Parliamentary and Health Service Ombudsman

Patient Safety Commissioner
Listening to Patients

Sir Chris Wormald KCB
Permanent Secretary of the Department of Health and Social Care
Sent by email

Thursday 8 February

Dear Sir Chris,

In our regulatory roles, we both see some excellent examples of learning from errors in the NHS. There are local cases where both leadership and frontline staff listen to patients, are open and accountable and make sure mistakes are not repeated. Sadly, as you are aware, this is not true across the whole of our health service. We appreciate continuing dialogue with you and your officials on this critical issue.

We are writing to convey our joint concerns regarding what we see as the confrontational culture created by the complaints process in some areas of the NHS that undermines patient safety.

In June last year, PHSO published '[Broken Trust: Making Patient Safety More Than Just a Promise]'. This report outlined cases where mistakes made in the NHS have led to serious harm or loss of life. The report also revealed serious issues with culture in some parts of the NHS, which compound harm for patients, families, and staff. The Patient Safety Commissioner has just released a report into redress for those harmed by pelvic mesh and valpropriate which evidenced the way patient complaints were ignored or dismissed when they raised concerns about these treatments.

Inevitably, things can go wrong in a complex health system. However, our offices see too many incidents which have not been adequately investigated or acknowledged. We also observe how difficult it is for patients, families and staff to know where to turn when they have concerns and are forced to enter the complaints process to raise these.

As you'll be aware, PHSO has invested heavily in improving the way that the NHS handles complaints through the NHS Complaint Standards. These standards, co-produced with the NHS, provide a practical framework, with a strong focus on early resolution by empowered and well-trained staff and robust feedback and accountability mechanisms to facilitate learning at all levels.

All the signs are that these Standards have had a positive impact, and later this year a progress report will document this. However, and additionally, what is needed to realise the true potential of complaints is a fundamental shift in cultures across the NHS from a combative to a restorative approach.

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This change should include patient voice at executive and non-executive director level to ensure senior level oversight of all complaints. It should include senior management in the NHS proactively engaging with the Complaint Standards and taking proactive steps to embed a culture that learns from mistakes within their organisations.

We also need to see a shift in practice to proactively invite feedback and act on it, as well as to resolve complaints at the earliest possible point, with a focus on restorative practice and fixing systemic problems.

Finally, there are countless oversight bodies involved in holding the NHS to account and scrutinising it when things go wrong. Such scrutiny is essential for a public service that invests more than £100bn of taxpayer funding each year. But the routes for people to raise a concern need to be simplified and there is an urgent need for a thorough review of the oversight landscape to ensure it is fit for purpose.

We would appreciate the opportunity to discuss our concerns and our thoughts with you, on how the complaints system and associated culture can be improved further.

We look forward to hearing from you soon.

Yours sincerely,

Rob Behrens

Rob Behrens
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