by a doctor while being restrained, nor later when she was given rapid tranquilisation. We concluded that there was a breach of manual handling regulations and felt that, if the situation had been managed differently – for example, by trying to calm the patient first – the use of restraint may have been avoided.

Our subsequent report contained more than 20 recommendations, many reinforcing guidelines by the National Institute for Health and Clinical Excellence (NICE).[11] For example, we recommended that:

- staff receive additional training in techniques to de-escalate situations and manual handling regulations
- the trust audit the use of its emergency response system
- medical staff are present when a patient is restrained, placed into seclusion or given rapid tranquilisation, and the trust consider using a body map to identify the areas of the body which should be restrained, by who and for how long
- patients are examined on admission to the unit so that any existing bruises or injuries can be recorded

The trust has accepted our recommendations.

The management of lists by GPs

The removal of patients from GP lists was a recurring theme, particularly among cases involving independent contractors. This issue has been raised a number of times by the Health Service Ombudsman.

Clear legislation exists for both GPs[12] and dentists[13] specifying the circumstances in which patients can be excluded from a list and the process for doing so. This legislation is supported by detailed guidance from professional regulatory bodies, such as the General Medical Council.[14] However, we found that:

- patients were not warned about the behaviour that would lead them to be removed
- GPs did not explain why a patient was removed from their list
- family members were removed from lists without reason
- where violence was cited as a reason for the removal of a patient from a list, the police were not contacted appropriately or, when they were, this was not recorded

We have sought apologies from GPs found not to be meeting the provisions of the legislation or following professional guidance. In some instances, we have requested the reinstatement of patients unfairly removed from lists and we have asked GPs to refine their processes, in line with the legislation or professional guidance.

In many cases, removal from a GP list was one of a number of issues raised by the complainant. Standards set by the Government make it clear that people who make complaints should not be punished for doing so. We have been closely monitoring GPs we believe may have unfairly targeted a patient following a complaint. Our findings may affect the overall annual performance rating of PCTs responsible for contracting with these practices.

Top five issues raised in complaints against GPs

1. Failure or delay in diagnosis
2. Quality of clinical care
3. Attitudes of GPs or their staff
4. Removal of patient from a GP list
5. Problems with record keeping or comments in records

Removing patients from GP lists (case one)

E complained to the Healthcare Commission that when he had arrived for an appointment with his GP nine minutes late, the receptionist made him wait five minutes and then said he would have to book another appointment. She said that he would need to come back another day.

E rang the patient advice and liaison service that day to make a complaint. A few days later he received a letter from the PCT informing him that he had been removed from the GP's list because of his "unreasonable, uncooperative and intimidating behaviour" at a recent attendance. The PCT had taken this action after it received a referral form from the GP requesting that E was placed on the register of violent patients. The form stated that E had been abusive to staff on three occasions. In response to E's complaint, the GP said the decision to remove him and his family was taken in line with the Government's zero tolerance policy on violence.

When the Healthcare Commission reviewed the file, we found a note of E's last attendance that said he had arrived 10 minutes late for appointment and was abusive when asked to make another appointment. There was no record of the other two incidents referred to by the practice. There was also no indication that there had been an investigation into E's complaint before a response was sent.

Given the serious nature of E's allegations, we referred the matter back for further action, and agreed that the PCT would appoint an independent investigator to the case.
The investigator found that the response of the GP was disproportionate to the incident and, because the GP had called the police, the PCT had no choice but to place E on the register of violent patients.

A number of recommendations were made to the practice to improve its procedures in view of this complaint. In particular, the practice was asked to report incidents so early action could be taken to discuss problems with patients, making use of staff from the PCT or a conciliator if appropriate. It was also recommended that training and support be provided to staff on how to deal with difficult situations.

In response to the complaint, the PCT said it would publish an article in its newsletter for GPs to encourage them to tackle difficult relationships early to avoid a situation escalating. It would also include examples of when patients should be referred to the register of violent patients. The PCT agreed to monitor the removal and allocation of patients to the register of violent patients so it could identify any trends at particular practices. It would also remind practices to inform patients of their right to complain about their removal through the complaints process. The PCT and general practice both offered to apologise to E.

