



**Making things better?
A report on reform of the
NHS complaints procedure
in England**

HC 413



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Foreword

As Health Service Ombudsman I see hundreds of complaints from patients and carers every year. These complaints have already been dealt with by the NHS before they come to me, giving my Office a unique overview of the complaints handling process.

Looking through these cases it is clear that many complainants face severe problems in getting a satisfactory response to their complaints from health care providers. Furthermore, the situation remains static as the NHS is not using the valuable information contained in complaints to improve its services and complaint handling processes.

In this report we highlight some of the problems with the current situation such as the fragmentation of complaints systems - within the NHS, the NHS and private health care and between health and social care. This - combined with a failure to focus on patients' needs, poor leadership and lack of capacity and competence in complaint handling - has led to a system which makes it difficult for patients to have things put right where they have gone wrong.

In laying this report before Parliament - in accordance with Section 14(4)(b) of the Health Service Commissioners Act 1993 - my aim is to look to the future. The timing is right to consider how we can develop a truly patient-focused complaints system. The Department of Health's decision to issue revised regulations on complaint handling in 2005 - after considering the findings of the Shipman Inquiry's 5th report - gives us all an opportunity to focus on how we can achieve this.

Health services that are truly responsive to patients will only come about if all health service leaders value feedback from patients - even when that feedback is a complaint.

In this report I call for leadership from the Department of Health and improvements from the Healthcare Commission and others to address key failings in the current system. The Department of Health needs to demonstrate leadership and commitment by creating a core standard for complaints services handling which meets patients' needs and by investing in trained staff who can treat complaints positively and learn from them. The current system focuses on process rather than outcomes and on meeting deadlines rather than delivering a quality service.

The ultimate goal must be to create a modern, responsive, patient-focused complaints handling system. We would be delighted to work with the Department of Health, the Healthcare Commission and other providers of NHS healthcare to help achieve this.

Ann Abraham
Health Service Ombudsman for England
March 2005

Chapter 1

A brief history of proposals for reform

The 'old' NHS complaints system

1996 Single complaints system introduced

1. The single complaints system introduced in April 1996 was a radical improvement on a previously fragmented and partial system. For the first time the same complaints system covered hospital, community and primary care services (family doctors, dentists, opticians and pharmacists), and could handle concerns about both administration and clinical treatment. Complaints were first considered and responded to by the service provider. This first stage was known as local resolution. If complainants remained dissatisfied they could ask a convener (generally a non-executive member of the organisation complained about) to arrange a review by a panel of lay people, with access to any necessary clinical advice. This was known as the second, or independent review stage. But there was no automatic right to such a review. Where complainants remained dissatisfied, or had been refused an independent review, they could complain to the Health Service Ombudsman.

1999 - 2001 Evaluation and listening exercise

2. It soon became clear that there were major difficulties with the single complaints system. The Department of Health had always intended to evaluate the effectiveness of the system and commissioned a research study, which ran from 1999 to 2000. The results, published in September 2001, revealed that many complainants felt a high level of dissatisfaction with the operation of the system, both at the local resolution and independent review stages. The main causes of dissatisfaction were unhelpful, aggressive or arrogant attitudes of staff, poor communication and a lack of information and support. The most important structural failure was the

'perceived lack of independence in the convening decision and in the review process generally'. The results of the evaluation resonated strongly with the experience of the Ombudsman's office.

E.1980/03

In July 2001, following her dissatisfaction with the Trust's response to her complaint about her late mother's care, Mrs A requested an independent review. The panel was held in March 2002 and in September Mrs A received a copy of the lay chair's report. She wrote to the Trust chief executive complaining that it was superficial, inconsistent and almost unintelligible. Furthermore, it covered only two of the four issues the panel had agreed to consider and did not refer to the findings of the clinical assessors. It was also unclear what the final recommendations were. The Trust did not respond to Mrs A's letter.

The Ombudsman upheld the complaint. She criticised:

- the poor quality of the report;
- the failure of the lay chair to consult the other panel members;
- the convener and panel members for failing to call the lay chair to account;
- the SHA for failing to ensure the lay chair adhered to complaints guidance and produced reports of the required standard

The Trust and SHA apologised for their shortcomings.

3. The Department of Health's evaluation report, *NHS complaints procedure: national evaluation* made 27 recommendations aimed at improvements throughout the system, including:

- a uniform national procedure, applied equally to primary care and hospital services, with clear and consistent time limits;
- dissemination of good practice, and more use of conciliation to achieve results swiftly and effectively;
- clear guidance on how the complaints procedure should be applied, and standard targets nationally for managing the performance of staff handling complaints;

- clear lines of responsibility for making sure the complaints system is run properly, with Chairs and Chief Executives answerable to the Department of Health for their performance;
- a responsibility on Trust Boards to ensure this work is funded properly, and staff are trained appropriately to handle complaints and that their clinical governance framework reflects complaints work as core business;
- a system of quarterly reporting by complaints staff to the Trust Board, summarising the causes and trends underlying complaints, and making recommendations for action. These reports to be copied to relevant patient representative organisations, and the Board to be responsible for implementing recommendations;
- support from Primary Care Groups (PCGs) (predecessors of Primary Care Trusts - PCTs) for practices in managing the system, with a named individual responsible for handling practice complaints;
- regional NHS bodies, or a new independent national complaints authority, to be responsible for holding panels to account and managing their performance;
- wide circulation of the panels' final reports to relevant patient representative bodies and the Commission for Health Improvement (CHI), with the Trust Board being responsible for implementing any recommendations for remedial action;
- new options for how panels should be convened: by the Health Authority, neighbouring Trusts/Health Authorities, or introducing a separate regional or sub-regional panel.

2001 The Department consults on key questions

4. To coincide with the publication of the evaluation results, in September 2001 the Department of Health issued *Reforming the NHS complaints procedure - a listening document*, which sought comments on the evaluation report's recommendations and set out key principles for an effective NHS complaints procedure.

5. Comments on the evaluation report's recommendations and the key

questions were sought by 12 October 2001. As well as written responses, a series of regional events was held across the country to gauge views of NHS staff and patient groups and research was carried out with hard-to-reach groups.

Proposals for the new procedure

6. The Department of Health's response, in January 2002, to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary said that they intended to have a new NHS complaints procedure in place by December 2002. However, no new procedure was proposed until April 2003, when the Department published *NHS complaints reform, making things right*. This described the vision of a new complaints procedure:

- **open and easy to access** - flexible about the ways people could complain and with effective support for people wishing to do so;
- **fair and independent** - emphasising early resolution so minimising the strain and distress for all those involved;
- **responsive** - providing appropriate and proportionate response and redress;
- **providing an opportunity for learning and developing** - ensuring complaints are viewed as a positive opportunity to learn from patients' views to drive continual improvement in services.

7. *Making things right* was not radically different from the listening document, although it did attempt to take account of subsequent developments in patient and public involvement. Responsibility for independent review would be placed with the new Commission for Healthcare Audit and Inspection (CHAI - now known as the Healthcare Commission), which was to regulate health services and so provide a link into the quality improvement process.

8. In November 2003 the Health and Social Care (Community Health and Standards) Act 2003 received Royal assent paving the way for CHAI to be set up; regulations to be made about complaints procedures in both health and social services; and for the Health Service Ombudsman to consider complaints about the handling of NHS complaints by any person or NHS body.

2004 Partial implementation

9. In December 2003 draft regulations for the new NHS procedure were issued for consultation. The intention had been to implement the regulations on 1 June 2004. However abbreviated regulations, the National Health Service (Complaints) Regulations 2004, were eventually laid before Parliament on 9 July 2004 and came into force on 30 July. Ministers had decided on a phased implementation to take account of recommendations from the Shipman Inquiry. The Inquiry's 5th report was likely to address complaints handling in some detail and was due to be published later in 2004. Reports from other inquiries about doctors who had repeatedly failed to observe proper standards of care were also expected later in 2004.

10. The July 2004 Regulations left the local resolution stage of the complaints procedure broadly unchanged. They consolidated and rationalised the statutory requirements for local resolution by NHS bodies and introduced a reformed independent review stage to be carried out by the Healthcare Commission. The Department intends to issue revised regulations in 2005 following consideration of the 5th Shipman report.

Inquiries

11. Whilst the new complaints procedure was in gestation there were a number of inquiries into situations where serious failings in systems or in standards of clinical care continued for lengthy periods and affected significant numbers of patients.

12. The Bristol Inquiry reported in 2001, the Neale and Ayling Inquiries in September 2004, the final part of the Shipman Inquiry in January 2005, and the Haslam and Kerr Inquiry reports are expected later in 2005.

13. Each of the inquiries has considered why existing systems, including the complaints system, did not mean that the problems were fully recognised and acted upon far sooner. Each has pressed for a more patient-focused approach. They have also produced specific recommendations on complaint handling.

14. The Neale and Ayling inquiries called for:

- advocacy;
- an independent element to the system;
- early resolution of complaints; accessible and easily-used systems;
- better communication;
- training in complaints handling for all staff;
- special training in handling sensitive matters for the Patient Advice and Liaison Services (PALS) and the Independent Complaints Advocacy Services (ICAS) staff;
- the establishment of systems to ensure that complaints about the same practitioner working in different organisations could be linked.

15. The Shipman inquiry report recommended key changes to handling complaints about GPs including:

- all complaints about GPs should be reported to the PCT and patients could lodge complaints direct with the PCT; *and*
- PCTs should develop the ability to investigate complaints properly and refer to the Healthcare Commission where necessary.

