

Making the NHS Complaints Process Fit for Purpose

A patient-centred framework for explanation, resolution, accountability and learning

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Executive Summary

The NHS complaints system should provide answers, accountability, learning and resolution to all areas of service concern, including when care goes wrong. Avma supports people affected by avoidable medical harm and sees first-hand how an effective complaint response can meet patients' needs and, in some cases, reduce the call for alternative, more complex and costly routes such as litigation. Too often, however, patients and families encounter delay, fragmentation, defensiveness, poor communication and complaint responses that do not answer their questions or show what has changed. The purpose of this paper is to use Avma's unique insights to help improve complaints handling in support of those who are avoidably harmed. In doing this we build on a strong body of evidence. In summary, we are calling for a remodified NHS complaints system based on eight key principles. Whilst all these principles are important, we give emphasis to the following:

Guarantee independence in serious cases: Local investigation remains appropriate for many complaints; however, where concerns involve avoidable death, serious harm, significant conflicts of interest, evidence-integrity issues or allegations of concealment, investigations should be undertaken independently of the healthcare provider concerned. In the most serious cases, the NHS should not be permitted to mark its own homework.

Provide independent advocacy and support: Patients and families require access to genuinely independent advocacy and support to help them navigate the system, participate effectively in investigations and ensure their concerns are properly heard.

Embed the principles of the Harmed Patient Pathway: The response to a complaint should not compound the original harm. Complaints handling should be humane, trauma-informed and patient-centred with clear communication, meaningful involvement, access to support and a continuing duty to avoid further harm.

Measure success through patient experience and learning: The test of a good complaints process should not simply be whether procedures were followed or a final response letter was issued. Success should be judged by whether people felt heard, informed, supported, treated with dignity and were able to participate meaningfully, alongside evidence that learning has been implemented and sustained.

1. Background and context

For more than a decade, independent reviews, public inquiries, ombudsman findings, academic research and Avma's own casework have identified remarkably consistent concerns. The Francis report highlighted the importance of complaints as an early warning system and exposed the dangers of organisational defensiveness and failures of accountability. The Clwyd-Hart review found widespread dissatisfaction with how complaints were handled and recommended a more patient-focused approach. Recent evidence suggests many of the same concerns remain unresolved.

Avma's casework continues to show that a poorly-handled complaint can become a second source of harm. Patients and families may struggle for clear answers, be excluded from investigations, endure long periods of uncertainty and receive responses that do not address their concerns. The burden of establishing what happened is often shifted from the healthcare system to the person already affected by harm.

Evidence from the Behavioural Insights Team (commissioned by NHS Resolution) shows that when patients do not receive satisfactory explanations, meaningful apologies or confidence that learning has occurred, they are more likely to pursue litigation. This suggests that effective complaints handling is not simply an administrative process but an integral component of patient safety, trust and the reduction of avoidable legal costs.

Trust is especially fragile where a provider investigates serious concerns about its own care, staff or leadership. Local investigation remains appropriate for many complaints, especially those relating to customer-service issues. However, it is neither credible nor fair for the complained-about provider to retain control of an investigation where there has been avoidable death or serious harm. In such cases, independence is essential: the NHS should not be permitted to mark its own homework.

Recent research on the experiences of patients and families after healthcare harm provides the most compelling reason for reform. Studies by Ramsey and colleagues found that investigative and complaints processes can themselves create "compounded harm", leaving people feeling powerless, abandoned, manipulated, dehumanised or excluded from decisions affecting them. The process designed to provide answers and restore trust can instead deepen distress and damage confidence in the health service.

The conclusion is clear. The NHS complaints system lacks consistent delivery, enforceable safeguards and credible independence in the cases that matter most. The NHS's constitution, the Public Service Ombudsman Complaint Standards and successive reviews describe the right ambitions, but too many patients still experience a gap between promise and practice.

"Avma helped me find the right place to begin my complaint against the NHS. The process was dense and overwhelming and I had become confused, but Avma pointed me in the right direction..." Avma service user, 2026.