Removing patients from GP lists (case two)

F complained about the attitude of a receptionist in his general practice after he experienced difficulties obtaining an appointment with his GP. The GP asked F to discuss any difficulties with him during his next consultation. Before this happened, the GP removed F from his list, but did not inform him until 10 weeks later.

When the Healthcare Commission reviewed the complaint, we found that the GP had failed to give any warning to F about the possibility of him being removed from the GP list. The GP did not give any explanation or reason for taking such action, and it was unclear from the GP's files why F was removed, apart from the fact that he had made a complaint. Although the GP had suggested a meeting to resolve the matter, this had not taken place. The GP said F had contributed to his removal by not making an appointment to discuss his concerns – even though F said that he had tried unsuccessfully to see the GP.

We upheld F's complaint. We asked the GP to apologise for removing F from the GP list without following the correct procedures. We also recommended that procedures for removing patients from lists were reviewed to ensure that they met the requirements of The National Health Service (General Medical Services Contracts) Regulations 2004[12] and adhered to guidance by the General Medical Council and the Royal College of General Practitioners.

We recommended that any plans to remove a patient from a list be clearly documented, including the dates and reasons for any warnings and the reasons why a warning may not have been appropriate. We also asked the GP to consider involving a senior partner to resolve difficulties with patients, before a patient was removed from its list. The GP accepted our recommendations.

Delays in referrals or diagnosis

Two-thirds of complaints received about GPs were about the provision of clinical care and treatment and, in particular, alleged failures by GPs in making accurate or timely diagnoses. Patients often complained that they should have been referred sooner for specialist treatment or further investigation of their symptoms.

Our team of clinical advisers – brought in to review such cases – found that the treatment and level of investigation undertaken by most GPs was appropriate. However, they found that the rationale for treatment or investigation could have been better explained during the complaints process. In many cases, a lack of detailed clinical records added to this problem. We also found that any improvements that had been made to GP referral procedures as a result of a complaint were not fully explained.

Where we did identify shortcomings in treatment by GPs, we asked the relevant PCTs to consider using the National Clinical Assessment Service to assess their competency, or provide further training to the GP involved. In a small percentage of cases (13%), we recommended that matters be referred to the General Medical Council for follow up under arrangements for dealing with professional misconduct.

Top five recommendations to GPs

1. Ensure local policies for removing patients from GP lists comply with legislation and relevant professional guidance

2. Ensure that records are kept in accordance with guidance by the General Medical Council[14]

3. Provide training to improve the communication skills of GPs and other staff working in general practices, as part of broader training and development programme

4. Maintain a log of when patient records are sent to the PCT, another practice or the Family Health Services Appeals Authority (FHSAA)

5. Apologise to the complainant

Treatment plans (dentistry)

Around 30% of complaints about dental services stem from disagreements over fees and charges. Many patients were concerned about the cost of treatments and the way in which fees and charges were determined by practices. We found that they were often unaware of how much their treatment would cost and many believed they were being treated in the NHS but were charged private rates for part of their treatment – this was a common source of complaint.

Recent changes to the new dental contract, preventing dental practices from charging patients for missed appointments and introducing written treatment plans, should go some way to reducing the number of complaints in this area and will have a positive impact on other common complaints. For example, some patients have challenged whether they gave their consent to treatment in the absence of a written treatment plan. However, as dentists are now required to provide patients with a written treatment plan as part of their terms and conditions of service, this should become less of an issue and the consent will be much more clearly demonstrated. We will recommend that practices introduce written treatment plans where there is evidence that this is not being carried out as part of normal working practices.

New provisions requiring practices to produce information leaflets should also help to prevent misunderstandings between dentists and patients about treatments, charges and other issues. We hope that PCTs will prioritise this issue to prevent further complaints arising and we have raised this with the Department of Health.

Top five issues raised in complaints against dental practices

1. Quality of care
2. Cost of treatment or challenge to the way in which costs are determined
3. Removal of patients from practice lists
4. Poor communication with patients
5. Problems with availability of dentists in the NHS

Dental services

Two months after the removal of a wisdom tooth, G went back to his dentist because the socket had not healed and there appeared to be an infection around the extraction site. He subsequently returned to the dental practice four times. He saw two dentists, who prescribed antibiotics and mouthwash. When there was no improvement in his condition, G finally went to see another dentist who immediately referred him to a dental hospital. He was diagnosed with oral cancer and, sadly, died soon after.