Developments in public and patient involvement

16. Between 1999 and 2004, there were significant developments in public and patient involvement which had implications for complaint handling.

PALS and ICAS set up and CHCs abolished

17. In 2000 the NHS plan proposed the creation of patient advocates and patient forums in every hospital to help services become more focused on patient needs.

18. Patient Advice and Liaison Services were to be in place in every NHS Trust and PCT by April 2002. PALS provide on the spot advice and information to patients, often helping to resolve concerns before they become complaints. PALS are not intended to be directly involved with formal complaints under the complaints procedure, but often act as a gateway to another new creation - the Independent Complaints Advocacy

Services, which were specifically designed to support complainants through the complaints procedure. Contracts were issued to independent advice/advocacy organisations to provide ICAS across the country from September 2003.

19. In effect PALS and ICAS were intended to take over the Community Health Councils' (CHC) role of helping complainants. CHCs were abolished in December 2003.

2003-2004 CPPIH and patients forums are set up then CPPIH is to be abolished

20. While PALS and ICAS were being put in place, a new national statutory body, the Commission for Patient and Public Involvement in Healthcare (CPPIH), was established in January 2003. Its role was to ensure that NHS services take account of the views of the public, providing and facilitating a framework for public involvement and acting as a champion for patients nationally. It did this, in the main, by setting up Patient and Public Involvement Forums whose role was to provide direct independent input into the day-to-day management of health services. They were introduced in NHS Trusts and PCTs during 2003. Then, in July 2004, the Secretary of State announced that CPPIH was to be abolished, as part of a wider review of the Department's 'arm's length bodies'. Patients Forums would continue but, to date, it has not been decided what other arrangements will be provided to support and advise them. The Department began a consultation exercise on this issue in November 2004.

Developments in clinical negligence

21. In June 2003 the Department of Health published a report by the Chief Medical Officer, *Making amends - A consultation paper setting out proposals for reforming the clinical negligence system*. It recognised that the present system is unfair, slow, costly in legal fees and encourages defensiveness. The report proposed a new NHS-based system of redress for patients who had been harmed by NHS care, as an alternative to litigation. It would be run by a body building on the work of the NHS Litigation Authority (NHSLA), which currently deals

with medical negligence litigation on behalf of NHS Trusts. Initially it would be limited to packages of care and payments to families of neurologically impaired babies and to those treated in hospital or community health settings but not by primary care services. In general, payments would be limited to £30,000, but more may be available for neurologically impaired babies. It recognised that those seeking financial redress should also have explanations, apologies and information about action to prevent recurrence of the problem, which they often did not receive when taking legal action.

22. In July 2004 the Department's review of arm's length bodies said that the NHSLA would be reconstituted to oversee the NHS redress scheme, and further details on the operation of the scheme would be published later in 2004.

Chapter 2

Our concerns

Current proposals and regulations

23. There are five key weaknesses in the current system and approach, which the interim changes introduced in 2004 have not resolved:

- **complaints systems are fragmented within the NHS, between the NHS and private health care systems, and between health and social care;**
- **the complaints system is not centred on the patient's needs;**
- **there is a lack of capacity and competence among staff to deliver a quality service;**
- **the right leadership, culture and governance are not in place;**
- **just remedies are not being secured for justified complaints.**

There are, in addition, a number of problems which arise from the way the interim changes were implemented.

Fragmentation in complaints handling

24. Despite the fact that NHS care is being delivered in an increasingly wide range of settings, it is our experience that most people see the NHS as essentially one organisation delivering one-off or ongoing packages of health care. The Secretary of State for Health is clear that an NHS patient is an NHS patient regardless of where they are treated. However, when someone wishes to complain about health services, the image of one NHS can quickly shatter if the complaint is about more than one NHS body or it involves the social services.

Complaints across the NHS

25. A significant number of complaints cut across services provided by more than one NHS organisation, for example, GP care followed by a hospital admission. The latest regulations, as originally drafted, imposed a duty on NHS bodies to co-operate in such situations so as to give

complainants a full, co-ordinated and comprehensive response. A specific patient-focused requirement of this sort would have been very helpful for patients making such complaints who may have to make two or more complaints, often with different timescales and stages. There is also the issue of complaints about failures of communication or service delivery between NHS providers. It is our experience that these are very difficult to pursue and secure a satisfactory outcome. However, following the decision to phase implementation (see paragraph 9) Ministers decided to leave local resolution unchanged. This meant that all new requirements, including the duty to cooperate, were removed from the interim regulations. The Department of Health has, however, said that it intends to reintroduce the requirement when it issues amended regulations later this year.

E.2470/04

The Ombudsman upheld Mr Q's complaint of unreasonable delay in diagnosis and treatment of his late wife's ovarian cancer owing to failures in communication between the GP and two hospital consultants who worked in both the NHS and a private hospital.

In January 2002 Mrs Q was referred by her GP to a consultant surgeon at a private hospital. After the consultation, the consultant arranged for an ultrasound scan and barium enema to be carried out. He wrote to the GP in early February but the letter was not entered on to the GP practice's electronic records system until late April. A few days before the tests were due to take place, a second GP, who was unaware of the surgical consultation and planned tests, referred Mrs Q, who was by then suffering from breathing problems, to a consultant physician in respiratory disorders at the private hospital and she was admitted. Later Mrs Q was transferred to a NHS hospital but remained under the care of the same consultant physician, who also worked there for the NHS. It was not established whether or not a photocopy of the consultant physician's notes travelled with her but the consultant surgeon's notes did not.

Mr Q informed the consultant surgeon's secretary that his wife was in hospital and could not, therefore,

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undergo the planned tests. However, the consultant physician and the consultant surgeon did not make contact and, a month later, it was Mr Q who contacted the consultant surgeon to rearrange the tests. They were re-scheduled for 10 days later. The connection between what were, apparently, two different sets of symptoms was not made; neither was a diagnosis of Mrs Q's illness. Eight days after that Mr and Mrs Q were shocked to be informed that Mrs Q had ovarian cancer. She died two months later.

NHS foundation trusts

26. Provision was made in the Health and Social Care (Community Health and Standards) Act 2003 for the establishment of NHS Foundation Trusts and by July 2004 the first 20 had been authorised. They were established to move management of local health services away from the Secretary of State for Health to local control. NHS Foundation Trusts have to achieve national targets and standards, but have freedom to decide how to deliver this. The Government's aim is to enable all NHS Trusts to apply for foundation status by 2008. But NHS Foundation Trusts - an increasing element of NHS care - are treated differently under the NHS complaints procedure.

27. Although subject to national targets and standards, the local resolution aspects of the 2004 regulations do not apply to NHS Foundation Trusts: indeed the regulations make specific provision for the situation where an NHS Foundation Trust does not have a complaints procedure.

28. An independent provider of NHS services must ensure arrangements are in place for the handling and consideration of complaints about any matter connected with its provision of services as if the NHS complaints regulations applied. That is only right: it would be quite wrong for NHS patients referred to independent providers to have less opportunity to have any concerns considered than those having services provided directly by the NHS.

29. The intention is that similar provision applies to NHS Foundation Trusts. We understand that at present they continue to operate local resolution

procedures which they were required to have prior to their change of status. The Model Contract used when they provide NHS services requires them to maintain an NHS complaints procedure 'compliant with all applicable Law (including any NHS complaints Regulations in force)'. However the 2004 Regulations do not apply to them as regards local resolution, so further clarification would be helpful.

30. We acknowledge that NHS Foundation Trusts are expected to provide high quality patient services and so should be in the vanguard of providing patient-centred complaint handling arrangements which enable them to improve their services. There should be no possibility of an NHS Foundation Trust's patient receiving a poorer complaints service than any other NHS patient. But it is the potential for confusion and inconsistency which is of concern to patients who, for example, have complaints about both a NHS Foundation Trust and other NHS bodies. It is possible for NHS Foundation Trusts to run separate systems which may, for example, reduce the opportunity for a joint approach to a complaint about the co-ordination of specialist care shared between a regional centre and a local hospital, when one is an NHS Foundation Trust and the other is not.

31. The Healthcare Commission can consider complaints about NHS Foundation Trusts in a similar way to those about any other NHS bodies where a complainant is not satisfied with the outcome of an investigation by an NHS Foundation Trust or it has no complaints procedure.

Complaints about both health and social services

32. At present the social services complaints procedure is entirely separate from the NHS complaints procedure. This can cause problems for users of both sets of services when things go wrong.

33. Many of those who receive both services are elderly, frail or suffer from long term, disabling conditions. Complaints can arise about both health and social services or about how they have worked (or not worked) together and it is not always clear to service users which organisation is responsible for the services they receive.

34. From complaints we have seen in the past, it is evident that cross-boundary complaints have often been handled very poorly. In some cases complainants were not told promptly of the respective roles and responsibilities of health and social services organisations. Sometimes they were not advised that they would need to pursue the health and social services aspects of their complaint through two separate procedures. We have seen cases where only at the conclusion of one complaints procedure was it clear that the fault lay with the other organisation.

E.629/02

Mrs H and her family were invited to a care-planning meeting to discuss arrangements for her mother's discharge from hospital. Staff from the acute Trust, the Community Trust and Social Services were present. When Mrs H later complained about the refusal to carry out a full continuing care assessment of her mother's needs, and the lack of information about the financial implications of placing her mother in a nursing home, she faced difficulties in addressing her complaints to the right body.