2. What principles should govern a redesigned complaint system?

We see the need for a series of tests to be met in a well-designed alternative complaint system. The following eight principles are drawn from our cumulative experience of supporting people whose lived experience of the current system is wholly inadequate:

- A. **Patient-centred and with advocacy support:** The patient should not have to understand NHS processes and organisations to obtain an answer and should be provided with independent advocacy support where required.
- B. **Prioritise resolution before defence:** Early candour, explanation, apology and remedy should be normal responses to harm without prejudicing legitimate legal rights.
- C. **Proportionate independence:** Local investigation in less serious cases should remain available, but independence must increase with seriousness, conflict and integrity risk.
- D. **Relational and humane incorporating the principles of the Harmed Patient Pathway:** The process should incorporate the restorative practices of the Harmed Patient Pathway and must recognise illness, bereavement, trauma, disability, language and other circumstances affecting participation.
- E. **Evidence-led and transparent processes throughout:** Findings and conclusions must be traceable to evidence; missing evidence and uncertainty must be acknowledged.
- F. **Professionally investigated:** Investigation is skilled work that requires training and should be resourced and accredited accordingly.
- G. **Closed-loop learning:** A complaint is not resolved when a letter is sent; significant recommended actions must be implemented and tested.
- H. **Accountable and with human-experience-led measures:** Boards and external bodies should be able to see whether the system is timely, fair, candid and effective with a human-experience test for complaint handling. Boards should appoint a person responsible for the oversight, quality and integrity of complaint handling.

Our 40-plus years' experience of supporting those who have been avoidably harmed through healthcare means we place particular emphasis on the following issues that need addressing through a reformed complaints system:

2.1 The need for independent advocacy

Independent advocacy is essential to a fair complaints system. Patients and families are frequently required to navigate complex NHS structures, clinical information and investigative processes while coping with illness, trauma or bereavement. Independent advocates help address this imbalance by ensuring people understand their rights and can participate effectively and have their concerns properly heard. Evidence from the [independent evaluation](#) of the Maternity and Neonatal Independent Senior Advocate pilot found that families overwhelmingly valued the role, particularly its independence from the organisations involved in their care. Families reported feeling more supported, better able to navigate investigations and more confident that their voice was being heard. The evaluation concluded that the role made a valuable contribution to ensuring families' concerns were listened to and acted upon. The cost of providing advocacy will deliver value-added benefits, such as enhancing trust and confidence, which are essential to a publicly funded NHS.

"It is helpful in pointing out the gaps in the systems. I need someone to help me understand the scope of a complaint I have about my GP surgery." Avma service user, 2026

"Your advice helped me decide how to move forward with my complaint about how my partner was treated by the NHS. Before talking to you, I did not know what options were open to me." Avma service user, 2025

2.2 Independent investigation where the concern is serious

Local investigation should remain the normal route for straightforward complaints. However, where the concern involves avoidable death or serious harm, alleged concealment or dishonesty, alteration or destruction of evidence, a serious breach of candour, senior management conduct, major conflict of interest or repeated systemic failure, the provider must not investigate itself. In these circumstances, independence is fundamental to fairness, public confidence and learning.

Such investigations should be commissioned and conducted outside the provider, agreeing the scope with the investigator who then controls the evidence gathering, findings and report. The investigator should have the requisite level of skill and expertise and, ideally, be professionally accredited to undertake such investigations. The provider should have a duty to cooperate and preserve evidence but no power to appoint or remove the investigator, narrow the terms of reference, edit findings or delay publication. Funding should be routed

through a national or regional independent mechanism so that the body under investigation cannot influence the investigator through financial pressure.

A rapid external triage route should allow a patient, family, advocate, staff member or regulator to request transfer where the integrity of a local process is in doubt. Reasons for granting or refusing independent investigation should be recorded and open to review. Put simply, in the most serious cases the NHS should not mark its own homework.

2.3 Preventing further harm through complaints handling

When healthcare causes avoidable harm the way in which concerns and complaints are subsequently handled can either support recovery and help rebuild trust or compound the original harm. Poor communication, delay, defensiveness, exclusion from decision-making and a failure to provide clear answers can leave patients and families feeling powerless, abandoned, disoriented or dehumanised.

Complaints handling should be understood not simply as an administrative process but as an important part of the healthcare system's continuing response to a person who may already have experienced significant harm.

The Harmed Patient Pathway, developed by Avma and the Harmed Patients Alliance, provides a set of restorative-based practices that can help prevent this compounding of harm. At its heart is recognition that an organisation's duty of care does not end when avoidable harm occurs. A continuing responsibility includes preventing further harm, communicating honestly and compassionately, supporting recovery, involving the people affected, enabling access to independent advice and advocacy, and learning from what happened.

Applying these practices would mean that complaints are handled in a way that is humane, compassionate and sensitive to trauma. Patients and families should receive clear and regular communication, meaningful opportunities to participate, practical and emotional support where required, and respect for their right to pursue other routes. Support should, ideally, be available from the point at which harm is identified or alleged and should not depend upon a person first understanding the system or submitting a formally constructed complaint.