Our review found that the first dental practice had not provided an appropriate level of care. G had complained of continual pain for nine weeks after the extraction and his mouth had not responded to three courses of antibiotics – the dentists should have considered the possibility of cancer and G should have been referred earlier to the dental hospital.

In view of the serious nature of this case, we referred the matter to the General Dental Council. We later found that both dentists had failed to renew their registrations so they were no longer licensed to practise in the UK. However, because we alerted the General Dental Council to our concerns, the dentists will not be able to apply for re-registration in the future.

Given that many dentists will not see a case of oral cancer throughout their careers, we sought assurance from the dental practice that procedures or guidance were in place to help detect oral cancer. The practice is part of a large chain of practices, with some 500 dentists, and its response to our review was very positive. It asked to use the case study in training to re-emphasise the importance of early investigation of any suspicious lesion. It also agreed to arrange a session on the assessment, diagnosis and referral of oral cancer for every study group in its practices, and decided to launch a company-wide clinical governance newsletter to help spread the learning from this and other complaints.

Out-of-hours services

Around 2.5% of cases related to the provision of services outside of normal working hours. In particular, complainants raised the following issues across a range of services:

- inadequate assessment and treatment, and the poor quality of information given to patients about persisting symptoms or how to refer on if their condition worsened
- failure to visit vulnerable patients at their homes
- poor handling of complaints – there was often confusion between the PCT and the provider about who was responsible for responding to complaints. Some providers simply asked the clinicians involved to respond to the complainant, without investigating or analysing the concerns raised. In around half of cases, we found that some or all of the concerns raised by the complainant required further investigation or analysis
- attitude of doctors – patients felt that they were either referred to A&E or, if the matter was not serious enough for referral, advised to wait until they could see their normal GP the next day. They reported that doctors working in out-of-hours services seemed reluctant to treat or examine them. Patients who were referred to A&E were upset that transport was not arranged by the provider
- delay in doctors attending or making calls back to the patient – many patients expected to be visited at home and were disappointed when advice was given over the telephone instead. One patient waited 13 hours for a visit

Generally, we found that patients had very different expectations from the provider about what services should be available out of hours. Many patients clearly felt that out-of-hours services should be able to respond to any request, including a request for a home visit, instead of focusing on emergencies or cases requiring urgent care.

"I had a satisfactory meeting with the PCT at long last. I wish to thank you for your help. Without your intervention, the PCT was not prepared to listen to me, but simply to skate over my complaint. I am very grateful that your organisation has the independence to check bureaucracy especially for people who are vulnerable through ill-health."

Feedback from patient on complaint about mental health services

A new approach for out-of-hours services

H telephoned the out-of-hours GP early one morning when he felt ill. The doctor said he should go to casualty or wait until 9am to see his own GP, as there was nothing she could do because any treatment would depend on him having tests. H made a complaint to the provider of the out-of-hours service, who passed it to the GP. The GP sent H a letter explaining the situation, which included a note from the medical director of the out-of-hours service saying they would not be taking the matter further.

The Healthcare Commission reviewed the complaint and, based on the advice of our clinical team, agreed that the GP had provided appropriate advice in view of the symptoms that were described to her. But we felt that the complaint had been handled poorly. The letter from the medical director was very brief and the tone was brusque. There was no apology, no offer of a meeting and the patient was given no information about how to take the matter to the next stage if they were unhappy with the response they had received.

We asked the PCT responsible for commissioning the out-of-hours service to undertake a joint review of complaints with the provider. The following changes were introduced to improve the handling of complaints about out-of-hours services based on the findings from that review:

- the provider's policy for complaints was revised and circulated to all doctors
- complainants were informed of any delays in the process, and a more conciliatory tone used when responding to the concerns raised
- responses drafted by GPs were sent to the provider for checking before being sent to the complainant
- training in the handling of complaints was being provided by the PCT to administrative staff in the out-of-hours service
- the board received detailed monthly reports on complaints
- the PCT's risk assessment panel received quarterly reports about complaints and how they had been resolved
- the board of the PCT received an annual report, showing numbers, trends and outcomes of complaints

The PCT has confirmed that it "is satisfied that, whatever the shortcomings that may have existed previously, [the provider] will in future improve their handling of complaints and are now aware of the sources of information and advice available through the PCT".