The acute Trust turned her complaints away and directed her to the Community Trust. When Mrs H brought in the acute Trust's patients' representative and asked him who was responsible for the care-planning meeting, he directed her to Social Services. In the end the Ombudsman investigated the actions of the acute Trust and the PCT, which now employs a key member of staff of the former Community Trust. The Local Government Ombudsman investigated the actions of the Local Authority Social Services Department.

Both Ombudsmen upheld the complaints. The acute Trust liaised with the Local Authority and a satisfactory financial remedy for Mrs H was obtained.

E.1324/02

Mrs X, who was in her late eighties and whose behaviour was becoming increasingly confused and aggressive, underwent a mental health assessment at a day centre. Present were: the consultant and his senior house officer (SHO); the approved social worker; the day centre manager; and the GP. After assessment, Mrs X was taken to hospital on a voluntary basis. Later she was detained under the Mental Health Act. Mrs X's family had expected to be present when their mother's future was decided. That did not happen and they later complained about the way in which she was assessed and detained, and about aspects of her care by the Trust.

Mrs X's family complained to Social Services about the actions of the social worker and their complaint culminated in the final stage of social services departments' local complaints procedure. However, some issues remained unresolved.

The family also complained to the Health Service Ombudsman after the Trust had failed to resolve several issues arising from Mrs X's care and treatment. Over time, their initial grievances became compounded by their dissatisfaction with the Trust's handling of their complaint.

It took 123 weeks for the Trust to deal with the family's complaints. It is evident that delays were compounded by the Trust having to investigate the complaint in conjunction with Social Services.

The Ombudsman upheld part of the complaint about the Trust. However, our investigation revealed that the social worker's actions were a major factor in the complaint, which the social services' investigation had not uncovered. The actions of staff employed by social services departments were not within the Health Service Ombudsman's jurisdiction and, therefore, she could not make findings on the part played by the social worker in relation to the detention of Mrs X.

E.748/05

The Ombudsman received a complaint from Miss B (who was expecting a baby) that the Trust had provided her with an inadequate explanation of the reasons for her referral to Social Services by a midwife and had not discovered the source of incorrect and misleading information forwarded on by the midwife.

The Ombudsman's investigation revealed information about social services' involvement which had not been uncovered by the Trust.

The midwife had been trying to arrange a multi-agency support package for Miss B - as recommended in guidance entitled *Working together to safeguard children*, which was published jointly by the Department of Health, the Home Office and the Department for Education and Employment, in 1991. The guidance describes how all agencies and professionals should work together to promote children's welfare and protect them. However, when Miss B thought she had cause for complaint which seemed to span both health and social services, there was no clear way forward.

Indeed, the Ombudsman found that Social Services, not the midwife, were the source of the incorrect information. However, the Health Service Ombudsman has no jurisdiction over the actions of social services' staff, and could not, therefore, comment on their actions.

2003 Provision for improvements

35. We welcomed the Health and Social Care (Community Health and Standards) Act 2003 provisions for similar new health and social care complaints procedures, which allowed for a complaint to be made either to the NHS or to social services. It was envisaged that the two systems would 'operate as far as possible in parallel so that for the complainant it appears as one system'.

36. However, to date, despite some work on developing regulations and guidance on social care which are similar to those on health care, no regulation has been made about the joint consideration of complaints. The situation was further complicated by the need separately to consider the adults' and children's parts of the social services procedures.

37. In October 2004 two separate consultations, by the Department of Health and the Department for Education and Skills, on the adults' and children's parts of the complaints regulations respectively, began. A month earlier the Commission for Social Care Inspection (CSCI) had begun to consult on the independent review stage.

38. There was a widespread commitment to joining up the health and social services complaints approach. Originally it had been hoped to launch the two new health and social service complaints procedures simultaneously in 2004 but this did not happen. Implementation of the new social services procedure was planned for April 2005 but is now likely to be later, to allow time for preparation.

Joint working - first and second stage

39. The draft Social Services Complaints Regulations do contain provision for complaints made under the adult social services procedure, but which also involve health matters, to be made to the local authority. The complaints manager must then consult with the complaints managers of the other bodies involved and decide who should take the lead. Where practicable a report should be prepared dealing with all aspects of the complaint. But there is no such provision relating to complaints made under the children's procedure in the draft Representations (Children) Regulations.

40. If provision were made for complaints made under the social services children's procedure to be dealt with in the same collaborative way, it would be a good step forward. Similarly, to complete the joint approach, the NHS complaints regulations need to include analogous provision for collaboration with social services.

41. There are also various differences in procedures and timescales for the local resolution stage of health and social services complaints which seem likely to cause unnecessary difficulty for complainants. Perhaps, most significantly, the health service time limit for making a complaint is six months but draft social services procedures allow 12 months.

42. At the independent review stage, however, the draft regulations allow for joint handling of complaints by the Healthcare Commission and CSCI, whether those complaints are made initially under the social services' adults' or children's procedures.

43. The Health and Social Care (Community Health and Standards) Act 2003 also amended the existing statutory social services complaints procedure, and placed a duty upon CSCI to work closely with the Healthcare Commission in matters of complaints concerning joint health and social care provision. Both the Healthcare Commission and CSCI have made general statements about working together but neither has yet given any real indication of how this will work in practice.

Procedural differences between the Healthcare Commission and CSCI

44. We recognise that there are differences in the way complaints have been dealt with in the past under the separate health and social services systems. There are also differences in the procedures which both the Healthcare Commission and CSCI have said they will use. For example:

- the Healthcare Commission describe panels using the results of the Commission's own (stage two) preceding investigation; CSCI envisage panels using information gathered at local resolution; both would allow representations from both sides;
- the Healthcare Commission will give the panel chair the final say in any disagreement about the conduct of a panel; CSCI say the conduct of the panel will be determined by the majority;

- the Healthcare Commission have a detailed target system for timescales for handling complaints; CSCI a much broader framework with shorter overall targets. For example, the former have a target of four months from request to completion of a panel; CSCI propose 45 working days (about two months). The Healthcare Commission say they are now looking at a broader framework of time-scales similar to CSCI to facilitate the handling of combined complaints.

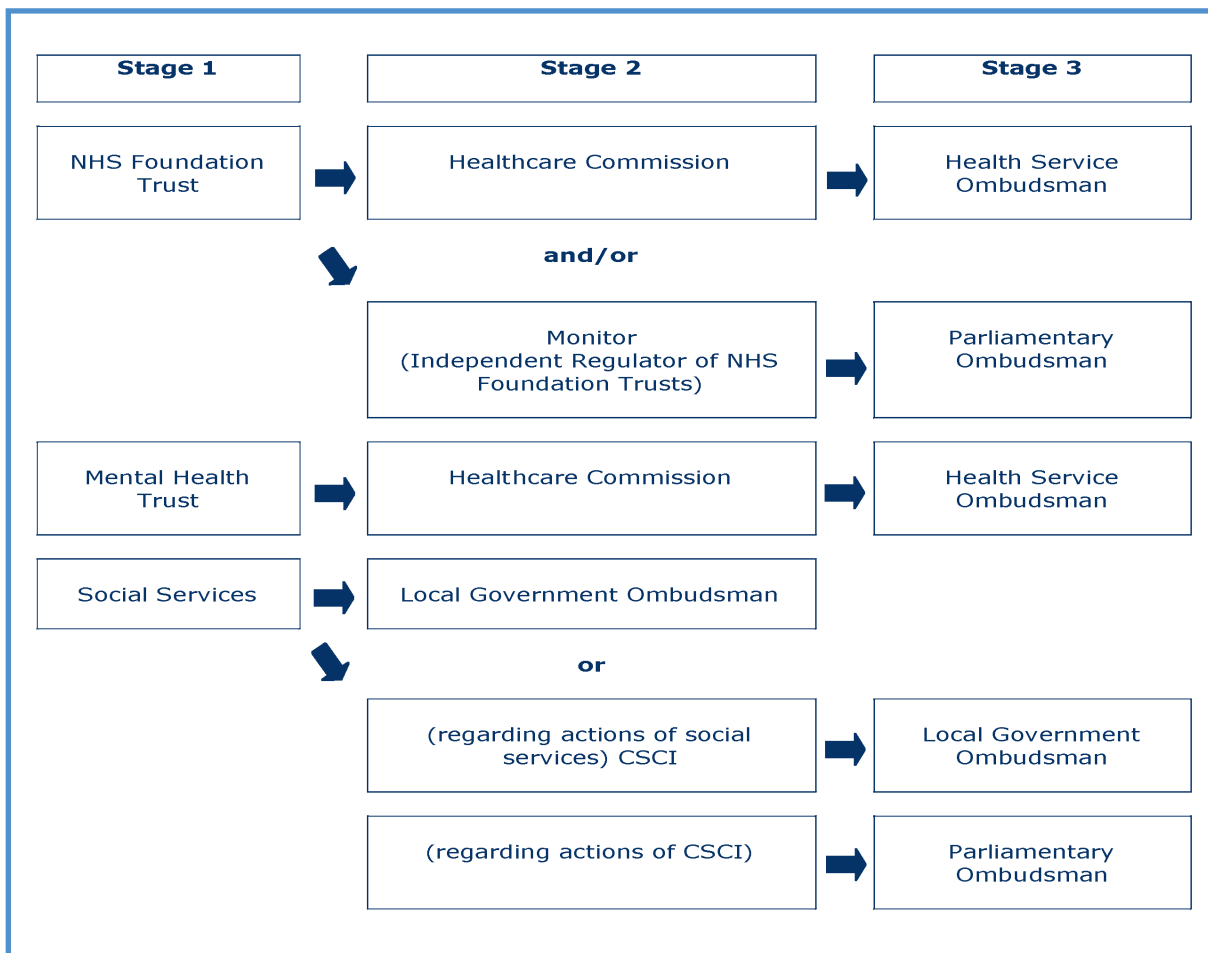
45. We have experience of working jointly with other Ombudsmen to investigate complaints which straddle the boundaries of health and social care. By adopting a creative and positive approach to joint working, we manage to overcome many of the difficulties which our separate legislations impose on our work. It is much more difficult to provide a seamless service under significantly different procedural frameworks. The new parallel legislation on health and social services complaints provides the opportunity to co-ordinate the two systems; it should not be missed. Clearly it would not be helpful to straitjacket the procedures into exactly the same format

where differences in approach would be helpful. However, unless joint working has been properly considered from the start, the needs of service users will not be well served.