2.4 A human-experience test for handling complaints

Ramsey and colleagues show why technical compliance is not enough. A system can complete an investigation yet compound the original harm. NHS organisations should,

therefore, measure the experience of people who have made significant complaints and ask whether the process left them:

- heard rather than ignored
- able to participate rather than powerless
- informed rather than disoriented
- supported rather than abandoned
- confident in the integrity of the investigation rather than manipulated
- treated as a person rather than dehumanised.

These measures should not be treated as a customer-satisfaction score. They are indicators of whether the process respects dignity, reduces inequality, supports meaningful participation and maintains trust.

3. Recommendations for required direction of complaints reform

Recurring weakness	Why it matters	Design principle (section 2)	Required direction of reform
1. Complexity and fragmentation	Patients may have to understand providers, commissioners, PALS, complaints, safety investigations and ombudsman routes while ill, bereaved or distressed.	Patient-centred, not institution-centred, and with advocacy support (Principle A)	One front door, one lead case owner and a personalised process.
2. Power imbalance	Patients may know that something went wrong but lack clinical knowledge, records, confidence or stamina to frame the right questions.	Patient-centred, not institution-centred, and with advocacy support (Principle A)	Independent navigation, advocacy and specialist clinical advice; investigator duty to help define issues.
3. Provider investigates itself	A provider cannot command confidence when it controls the investigation of serious concerns about its own care, staff, leadership or evidence. Actual and perceived conflicts of interest undermine trust and may compromise learning.	Proportionate independence (Principle C) Evidence-led and transparent (Principle E)	Mandatory transfer to an independent investigator for defined serious cases, with independent clinical expertise, secure evidence access and timely disclosure and no provider control over scope, findings or publication.
4. Defensiveness and weak candour	Reputation management can distort investigation, apology and disclosure; the most serious allegations concern evidence integrity.	Resolution before defence (Principle B)	Evidence-preservation duties, auditable amendments, external escalation and consequences for deliberate obstruction.

Recurring weakness	Why it matters	Design principle (section 2)	Required direction of reform
5. Poor-quality responses	Lengthy letters can fail to answer the questions raised, obscure admissions or use defensive language.	Resolution before defence (Principle B)	Agreed statement of questions and a mandatory question-by-question response format.
6. Delay and silence	Delay compounds distress and erodes trust; an open-ended timetable transfers the burden of chasing to the complainant.	Accountable and with human-experience-led measures (Principle H)	Presumptive national timescales, reasoned extensions and scheduled progress updates.
7. Weak support and emotional harm	People may feel powerless, abandoned, disoriented or dehumanised by the process itself.	Relational and humane incorporating restorative practices from the Harmed Patient Pathway (Principle D)	Named liaison contact, trauma-informed communication, vulnerability assessment and post-investigation support.
8. Learning asserted, not demonstrated	Generic statements that lessons were learned do not show whether change happened or worked.	Closed-loop learning (Principle G)	Closed-loop action records with owners, dates, evidence of implementation and effectiveness review.
9. Under-professionalised investigation	Investigators need authority, skill, clinical access, time and support.	Professionally investigated (Principle F)	National competencies, accreditation, protected time, supervision and manageable caseloads.
10. Complaints separated from	Formal closure may be treated as the endpoint instead of an opportunity to detect recurring risk.	Closed-loop learning (Principle G)	Board dashboards, thematic analysis, regulatory sharing and verification of learning.

Recurring weakness	Why it matters	Design principle (section 2)	Required direction of reform
safety intelligence		Accountability and human-experience-led measures (Principle H)	
11. Complaint resolution often fails to provide meaningful remedy	Patients often seek practical resolution, acknowledgement and restoration rather than simply a final response letter. Processes that do not consider remedy can leave legitimate concerns unresolved and undermine confidence that justice has been done.	Closed-loop learning (Principle G)	Resolutions should focus on putting matters right where possible rather than simply issuing correspondence and closing cases.
12. Processes can compound harm	Investigations and complaints processes can themselves become a second source of harm, leaving people powerless, abandoned, feeling manipulated and dehumanised or excluded from decisions affecting them.	Relational and humane incorporating restorative-based principles and practices from the Harmed Patient Pathway (Principle D)	Measures whether people feel heard, informed, supported and treated with dignity throughout the process.
13. Too much reliance guidance rather than enforceable safeguards	Rights and standards may exist on paper but are applied inconsistently in practice. Without mandatory safeguards and independent scrutiny, patients continue to experience a gap between policy and reality.	Accountable and with human-experience-led measures (Principle H)	Key protections should be mandatory, externally scrutinised and consistently applied across the NHS.