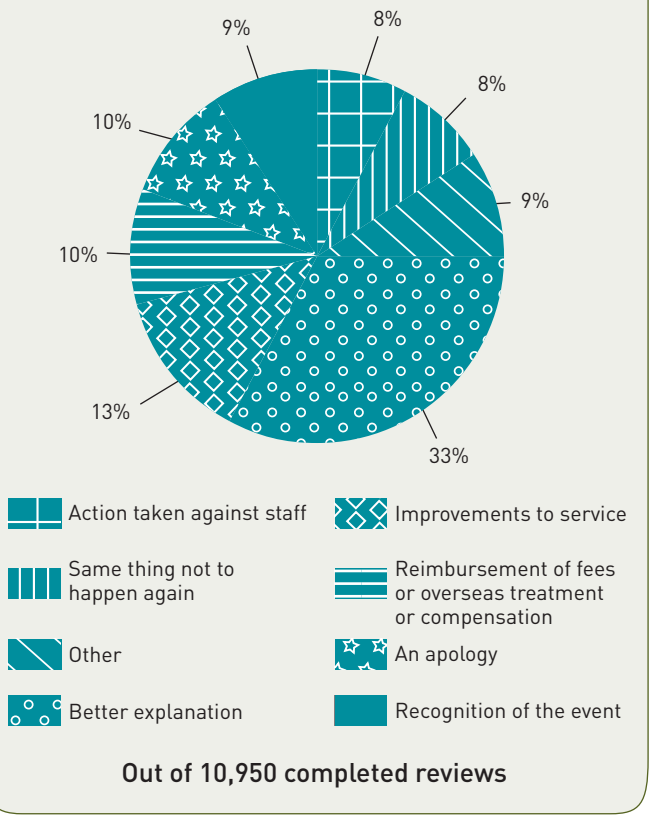
Handling complaints better locally

The majority of NHS complaints are resolved at local level. Among the cases referred for independent review, we have seen a great deal of very good practice in the way that complaints are handled.

However, in 33% of cases, we have found that the healthcare provider could have done more to resolve the complaint. Very often, relatively straightforward measures would resolve these complaints and, in 85% of cases, referring back to the provider for further action appears to have been successful in resolving the complaint.

Complainants have mostly sought a better explanation of the care they have received or of a decision taken by the healthcare provider. As a result, we have often recommended that providers hold further local meetings or offer patients better explanations in response to their concerns.

Figure 7: What complainants told us they wanted from their review



Out of 10,950 completed reviews

Tight deadlines for local resolution (20 working days for local NHS trusts, 10 working days for GPs and dentists) have made it difficult for trusts to provide more detailed responses to patients. In some cases, we have also found that the provider has not had a reasonable opportunity to respond thoroughly.

Frequent problems we have seen in the way complaints have been handled at a local level include:

- failure to acknowledge that a complaint is valid
- failure to apologise, even where local shortcomings are identified
- responses which do not explain what steps have been taken to prevent the recurrence of an event, which has given rise to a complaint
- responses which contain technical or medical terms, which the complainant may not understand
- failure to involve staff directly concerned in the complaint in the local investigation

Table 1 shows the trusts with the highest percentage of cases returned for local resolution.

The Department of Health has introduced new legislation that increases the timescales for responding to complaints at local level and provides more flexibility for complaints managers in NHS trusts to extend local resolution deadlines, in agreement with the patient, so that they can provide a more robust response.

The Healthcare Commission welcomes this new legislation. We will be looking to NHS trusts to use this increased flexibility to respond better to more complaints.

We will also be looking for providers of primary care services (some of which are not covered by the new regulations) to use the flexibility in their existing legislation to respond to complaints more fully at local level. The Healthcare Commission will not take issue with a provider who agrees additional time to respond to a complaint, where this has been done in order to provide a more meaningful response. We will, however, be looking for providers to have consulted with the complainant when extending timescales and to keep them up to date with progress. Where a complainant unreasonably escalates their case for independent review, we will also take this into account.