Joined-up and patient-focused?

46. We have grave concerns that if cross-cutting health and social care complaints remain unresolved at the end of the second stage of the different complaints procedures, and a third and final tier is needed, the difficulties for the complainant will multiply.

47. To illustrate this let us take a hypothetical, but not untypical, case study involving a 14 year old girl, Jane. Jane suffers from a mental illness and receives care from her local mental health trust and social services. She also regularly injures herself and on those occasions requires admission to the local acute trust, which now has Foundation status. Something goes wrong and Jane tries to complain about an event in her continuing care and treatment which crosses the boundaries of the various systems. Local resolution fails to answer her complaint so Jane wants to ask for an independent review. At each stage she might need to approach three different bodies:



(The situation is no simpler if Jane wants to involve an Ombudsman at an stage. Not only might she have to approach both Health and Local Government Ombudsmen to cover the full range of her original complaint, but if she had concerns about how it was handled by Monitor or CSCI she would also need to approach the Parliamentary Ombudsman.)

48. In our view, it is quite wrong that there is no over-arching joined-up complaints framework which attempts to address these issues. As we have already noted, those who receive services both from the NHS and social services are among the most vulnerable members of society. Such a convoluted system seems to work against the aim expressed in the *NHS improvement plan 2004* to 'put people at the heart of public services'.

Complaints system not centred on patients' needs

Inflexible processes

49. Much emphasis is currently being placed on moves to make the NHS work in a way which better meets the needs of patients: and rightly so. Too often in the past the focus was on a clinical or managerial perspective. That is not appropriate for a publicly funded service in the 21st century. A real commitment to a patient-centred service means accepting that it is only right for patients to be able to express any dissatisfaction they may have with the NHS and that the system which considers their concerns should be customer-focused.

50. The survey of complainants to our Office, carried out on our behalf by MORI in 2004, found that:

- by the time complainants get to us, at the end of a protracted complaints procedure, they feel isolated and exhausted;
- complainants want to talk to someone about their complaint and to know who will be dealing with it and how it will be dealt with. They want to know how their complaint is progressing and be updated on our work and thinking;
- complainants want an appropriate outcome to their complaint, usually

an apology, where appropriate, a change in working practices so that it does not happen to someone else, and for someone to be held accountable for what went wrong;

- few complainants started out to seek financial recompense. But the **process itself** makes them more likely to ask for financial redress because of the time and effort they have expended in trying to get their complaint resolved. Worse - when compensation is offered, a small amount can antagonise them even further.

51. We have tested these findings with complaint handlers in the NHS who have told us that they reflect what complainants say to them. Every complaint and complainant is different: one size and shape of procedure will not fit all circumstances. To be patient-focused a complaints system needs to have sufficient flexibility to meet these varying needs. Our surveys of complainants who approach us demonstrate that complainants recognise that some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of investigation work required. They want a fit for purpose response to them and their complaint with a focus on appropriate resolution, not a one size fits all process. Complainants are prepared to wait for a comprehensive investigation and response, so long as the reasons for this are explained and they are kept informed of progress. The CPPIH expressed similar views on behalf of service users in their comments on the draft regulations: they would rather have a longer timescale which was adhered to than an ambitiously short one which proved difficult to meet.

52. There can be some tension between a desire to provide that flexibility and a wish to improve performance by setting explicit and measurable standards which all services must meet. Plainly, a clear basic framework needs to be given and some standards set. However, care is needed to avoid focusing on rigid time targets or developing complex procedures which will result in the needs of significant numbers of complainants not being met.

Speed of response/targets and timescales

53. Complainants are interested in outcomes, not time targets, but that is not how complainants or, indeed, complaint handlers experience the current system. The focus on process in the current Regulations and the significance of achieving the time targets for the star rating system has led to a perverse incentive for Trusts to make and communicate a decision, signed by the Chief Executive, within 20 working days. Unfortunately, we have seen many instances where the pressure to communicate a timely decision has outweighed the need to consider the complaint properly.

54. To make matters worse, there is no further target which is monitored centrally. We have seen many cases where a complainant expressing legitimate dissatisfaction with that first decision has waited months for a response. While, therefore, one size fits all targets are unhelpful, complainants do need to know, at the outset, how long a decision on **their** complaint is likely to take and to be told of any changes to that timescale.

55. In November 2004 the Healthcare Commission undertook a consultation exercise on the approach they should take in assessing whether organisations meet the Department of Health's Standards for Better Health. The consultation is proposing that the assessment for the core standard on complaint handling is based on more than the timeliness of response and we welcome this.

56. Introducing unnecessary complexity to the procedures for complaint handling will exacerbate difficulties in responding in a timely way. This is perhaps most apparent in the detailed and complex procedures adopted by the Healthcare Commission. The regulations give them considerable discretion on how to handle complaints including the option to go direct to a panel hearing. However the Commission's procedures have suggested that they intend to use panels mainly as an additional stage: if a complainant remains dissatisfied following an initial review and investigation. The Commission say that they are motivated by a desire to give

the patient 'the strongest sense of independent resolution', Given the ability of the complainant to appeal to the Ombudsman as a final recourse, used in this way the panel would appear only to lengthen and complicate matters for the complainant rather than speeding up and simplifying them. The process would then have 15 separate actions listed, each with a separate time target, leading to a total time target for cases going to a panel hearing of over a year from the point of first contact with the Commission: though their overall target is to resolve complaints in six months.

Deterring primary care complaints

57. Another important aspect of complaints handling in the NHS which is not meeting patients' needs concerns complaints about primary care contractors (GPs, dentists, pharmacists and opticians). Currently patients can find themselves having to complain directly to the very person about whom they have a complaint. That person may also be the one who responds to them, without any input from a third party. For the patient, dealing directly with a practitioner with whom they have a continuing relationship can be very difficult.

E.1152/03

Mrs R asked Dr G to make a home visit to her mother and subsequently made a complaint about his behaviour. Dr G asked Mrs R's mother to find another doctor.

The Ombudsman investigated his action and upheld the complaint. She found that Dr G had acted unreasonably by ending his professional relationship with Mrs R's mother as a result of Mrs R's complaint. It was inappropriate for a GP to try to remove a patient from his list because of difficulties with another member of the family.

Dr G agreed to familiarise himself with GMC, RCGP and BMA guidelines relating to removals from lists. He also agreed to familiarise himself with the statutory position from April 2004 whereby a GP normally needs to warn a patient before they can be removed. He also agreed to discuss his approach to complaint handling with the PCT.

58. For some time it was intended to resolve this problem through the new complaints procedure. *Making things right* proposed that patients, if they wished, should be able to complain direct to the

PCT about a primary care contractor rather than to the practitioner. The original draft of the 2004 regulations made such provision and we supported that change. However no such provision was retained in the final version, though the Department of Health say that will be included in revised regulations in 2005. A patient-centred complaints system would recognise the difficulty for some patients in this situation and make provision for complaints to be made to the PCT. The 5th Shipman report recommended a much enhanced role for PCTs in handling complaints about GPs - including such direct access for complainants.

Need for support and advice

59. We recognise that access to special support can often help a complainant present their complaint effectively. Complainants may need help in writing their complaint, translation and the intervention of interpreters, or to talk to someone who can explain and help them through the present, complicated process. PALS and ICAS do provide such help and we have received complaints which are comprehensive, clear, thorough and well argued because of their involvement. Our knowledge of complaints supports the recommendations made by recent Inquiry reports about the need for competent and sensitive advocates.

Quality service

Inadequate investigation

60. Rigorous and evidence-based investigations by competent staff are essential. But, in our experience, both the quality of the complaint investigation and the competence of staff handling complaints vary significantly and are often inadequate for the task. We have received many complaints where the local resolution:

- had had no clinical input although the complaint was about diagnosis and treatment;
- was based on inadequate or uncorroborated evidence;
- was flawed because of the partiality or perceived partiality of the reviewer;
- accepted the views of Trust staff without question;
- did not cover all aspects of the complaint;

- was based on poor analysis and judgment;
- was poorly documented and failed to give reasons for the decision.

Such concerns have been highlighted in a number of recent Inquiry reports. Different perceptions of the quality of local investigation in health and social services, (ie that in the past it has been less robust in the NHS), have also contributed to the differences in approach between CSCI and the Healthcare Commission, though the Healthcare Commission are anxious to use their powers to help ensure that local investigation and resolution in the NHS is more effective. However, we do see examples of good complaints handling too:

E.2146/03

Mr S complained about his diagnosis and the care provided to him within a Trust's general mental health and psychotherapy services. Mr S sent numerous letters to Trust personnel which all sought to expand his original complaint.

The Trust investigated his complaints speedily and a response from the Chief Executive was sent to Mr S a month after he submitted a formal complaint. A subsequent letter offered a further attempt at local resolution but once that had again failed, the complaint was referred to the convener for possible independent review. The convener took appropriate clinical advice and rejected the request for a review. Mr S complained to the Ombudsman.