4. Conclusion

Complaints reform will succeed only if it changes both process and power. Patients and families need one accessible route, independent support, meaningful involvement, timely and direct answers, proportionate remedy and proof that learning has been implemented. Where the concern is serious, confidence cannot depend on the provider investigating itself. A credible national system must guarantee independent investigation whenever seriousness, conflict or evidence-integrity risk requires it while drawing on the restorative-based practices from the Harmed Patient Pathway so that the response to harm does not inflict further avoidable harm.

Reforming complaints handling will require investment (in independent advocacy, skilled and properly resourced investigators, proportionate independent investigation, staff training, better communication and systems that can demonstrate that learning has been implemented). But the cost of reform must be weighed against the human, organisational and financial costs of continuing with a system that too often fails patients, families and NHS staff alike.

Good complaints handling is not an administrative overhead. It is an essential part of safe, accountable and compassionate healthcare. When people receive timely answers, meaningful involvement, an honest explanation and confidence that lessons have been learned, complaints are more likely to achieve resolution. When they do not, it undoubtedly drives towards escalation or litigation.

The NHS should, therefore, invest in complaints reform as a core component of patient safety, quality improvement and the responsible use of public resources. National leaders should now commit to a properly funded programme of reform, developed with patients, families, advocates and NHS staff, which turns the principles in this paper into enforceable and consistently applied practice.

The question is not whether the NHS can afford to reform complaints handling. It is whether patients, families and the NHS itself can afford the continuing cost of failing to do so.

Appendix A

Evidence base and principal sources

This paper draws together the following reports, standards and evidence. They are listed so that the provenance that underpins our principles and recommendations is clear. The historical reports remain relevant because later evidence repeatedly identifies many of the same weaknesses.

NHS Constitution for England — Department of Health and Social Care. States the legal rights and NHS pledges relevant to complaints including proper investigation, progress information, explanation, apology, appropriate support and learning. [Link](#)

Handbook to the NHS Constitution for England — Department of Health and Social Care, updated January 2025. Explains the legal sources of complaints rights and the roles of commissioners, CQC and the ombudsman. [Link](#)

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis report) — Robert Francis QC, 2013. A foundational account of systemic failure, defensiveness, accountability and the importance of complaints as warning signals. Avma's analysis of the complaints' recommendations supplied for this work has also informed the paper. [Link](#)

Putting Patients Back in the Picture: Review of the NHS Hospitals Complaints System — Rt. Hon Ann Clwyd MP and Professor Tricia Hart, October 2013. Examined how hospital complaints were listened to and acted upon and made recommendations on quality, handling, independence and whistleblowing. [Link](#)

Behavioural insights into patient motivation to make a claim for clinical negligence — Behavioural Insights Team for NHS Resolution, August 2018. Examined why patients pursue clinical negligence claims and the role played by explanation, apology, investigation, communication, accountability and prevention of recurrence. [Link](#)

NHS Complaint Standards — Public Service Ombudsman. Current standards emphasise early resolution, empowered and trained staff, senior review of learning and use of complaints to improve services. [Link](#)

Sir Rob Behrens: observations on NHS openness and “cover-up culture” — *Guardian* reporting of the outgoing NHS ombudsman, 17 March 2024. Behrens warned that reputation management could be placed ahead of openness and referred to cases involving concealment, missing documents and altered records. [Link](#)

Humanising processes after harm part 1: patient safety incident investigations, litigation and the experiences of those affected — Ramsey L et al., *Frontiers in Health Services*,

published 3 January 2025. Qualitative research describing cautious hope followed by lack of power, knowledge and support, compounded harm, fear-driven processes and the need for relational, properly resourced investigations. [Link](#)

Harmed Patient Pathway — Action against Medical Accidents (Avma) and the Harmed Patients Alliance, final version December 2025. Reframes the response to healthcare harm around a continuing moral duty of care: do no more harm, support recovery, communicate honestly and compassionately, provide access to specialist independent advice and advocacy, involve harmed patients meaningfully in investigations, and respect their use of parallel external processes. [Link](#)

Humanising processes after harm part 2: compounded harm experienced by patients and their families after safety incidents — Ramsey L et al., Frontiers in Health Services, 2024. Identifies six forms of compounded harm: feeling powerless, inconsequential, manipulated, abandoned, dehumanised and disoriented, and recommends equal partnership, transparent cultures and restorative responses. [Link](#)

Appendix B

References and links

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