Table 1: Trusts which have the highest percentage of cases returned for further local resolution

Chesterfield Royal Hospital NHS Foundation Trust	64%
Southampton University Hospitals NHS Trust	63%
Lancashire Teaching Hospitals NHS Foundation Trust	62%
University Hospitals Coventry and Warwickshire NHS Trust	61%
Aintree University Hospitals NHS Foundation Trust	59%
Ashton, Leigh and Wigan Primary Care Trust	59%
Pennine Acute Hospitals NHS Trust	59%
Worcestershire Acute Hospitals NHS Trust	58%
South of Tyne and Wearside Mental Health NHS Trust	57%
Barking, Havering and Redbridge Hospitals NHS Trust	56%

We will also be looking for chief executives of NHS organisations to confirm that they are assured that there is no further action that can be taken at local level to respond to a complaint.

It is important that there is leadership on complaints within NHS organisations to ensure that they are seen as avenues for learning and service improvement. Leadership is also required within professions so that common and recurring themes in complaints are tackled at every point. There is also a role for leaders of clinical teams locally to review complaints to identify ways to improve care.

To assist them with this, we have produced a protocol[15] (available on our website) setting out the key elements we want to see evidenced in the cases we receive. We are also sharing information with providers about complaints as it had been referred to the Commission, in case there are new issues or concerns not initially raised locally (or which have changed over time) that the provider feels it could do more to resolve.

We hope that this information, along with the information provided regularly on our website, will be helpful in resolving more complaints at local level.

Conclusions and next steps

A key aim of the Healthcare Commission is to encourage improvements in healthcare services by sharing information. This report starts this process in the area of complaints handling.

The Healthcare Commission is in a unique position to offer a broad view of complaints about the NHS and identify trends and lessons for all providers. But we do not think that it is appropriate for us to process the bulk of complaints about the NHS. We are therefore committed to sharing our learning to allow NHS organisations to respond better to complaints. We will follow up through our process of assessment and inspection where organisations consistently fail to learn from complaints or the recommendations from our reviews.

Our review of the complaints we have received to date has generated some important messages for us to feed back to the NHS. We have seen a lot of good practice, in which organisations have helped to address complaints in a patient centred, transparent and robust way. But, there are areas where more can be done to better respond to complaints by:

- taking a more patient centred and flexible view when investigating complaints locally – for example, organisations should consider whether complaints made outside the six month deadline can be investigated, rather than being routinely refused (if there are good reasons for doing so)

- explaining to patients from the outset the full complaints process and what can be realistically achieved. Organisations should also direct the complainant to the most appropriate place (for example, the NHS disciplinary process, professional regulatory bodies, or the courts) to achieve the outcome they seek, confirming their key issues and desired outcome

- using the increased timescales for local resolution set out in The National Health Service (Complaints) Amendment Regulations 2006 to investigate more thoroughly the concerns of patients, involving where necessary advice from clinicians and providing better explanations when things have gone wrong

- testing responses against existing national guidance before they are issued to complainants. This process should be explained fully to the complainant, comparing the action involved in the complaint against national standards. Any variations should also be explained fully, along with the steps that are being taken as a result of the complaint to prevent recurrence (and how the complainant will be informed that this action has happened)

- providing a full range of remedies to resolve complaints. Consideration should always be given to an apology, a full explanation, remedial treatment (if needed), support to obtain further treatment, reimbursement of out of pocket expenses, meetings with senior staff to provide explanations and, in some circumstances, appropriate financial recompense for loss

In addition, systems for handling complaints need to:

- be more focused on complainants and what they seek from making a complaint

- have better ways of learning from complaints at a local, regional and national level, sharing best practice and responding to trends in complaints

- have more capacity in terms of the availability of well supported and trained complaints investigators and clinical advisers – this should provide more robust local investigations into complaints

- take into account other measures of the satisfaction of patients, such as those used by professional bodies, the proposed NHS redress scheme, and other clinical negligence and disciplinary processes, to avoid duplication of investigations and speed up final responses for complainants and staff

- support and train staff in responding better to complaints as soon as they arise and encouraging less defensive responses

Next steps

The Healthcare Commission is committed to supporting NHS organisations to improve the way complaints are resolved at a local level. To achieve this, we have:

- helped to refine the existing core standard on complaints following consultation with the Health Service Ombudsman, to focus more on resolving complaints in a flexible way. This is now with the Department of Health for consideration

- held eight regional conferences for complaints managers and lead officers on the boards of NHS trusts, focusing on regional trends and learning from independent reviews