The Ombudsman decided not to investigate Mr S's complaint. She had no concerns about the standard of care given to Mr S and commended the Trust for making significant and strenuous efforts to address all Mr S's complaints with considerable patience, understanding and sensitivity, and in a timely way.

Lack of capacity and competence

61. Often the shortcomings in the investigation relate directly to the lack of competence of the staff handling the complaint. Local complaint handlers are often junior staff, selected for their interpersonal skills, but not necessarily their analytical skills. For example, it is still not uncommon for the former secretary to the Chief Executive to lead on complaints. Certainly it is rare to find that all front line staff have received training in handling complaints.

62. One of the recommendations of the evaluation of the old complaints procedure¹ was that Boards of NHS bodies should ensure that:

- all staff are adequately trained to deal with complaints and are supported in the event of a complaint being made against them. Training in handling complaints should be a compulsory part of induction and continuing education;
- staff managing complaints are appropriately trained, have adequate administrative resource and access to senior managerial supervision and support.

63. An early draft of the current regulations contained a requirement² that NHS bodies must ensure staff were appropriately trained in the operation of the complaints arrangements. There is no mention of training in the final version or in the guidance. The Department says that this requirement will be reintroduced in revised regulations to be issued this year.

64. We welcome the fact that training initiatives in complaint handling are underway. The NHS and Middlesex Universities are developing an accredited qualification in complaint management, which will be relevant to those with specific responsibilities for complaints. The present good practice toolkit for local resolution (developed under the old complaints system) includes a list of competencies for complaints managers. However this has not been revised and strengthened to match the new system and there is no evidence, of which we are aware, that these competencies have been widely embraced at the local level. A crucial point in complaint management is the time that concerns are first raised and this means that **all** staff need to have a basic understanding of how to deal with complaints and concerns and the communication skills to do so effectively.

65. Whilst developments in training and guidance are to be encouraged, the general pace of progress in this area and the emphasis placed upon it is disappointingly limited in an NHS which aims to be more patient-centred. As the Department's evaluation and subsequent inquiries have recognised, there has not been sufficient emphasis on developing a

group of appropriately influential and competent staff to undertake thorough and open complaint investigations.

Leadership, culture and governance

Strong leadership and a learning culture

66. In our experience, clear, positive leadership is essential for the development of an open, learning culture in which complaints are welcomed and resolved and lessons learned. Certainly we have direct experience of clusters of complaints against specific trusts or other bodies which reflect a defensive approach to complainants, and indeed us, by the Chief Executive. Those organisations, despite ostensibly accepting our recommendations, have failed to address systemic issues and created a context for repeated mistakes...and complaints. Chief Executives who welcome complaints and support a learning rather than a blame culture by their own example, rarely have complaints upheld by this office.

Governance and accountability

67. The Department's 2001 evaluation report recommended that the Board of every NHS organisation should be held accountable for the performance of the organisation in handling complaints. We wholeheartedly endorse that. It is the Board and Chief Executive who can create a culture of openness and learning, monitor performance on complaints handling, and make effective connections with clinical governance.

68. The 2004 regulations require a Board member to take responsibility for ensuring compliance with the arrangements and that action is taken in the light of the outcome of any investigation. While that goes some way towards building a framework of accountability, it is not sufficient. There is nothing to prevent the Board level sponsor from being an executive director who is already managerially accountable for complaint handling, and who may have a vested interest in convincing the Board that all is well.

69. The evaluation also recommended that Boards had to ensure that agreed

¹ 6.12²29

actions were implemented. But the 2004 regulations are weaker, requiring only that the designated Board member must ensure that action is taken in the light of the outcome of an investigation. That leaves scope for the wider Board not to accept accountability and for partial implementation of agreed actions. Our own experience has shown us that some NHS bodies lose interest in the outcome of complaints once a response promising action has been sent and implementation may be poorly monitored. It is important in a patient-centred service that actions are delivered and that implementation is monitored from outside the department concerned.

70. The 2001 evaluation report also recommended that complaints handling should be an explicit part of the performance management of Chairs and Chief Executives of NHS bodies. No such provision has been made.

Integration of complaints procedure with other NHS systems

71. Clearly the NHS complaints system should not operate in isolation. The original evaluation recognised this and recommended that Boards should ensure that 'the complaints procedure is integrated into the clinical governance/quality framework of the organisation.' That is not fully reflected in the regulations or guidance. The guidance says only that the designated Board member for complaints 'may' wish to link the complaints procedure with clinical governance processes and risk management strategies.

72. It is essential that connections are made which facilitate learning from complaints. At national level the integration of the second stage of the procedure into the Healthcare Commission's work should provide that connection. But matters should not have to reach the Healthcare Commission before such a connection can be made and lessons can be learned.

73. Since the evaluation there have been many relevant developments at national and local level, particularly in patient and public involvement, and links between these and complaints systems will also be important, especially in improving patient focus. However it is less clear how and whether links will be

made with other work, especially at local level. In particular, there is no reference in the present complaints regulations and guidance to establishing links with Patients Forums despite there being real potential in involving them (and ICAS and PALS) in reviewing plans for, performance and outcomes of complaints procedures. Indeed, in commenting on the role of Patient Forums, we have supported the suggestion that such forums could usefully check whether recommendations have been followed up.

Just remedies

Long standing concerns

74. The existing NHS complaints system says nothing about financial redress, and it is rarely, if ever, recommended or paid. Financial regulations governing the NHS have sometimes been quoted as preventing this. But NHS bodies may make special payments where there has been a financial loss as a result of the actions or omissions of the NHS body. Other payments may be made in exceptional circumstances. We have increasingly been recommending, and securing, financial redress for complainants from NHS bodies in appropriate circumstances. But, in effect, other than by submitting a complaint to the Ombudsman, financial redress has generally only been available through legal action for medical negligence. Complainants who have given any indication that they intended to take legal action have been excluded from the complaints procedure.

75. We have been raising our concerns about this situation for several years. In our *Annual Report* for 1998-1999, we pointed out that:

'It is relatively easy to decide the appropriate way of dealing with the extremes: for example, clinical negligence causing serious damage is appropriate for the courts; relatively minor shortcomings without serious consequences can be dealt with by an effective and responsive complaints procedure. It is the middle group of cases, lying between the extremes, which is more difficult to deal with. Those are cases in which the complainant has suffered significant loss or damage through what he or she perceives - sometimes rightly - as shortcomings in the standard of care which do not amount to negligence as that term is understood by the courts. As things now stand, complainants in such circumstances have no means of pursuing their case

except through the courts. Their case will probably fail; so that they will be left with an unremedied grievance, which on some occasions may be justified, and legal costs to pay as well. In this respect the NHS treats complainants worse than either central or local government. Both central and local government are willing, if they consider a complaint justified, even if there is no legal liability, not only to give financial compensation for any ascertainable loss due to their failings, but also to make payment for distress-including any distress occasioned by difficulty in having the complaint accepted.'

76. The issue was again raised in our *Annual Report* for 2003-04:

'It is ... important that injustice is fully and appropriately remedied. Most complainants want to understand what went wrong and to receive an apology for the distress caused. The concept of financial redress has gained ground in central and local government, but there is a marked reluctance to accept it in the NHS. It is gratifying to note, therefore, that there are several examples of trusts agreeing to offer a financial remedy to complainants as recompense for the severe difficulties they had experienced in trying to make their complaints. For example, a trust which had consistently failed to deal with a request for an independent review agreed to our recommendation that the complainant should receive an ex gratia payment in recognition of the inconvenience he had suffered. We aim to see the NHS aligning itself with other parts of the public sector in this regard and we will continue to promote discussion within the NHS about this significant issue for complainants.'

Limited scope of the proposed NHS redress scheme

77. None of the recent documents about the reform of the complaints procedure says how, if at all, it is planned to relate to the NHS redress scheme proposed in *Making amends*.

78. The NHS redress scheme, as described in *Making amends*, would be limited to cases where there were serious shortcomings in the standards of care and where the adverse outcome is not the result of natural progress of a disease. But there are situations where significant, but perhaps not in themselves serious, lapses in standards of care can have detrimental consequences which are highly significant for the patient.

79. The proposed redress scheme rightly emphasises the responsibility of

the NHS to deliver a package of care and remedial treatment by way of redress. But such NHS care and treatment, if required, should be provided in any event. There are also a number of situations where the NHS is at fault but no such remedial care and treatment is needed or possible and where, nevertheless, natural justice suggests that financial redress would be appropriate. That includes the most serious cases where the patient dies, and situations where the patient incurs significant unnecessary costs because of a non-clinical failing. The current proposals are too narrow to accommodate these situations.

Lack of clarity in current system

80. It is unclear what is intended to be done about financial redress under the new NHS complaints procedure. The 2003 Act³ says regulations may include provision for recommendations about a complaint and the action to be taken as a result. However, the regulations refer only to a 'response' to the complaint and say nothing about any recommendations or action at local resolution⁴. Nor is the guidance significantly more helpful, saying only that 'An outcome, or explanation of planned action, should be included where the investigation finds that something could/should have been done differently, or if there is anything to be done as a result of the complaint'⁵ and that 'it is good practice for replies to be as conciliatory as possible, including appropriate apologies'⁶.

81. The Healthcare Commission's procedures allow an investigation report to explore 'any options for resolution'. It will include any recommendations for improving services or actions to rectify the situation. The procedures also state that panels will make two sets of recommendations when called for: one relating to redress for the individual and the other relating to improvements to services. However, their leaflet for complainants says that they cannot award compensation: and the Commission say that they have had legal advice to that effect.

82. It cannot be acceptable that those who have had their complaints upheld locally or by the Healthcare Commission can receive redress only by complaining to the Ombudsman's Office. There needs

³ Section 115(2)(h) and (i)

⁴ (13) ⁵ (3.55) ⁶ (3.54)

to be provision for a full range of remedies at all levels of the complaints system, including explanations, apologies, specific actions or treatment, and, where appropriate, financial compensation.

Problems with implementation

Delay

83. It has taken more than three years from the evaluation of the previous procedure, which indicated major problems, to the first changes being made. The changes are still far from complete.

84. The pattern in moving towards a new procedure seems to have been one of 'slippage and scramble'. The slippage is exemplified both by the time between the end of the listening exercise in October 2001 and the issue of *Making things right* over 18 months later in April 2003, and by the delay from intended full implementation in April 2004 to partial implementation at the end of July 2004. More changes are promised in 2005. The scramble is exemplified by the six week listening exercise in 2001 (rather than the usual three month consultation period) and the rushed finalisation of regulations for the Healthcare Commission's new role in July 2004. Such a pattern of long periods of comparative inactivity, interspersed with much shorter periods of frantic activity to unrealistic deadlines, is not conducive to well-planned and thought-through change.

Lack of preparedness and confusion

85. The result of the scrambles for change was often confusion. The implementation of the 2004 regulations and the transfer of responsibility for the second stage of the procedure to the Healthcare Commission exemplify this. The Healthcare Commission formally came into existence in April 2004, although it had operated in shadow form for some time before that. Its complaints handling role was entirely new. At one point it had been hoped it could take on complaints from April 2004. However consultation on new draft regulations did not begin until December 2003 and this delayed their planned implementation until 1 June 2004. The original draft regulations included detailed changes

relating to local resolution as well as defining the Healthcare Commission's new role. In March 2004 we raised concerns that it would be difficult, if not impossible, for the Healthcare Commission to deliver an effective complaints handling process from 1 June 2004 and that this risked bringing the new arrangements into disrepute from the outset.

86. The Department of Health gave little extra time to the Healthcare Commission to prepare for their new role, even though major changes to local resolution were postponed to 2005. By May 2004 it had been decided to introduce the changes affecting the Healthcare Commission on 1 July. In fact the relevant regulations were not laid until 9 July and came into force on 30 July.

87. The rushed introduction, and consequent lack of preparedness, impacted on both complainants and those trying to operate the procedure at all levels. Although the delay in the implementation of the original plans further weakened the effectiveness of the old system, this difficulty needed to be balanced with the confusion surrounding a rushed implementation. Implementing regulations three weeks after they were laid in Parliament gave inadequate time for the public, NHS staff, advisers and voluntary agencies to understand them and use them effectively. Guidance on the application of the regulations for NHS bodies other than the Healthcare Commission was not issued until 19 August, nearly three weeks after the regulations came into force.

88. Given that public confidence in the system was already low, as shown by the evaluation report published in 2001, we expressed our concern at the time that a bad start to the new system was likely to create a further loss in public confidence which would be difficult to overcome.

89. The Healthcare Commission had to build up their capacity to handle the second stage from scratch: an enormous task. By May 2004 they had developed their communications strategy, had filled 41 of the 70 posts they forecast they needed to handle complaints, and were recruiting lay people to sit on independent panels. They had been testing an IT system. Despite those achievements there was much to do. For example:

- they were not able to issue information on how they would operate the second stage until July, and there was subsequent further review after that;
- by May 2004 they had not developed a policy on access to expert advice (an important area, which had been a difficulty with the previous arrangements).

90. The Healthcare Commission say the IT system was fully operational by the launch of their complaints role and that they have been able to obtain expert advice for the cases they have considered. However they have received significantly more complaints than originally forecast. The overall effect for complainants has been a severe delay in having their complaints addressed. We have been in active dialogue with the Healthcare Commission and we are assured that they now have action in hand to address the backlog of complaints.

Transitional arrangements

91. Transitional arrangements (for complaints part way through the old procedure) have also suffered in the scramble to introduce the new procedure. The 2004 regulations say that, where local resolution has already been completed and the complainant has requested an independent review under the old procedures, 'the independent review panel must be established in accordance with the former complaints provisions, conduct its investigation and make a report in accordance with those provisions.' This takes no account of the fact that under the old procedure conveners rejected a significant proportion of requests for independent review. Taken literally the regulations appear to suggest that a panel should be held in every case where the complainant requests it.

92. There is evidence that in practice there was considerable uncertainty about what could or should happen when complainants expressed dissatisfaction with the outcome of local resolution in June/July 2004, when there was confusion across the health service about when the new arrangements were to be introduced. The Department of Health clarified that, strictly, anyone who had made a panel request locally before 30

July 2004 should be allowed to proceed by that route if they wished. However, there also seems have been an understanding by the Healthcare Commission that the second stage for such complaints could be handled by them, from earlier in the summer. Some NHS bodies were referring requests for panels to the Healthcare Commission during July. This may have been a pragmatic approach, as local systems for arranging independent reviews were winding down, but given the confusion about what approach should be taken and the lack of publicity around the transition and new arrangements, complainants were unable to make an informed choice. We have seen a number of cases where complainants were given inaccurate information about the options for progressing their complaints - no doubt in good faith, by conveners or Trust staff who were unaware of the most recent changes to the proposed arrangements or timetable. It is essential that lessons are learned from this before new regulations are introduced in 2005.

Our commitment to collaboration and comment

93. Throughout the development of policy and regulations on complaint handling in the NHS we have been in dialogue with the Department of Health, either directly with officials or in formal responses to consultations. There have been many things to welcome, including the stated aims of making the system more accessible, responsive, independent and better linked to improving services. However, we have clearly expressed our concerns to the Department and indeed to the Public Administration Select Committee throughout this period. The Department's intention to issue further regulations in 2005, taking account of the Shipman and other Inquiries, presents a fresh opportunity to reflect on the shortcomings that still exist and what must be done to address them.

Chapter 3

Key elements of a new system

94. It is only right that, if we are to express such significant concerns about present system, we should also make clear what we believe needs to be done. The essential elements in the new system should be those that ensure:

- **coherent and comprehensive coverage;**
- **customer focus, accessibility, flexibility and transparency;**
- **a quality service;**
- **leadership, culture and governance;**
- **the provision of just remedies;**
- **improvements in service as a result of learning from complaints.**

To be effective such new arrangements must be introduced in a planned and project managed way.

95. It is not for us to set out how these outcomes should be achieved, that is a matter for the Department of Health, working with others such as the Healthcare Commission and local NHS bodies. We would certainly want to work with the Department to share our knowledge and learning and expand the principles which we propose must underpin the system.

Coherent and comprehensive coverage

96. So that complainants can complain easily about a single provider, two or more NHS providers, or organisations which provide social care as well as health care, there must be a **consistent approach** to the handling of complaints across all providers of NHS services, irrespective of where those services are delivered, including primary care, NHS Foundation Trusts and independent providers of NHS services, as well as in social care. But that is not enough. There needs also to be a clear commitment that all these organisations will collaborate to

address complaints in a joined up way and arrangements must be built into the system to achieve this.

Customer focus, accessibility, flexibility and transparency

97. All users of health and social care services should know how to complain and **access** to the complaints process must be equally available to all groups in our community. Complainants need to feel confident that a properly made complaint will not have an adverse effect on their future relationships with the service providers, particularly where s/he is their GP. Complainants who do not wish to complain direct to family health practitioners, should be able to **complain to PCTs**. Complainants must know how they can pursue their complaint where they are dissatisfied with the result achieved locally, or at the Healthcare Commission. The new approach should be based on **listening** to complainants and offering **support and advocacy** to enable them to pursue their concerns in the best possible way.

98. The system should allow for a **flexible approach to complaint resolution tailored to different complaints and complainants' needs**. It should encourage skilled staff to adapt the investigation and outcome to their varied circumstances. Key issues raised by the complainant must be addressed in any response and **explanations** given orally or in writing in terms which the complainant can understand. Responses should be timely, and any targets must be carefully constructed to **avoid introducing perverse incentives**. Targets should cover both timescales and the quality of the service and outcome.

Quality service

99. Those working throughout the NHS should be **open** about mistakes and failures by individuals or systems. Acknowledging and addressing mistakes should be encouraged not punished. Complainants and staff need to feel confident that they will be **treated fairly**, given an opportunity to contribute to the

process and provided **with support and feedback**.

100. The initial investigation must be adequate to enable **a full, carefully considered response** to the complainant, and opportunities for **early resolution** should be taken.

Investigations must be **evidence-based** and sufficiently **rigorous** to be used as an initial investigation for subsequent parts of the complaints system and the redress scheme, or in deciding whether the body needs to consider other action in the interests of patient safety or improving performance. Those handling the complaint need to have the authority **and skills** to decide how detailed an investigation is required for each complaint and to carry out the investigation: in some cases this will involve seeing records, interviewing staff and taking clinical advice. Arrangements to obtain appropriate advice are required, as is access to mediation, where appropriate.

101. Delivery of a new high quality local complaints service will require a **new focus on the training and competence of complaints staff**, for an enhanced role and responsibility in complaints investigation. Managers and front-line staff should also be well-motivated and trained in customer service and complaint handling.