- begun to improve the flow of information from the Healthcare Commission to strategic health authorities and Monitor, so that they can monitor the progress of action plans arising from complaints from relevant trusts and assure themselves that local issues and trends arising from complaints are being addressed

- shared examples of answers to common complaints through our website and research articles

- begun to visit trusts where a higher than average percentage of cases have been returned for further action and follow up, as part of our processes for assessing and rating the performance of the NHS

- identified the 10 most common areas of complaints, which might be addressed by national action raised with the Department of Health

- published the first three newsletters on complaint issues on our website

We are also planning to audit the standard of complaint handling in the NHS to identify areas of good and poor practice against the core standard on complaints and the Healthcare Commission's protocol and criteria for effective handling of complaints. The audit will cover all NHS organisations and its findings will feed into the annual health check in 2006/2007. The audit will:

- focus on the top and bottom 10% of all trusts in terms of performance in the handling of complaints

- draw on available evidence from annual reports by trusts, as well as the Healthcare Commission's (and other stakeholders) findings from reviewing complaints

- look at local arrangements, operationally and at board level, for investigating, resolving and learning from complaints
- look to identify and share examples of good practice

The results of the audit will be shared widely in a report on good practice. It is hoped that this work will encourage better local handling of complaints where it is needed most, and will foster a more responsive approach to complaints. Complaints are best resolved as locally as possible and the Healthcare Commission will work with healthcare organisations to ensure that this occurs in a greater percentage of cases.

Proposed new core standard on complaints

Existing core standard C14

Healthcare organisations have systems in place to ensure that patients, their relatives and carers:

a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services

b) are not discriminated against when complaints are made

c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery

Proposed new core standard

Healthcare organisations have an approach to handling complaints which:

a) is prepared for and successfully meets the diverse needs of actual and potential complainants

b) is simple and clear to the complainant and consistent and integrated with that used by any other bodies involved with the same complaint

c) properly equips and supports those involved to achieve appropriate outcomes

d) demonstrates that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's management and development

References

[1] Parliamentary and Health Service Ombudsman (2005) *Making things better? A report on reform of the NHS complaints procedure in England*

[2] Parliamentary and Health Service Ombudsman (2005) *Three Year Strategic Plan 2005-08*

[3] Department of Health (2005) *When a patient dies: Advice on developing bereavement services in the NHS*

[4] National Institute for Health and Clinical Excellence (2005) *Pressure ulcers: The management of pressure ulcers in primary and secondary care*

[5] Department of Health (2001) *The Essence of Care: Patient-focused benchmarking for health care practitioners* (new benchmark 2006)

[6] Department of Health (2003) *Discharge from hospital: pathway, process and practice*

[7] Department of Health (2003) *Winning ways: working together to reduce healthcare associated infection in England*

[8] Department of Health (2005) *Saving lives: A delivery programme to reduce healthcare associated infection (HCAI) including MRSA*

[9] Department of Health (2006) *Essential steps to safe, clean care: introduction and guidance*

[10] Healthcare Commission (2005) *A snapshot of hospital cleanliness in England*

[11] National Institute for Health and Clinical Excellence (2005) *Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments*

[12] The National Health Service (General Medical Services Contracts) Regulations 2004

[13] The National Health Service (General Dental Services Contracts) Regulations 2005

[14] General Medical Council (2006) *Good Medical Practice*

[15] Healthcare Commission (2006) *Effective responses to complaints about health services – a protocol*

Useful publications and guidance

Below is a list of the documents we refer to when making recommendations as part of our independent reviews (listed under the category that they relate to most).

General/nursing:

- Nursing and Midwifery Council (2004) *The NMC code of professional conduct: standards for conduct, performance and ethics*

Bereavement:

- Department of Health (2003) *Families and post mortems: a code of practice*

Falls:

- Department of Health (2001) *National Service Framework for Older People*

- National Institute for Health and Clinical Excellence (2004) *The assessment and prevention of falls in older people*

Consent:

- Department of Health (2001) *Health Service Circular 2001/023: Good practice in consent: achieving the NHS Plan commitment to patient-centred consent practice*

Nutrition:

- National Institute for Health and Clinical Excellence (2006) *Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition*

The control of infection:

- Royal College of Nursing (2005) *Good practice in infection prevention and control: Guidance for nursing staff*

This information is available in other formats and languages on request. Please telephone 0845 601 3012.

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