Leadership, culture and governance

102. This will involve the Boards and Chief Executives of NHS bodies creating **a culture of openness and learning**. There should be clear standards of behaviour set and followed by the leadership of each local organisation, and the **monitoring of performance** on complaints by managers and by the Board. Managers need to ensure that arrangements for complaint handling are **well connected with clinical governance and quality improvement activity**.

Just remedies

103. All levels of the complaints system should include provision for a full range of remedies for justified complaints, including explanations, apologies, specific actions or treatment for the patient, changes to prevent recurrence and,

where appropriate, financial compensation. Redress should be designed to put the complainant back in the position they would have been in had the service failure or maladministration not occurred; or, if that is not possible, to compensate them appropriately.

Improvements in service

104. Recommendations arising from complaints should lead to **practical improvements in service**, and progress on implementation and effectiveness should be **monitored**. As well as reporting to the Board, NHS bodies need to build in systems locally to feed back learning from complaints to directorates/teams. Inquiries have highlighted the need for systems to be in place to ensure that those (fortunately rare) clinicians who repeatedly harm or pose a risk to patients are identified, wherever they are working.

105. The Healthcare Commission is in a strong position, in collaboration with others, to identify and drive forward learning from complaints nationally.

106. And our Office is committed to making an active contribution to the improvement of services from the evidence we gather.

Implementation

107. Implementation needs to be **planned** in more detail and with sufficient **time** for NHS and other organisations to be informed about what is expected of them. Patients, complainants and those supporting them need to be given clear information about the changes and the implications for them, well in advance of the change taking effect. Detailed guidance should be in place well before implementation of new procedures, together with training for staff. Transitional arrangements should be well thought through and clearly publicised.

Chapter 4

Recommendations

108. The outcomes we seek to achieve from the complaints system are clear. The pause in the implementation of a revised complaints process, prompted, in particular, by the Shipman Inquiry, presents the opportunity for the Department of Health to take a lead and ensure that these outcomes are finally secured for complainants in a new health and social care complaints system.

109. The history of proposals for reform, described in Chapter 1 of this report, shows that there is remarkable consensus about what an effective complaints system should look like and what it needs to deliver. The Department of Health's publication, *Making things right*, echoed the recommendations that emerged from the 'listening exercise' and the Bristol Inquiry, and has been reinforced by the recommendations of the Ayling, Neale and Shipman Inquiries. We do not dissent from that vision - indeed we have positively welcomed it.

110. The challenge, therefore, is not in determining the vision of an effective complaints system, but in avoiding the mistakes of the past and turning the aspirations of *Making things right* into a reality for patients and their families and NHS staff. Our recommendations are framed to that end.

111. A number of bodies need to work together to ensure that we now create the modern, responsive, patient-focused system to which we all aspire. In particular we see clear roles for the Department of Health, the Healthcare Commission and all providers of NHS healthcare.

Setting the national framework

112. The Department should set the framework and principles for the new complaints system. The core standards set by the Department of Health for all NHS bodies should set out the quality standards to which they should adhere. The standards should focus on outcomes and approach, not process.

113. We recommend that the Department of Health set core standards for the complaints system. This will ensure that the key outcomes, clearly described in our principles, are secured. The outcomes we seek are:

- a simple, consistent approach across all health and appropriate social care providers, so that a complainant can use the same approach when complaining about any NHS care and is enabled to pursue a complaint which crosses organisational boundaries easily and to similar timescales;
- a complaints service accessible to all members of our diverse community, tailored to the needs of the complainant and the particular complaint and providing support for those who need it to pursue their complaint. Those handling the complaint should understand what the complaint is about and what the complainant would like to happen as a result of the complaint. The complainant should be clear how and to what timescales his/her complaint will be dealt with and be kept in touch with progress;
- fit for purpose, thorough, rigorous and evidence based investigations of complaints with clear, well explained decisions. An approach which is fair to complainants and NHS staff and earns their confidence. Complaints handled by motivated, competent staff with the authority to secure the active participation of all relevant staff;
- a culture of openness and non-defensiveness which welcomes complaints as a way of remedying mistakes and improving service. Leadership by senior managers who live out this commitment and have in place systems to incorporate this learning through clinical governance and quality improvement;
- provision for a full range of remedies for justified complaints at all levels of the complaints system to include explanations, apologies, specific actions or treatment and, where appropriate, financial compensation for loss, distress or inconvenience.

This would need to include provision for the Healthcare Commission to recommend financial redress. Redress should be designed to put the complainant back in the position they would have been in had the service failure or maladministration not occurred; or, if that is not possible, to compensate them appropriately;

- recommendations arising from the investigation of complaints should be implemented to ensure the mistakes do not recur. Systemic faults should be identified and addressed both in relation to individuals, organisations and across organisations to bring about continuous improvements in patient service;

114. We recommend that the Department of Health require these standards to be met by all providers of NHS care irrespective of whether that care is provided in an NHS Trust hospital, an NHS Foundation Trust, by independent contractors to the NHS such as family doctors and dentists, by contractors in the private sector or by any other service providers.

115. We recommend that the Department of Health take the lead in ensuring that the core standards and common approach to complaints are adopted across health and social care by co-ordinating discussions involving all the interested parties: specifically the Department for Education and Skills, the Healthcare Commission, the Commission for Social Care Inspection, the Local Government Ombudsmen and the Health Service Ombudsman.

116. We recommend that the Department of Health ensure that patients are able to complain direct to their Primary Care Trust about primary care providers such as their GP or dentist and be supported by the PCT in pursuing the complaint.

The Healthcare Commission

117. The Healthcare Commission plays two distinct roles in delivering the complaints system: the provider of the independent stage of the process and the Regulator and Inspector of healthcare.

118. As the deliverer of the independent second stage **we recommend** that the Healthcare Commission should ensure that both the local resolution stage and their own delivery meet the core standards set down by the Department of Health. In doing so they should review their own complaints process.

119. As Regulator and Inspector, **we recommend** that the Healthcare Commission:

- review their assessment proposals for complaint handling in the light of the adoption of a new core standard to ensure that local NHS bodies take real responsibility for handling their own complaints;
- develop best practice guidance in complaint handling as a developmental standard for NHS providers;
- capture and share learning from complaints and best practice across the health service.

Delivery by all NHS providers

120. NHS bodies will be at the forefront of delivering the core standards of the new NHS complaints system. To achieve this **we recommend** that each NHS body (including PCTs):

- develops and documents its own fit for purpose local procedure;
- ensures that its complaints system is accessible to all members of their local communities;
- provides appropriate support to enable patients or their representatives to make a complaint effectively;
- ensures that it has sufficient competent and influential staff to investigate and deal with complaints effectively;
- provides training in handling complaints to **all** staff to ensure the patient receives a quality service wherever they make their complaint;
- provides clear leadership so that complaints are welcomed and learning is secured;
- works collaboratively with all members of their local health and social care economy to enable a complainant to make a single complaint about cross organisational issues.

Introducing the new system

121. The new NHS complaints system which will follow from these core standards will only work in practice if it is implemented effectively.

122. We recommend that the Department of Health draw up and publish a clear project plan for the introduction of the new system which:

- provides comprehensive publicity for the new scheme for complainants and NHS staff;
- sets clear timescales for the delivery of each step of the implementation process;
- provides for the development and dissemination of clear guidance to support the new system;
- provides for the necessary training of staff.

Annex A

Chronology of key complaints handling events - following the commissioning of the 1999 evaluation

1. An independent evaluation of the existing NHS complaints procedure was commissioned by the Department of Health in **1999**. Between 1999 and publication of the evaluation, in September 2001, a number of other NHS developments (detailed below) took place.

2. *The NHS Plan: a plan for investment, a plan for reform* was issued in **July 2000** detailing the Government's plans for investment, reform and 'a health service designed around the patient'. The Plan said that patient advocates would be set up in every hospital, along with patients' forums, to help services become more patient centred. (With the independent evaluation of complaints procedures continuing during 1999-2000, the NHS Plan committed Ministers to acting on the results of the evaluation.)

3. The report of the inquiry into children's heart surgery at the Bristol Royal Infirmary was issued in **June 2001**. That recommended in chapter 23:

'36. Complaints should be dealt with swiftly and thoroughly, keeping the patient and carer informed. There should be a strong independent element, not part of the trust's management or board, in any body considering serious complaints which require formal investigation. An independent advocacy service should be set up.

'37. There should be an urgent review of the system for providing compensation to those who suffer harm arising out of medical care. The review should be concerned with the introduction of an administrative system for responding promptly to patients' needs in place of the current system of clinical negligence and should take account of other administrative systems for meeting the financial needs of the public. ...

'55. There also needs to be an open and easily accessible system for the patient or carer to [complain]. Currently, the complaints system operated in trusts is widely acknowledged to be cumbersome and bureaucratic. Despite efforts to reform it in the mid-1990s the system has too many layers and lacks a sufficient element of independence. ... The decision to establish Patient Advocacy and Liaison Services within trusts is a first and important component of a broader system to identify and respond to problems as early as possible. ...

'57. Patients, for the most part ... do not want to complain. Often they feel forced to because their concern has been ignored or not properly addressed. The message is clear: improve communication generally, be more open with patients, and complaints will go down. For the complaints which remain, the system in place must be open, minimally bureaucratic, receptive, and appropriately independent.'

Parallel policy developments on patient/public involvement in healthcare and clinical negligence

4. In **July 2001** the Secretary of State for Health announced plans to produce, early in 2002, a White Paper setting out reforms to the system for dealing with clinical negligence claims.

5. In **September 2001** the Department of Health issued a discussion document outlining proposals for involving patients and the public in healthcare. Proposed developments included:

- introducing **Patient Advocacy and Liaison Services** (PALS) - providing information and on the spot help - in every Trust;
- providing locally based **Independent Complaints Advocacy Services** (ICAS) in England, operating to core standards;

- introducing **Patients' Forums** in every Trust, to bring the patient's perspective to Trust management decision-making. These Forums would also be able to elect one of their members to sit on the Trust Board as a Non-Executive Director;
- setting up a **'Voice'** in every Strategic Health Authority area, a professional group acting as a local resource for helping communities;
- setting up a new national patients' body to set standards and provide training, and to monitor the new arrangements.

6. Details of the final arrangements were published in November 2001. PALS were now to be Patient Advice (rather than Advocacy) and Liaison Services. Rather than both the local 'voice' and a national patients' body, a national Commission for Patient and Public Involvement in Health (CPPIH) was to be established with local networks and community outreach workers. It was envisaged that PALS would be available in all Trusts from April 2002, CPPIH and Patients Forums would be established at the beginning of 2003, and Community Health Councils would cease to operate in April 2003. (Provision for these changes was subsequently made in the National Health Service and Health Care Professionals Act 2002.)

Progress on complaints systems

7. In **September 2001** the Department of Health published the evaluation of the old procedure (commissioned in 1999) as two documents, an evaluation report, *NHS complaints procedure: national evaluation*, and *Reforming the NHS complaints procedure - a listening document*. The evaluation report found a high level of dissatisfaction amongst complainants about the operation of both the local resolution and independent review stages. Most found both stages stressful, unfair and biased and they were dissatisfied with the outcome. Amongst Community Health Councils (which often advised and supported complainants) only a small minority thought the systems of local resolution and independent review worked well.

8. The summary of the evaluation report said (paragraphs 6 and 10):

'The main causes of dissatisfaction among complainants are operational failures: unhelpful, aggressive or arrogant attitudes of staff, poor communication and a lack of information and support. The most important structural failure is the perceived lack of independence in the convening decision and in the review process generally.'

'Among those operating the procedure there is a broad consensus about the elements which need to be improved:

- *There is a wide measure of agreement that independent review should be more independent and should be seen to be so. Irrespective of the impartiality of a convenor, it is accepted that complainants do not perceive the current procedure to be independent.*
- *There is a perception that current procedures, particularly those involving independent review, are time-consuming and costly to operate.*
- *Performance targets relating to the convening decision, the appointment of panel members and drafting a report of a panel are all perceived to be difficult to meet.*
- *There is agreement that procedures need to be improved to ensure that services improve following a complaint...'*

9. The report went on to identify a range of policy implications and made 27 recommendations for change. These recommendations were summarised in the listening document as follows:

- *'a uniform national procedure, applied equally to primary care and hospital services, and with clear and consistent time limits;*
- *dissemination of good practice, and more use of conciliation to achieve results swiftly and effectively;*
- *clear guidance to clarify how the complaints procedure should be applied, and standard targets nationally for managing the performance of staff handling complaints;*
- *standardised administrative and financial support, and standard expenses and retainers for chairs and lay members;*
- *clear lines of responsibility for making sure the complaints system is run properly, with Chairs and Chief Executives answerable to the Department of Health for their performance in this area.*

- *Trust Boards responsible for ensuring this work is funded properly and staff are trained appropriately to handle complaints.*
- *Trust Boards also responsible for ensuring their clinical governance framework reflects complaints work as core business.*
- *A system of quarterly reporting by complaints staff to the Trust Board, summarising the causes and trends underlying complaints, and making recommendations for action. These reports to be copied to relevant patient representative organisations, and the Board to be responsible for implementing recommendations.*
- *As this would apply equally in primary care services, support from Trust Boards and PCGs [Primary Care groups - the predecessors of the current Primary Care Trusts - PCTs] would be needed for individual practices in managing the system, with a named individual responsible for handling practice complaints.'*

10. The report also recommended the following reforms for the second level Independent Review stage:

- *'consistently applied criteria for convening Independent Review Panels.*
- *Regional NHS bodies, or a new independent national complaints authority to be responsible for holding the panels to account and managing their performance to minimum standards.*
- *Possible wider powers for panels to summon witnesses and hear evidence, supported by an up to date database of clinical assessors, and also the potential to handle some cases on a "fast-track".*
- *Wide circulation of the Panel's final reports to relevant patient representative bodies and the Commission for Health Improvement, with the Trust Board being responsible for implementing any recommendations for remedial action.*
- *new options for how Panels should be convened: by the Health Authority, neighbouring Trusts/Health Authorities, or introducing a separate regional or sub-regional panel.'*

11. The listening document said that the Department of Health believed that to be effective and to work for the people it affects, the NHS complaints procedure needed to:

- be easy for patients to access;
- resolve complaints quickly;
- be an open process, which is independent where appropriate;
- be responsive to the outcome of complaints so effective improvements are made as a result.

12. Comments on the evaluation report's recommendations and certain key questions were sought by **12 October 2001**. As well as seeking written responses, a series of regional events was held across the country to gauge views from NHS staff and patient groups and research was carried out with hard-to-reach groups.

13. When in **January 2002** the Department of Health published its formal response to the Bristol Royal Infirmary Inquiry, it said (para 13) that its programme of reform included 'a reformed NHS complaints procedure by December 2002'. However it was not until **28 March 2003** that the Department published, *NHS complaints reform - making things right*, outlining the Government's plans for improving the complaints procedure.

NHS Complaints reform - making things right - March 2003

14. This Department of Health publication described the vision of a new complaints procedure as being:

- *'open and easy to access - by being flexible about the ways people could complain and with effective support for people wishing to do so,*
- ***fair and independent** - with the emphasis on early resolution so minimising the strain and distress for all those involved,*
- ***responsive** - providing appropriate and proportionate response and redress,*
- ***learning and developing** - ensuring complaints are viewed as a positive opportunity to learn from patients' views to drive continual improvement in services.'*

15. This would involve:

- changing attitudes and forming positive relationships, through better access to

- information; developing customer awareness; improving communication skills; and through the demonstrable use of patient feedback to improve services;
- acting on concerns and getting the response right. This would involve Patient Advice and Liaison Services; modern matrons (who would make sure standards were met); promoting good practice in local resolution (e.g. by producing a good practice toolkit). Access to the complaints procedure would also need to be made easier, for example by enabling complaints to be made direct to a Primary Care Trust (PCT) where there are concerns about a Family Health Service practitioner;
- providing remedies, responses and support which people want. This would involve tailoring responses, delivering explanations and apologies as well as practical measures, quickly and directly and broadening the options for resolving complaints - including promoting the use of methods of alternative dispute resolution such as conciliation. It would also include reviewing existing guidance in relation to financial redress and the relationship between the systems for dealing with complaints and clinical negligence claims; and providing easy access to ICAS (ICAS performance standards would be set by CPPIH, and commissioned by Patients' Forums);
- introducing 'Truly Independent Review'. Responsibility for this stage would be placed with the new Commission for Healthcare Audit and Inspection (eventually known as the Healthcare Commission). This would provide a direct link into the quality improvement process and enable robust assessment of cases and more options, as cases could be investigated in detail as an individual complaint or considered as part of an inspection or enquiry about failures in an organisation. This would also provide harmonisation with social care complaints, as the equivalent body for social care - the Commission for Social Care Inspection (CSCI) - would have similar powers for social services complaints and the two organisations would be under a duty to co-operate with each other;
- integrating complaints into wider systems, for example, individuals at Board level would be required to take overall responsibility for the investigation of and learning from adverse events, complaints and negligence claims. Quality and the patient's experience would also be improved by promoting the use of complaint material within wider initiatives such as clinical governance, a new adverse incident reporting system, reform to professional regulation and development, and risk management. In addition, the skills and competencies needed to deal with complaints effectively would need to have a high profile within education, training and professional development.

16. Because of the need for primary legislation to establish CHAI and CSCI, those bodies could not be established before April 2004.

Reforming the approach to clinical negligence in the NHS - June 2003

17. In the interim, in **June 2003**, the Department of Health published a report by the Chief Medical Officer - *Making amends. A consultation paper setting out proposals for reforming the clinical negligence system*. The report recognised that the system is complex, unfair, slow, costly in legal fees, and that it encourages defensiveness. It also found that patients were dissatisfied with the lack of explanations and apologies or reassurance that action has been taken to prevent repetition.

18. This report proposed a new NHS-based system of redress for patients who have been harmed as a result of NHS hospital care. The system would be administered by a body 'building on the work' of the current NHS Litigation Authority (NHS LA). Payment would only be made if there were serious shortcomings in the standards of care, the harm could have been avoided or if the adverse outcome was not the result of the natural progression of the illness.

19. Initially this system of redress would be limited to payments to families of neurological impaired babies, payments under £30,000 and those treated in hospital or community health settings (e.g. not in primary care). Consideration would be given to extending it later. The new arrangements would have four main elements:

- investigating the incident;
- providing an explanation to the patient and action to prevent repetition;

- developing and delivering a package of care;
- providing payment for pain and suffering, out of pocket expenses and care or treatment which the NHS could not provide.

20. Access to the scheme would be available following local investigation of the adverse event or complaint; investigation of a complaint by CHAI; delivery of a recommendation by the Health Service Ombudsman; or following the investigation of a claim made directly by a patient or relatives to the NHS Litigation Authority.

21. Other recommendations included:

- setting a new standard for after-event/complaint management by local NHS providers with CHAI assessing compliance through its inspections;
- removing the current NHS complaint procedure rule requiring a complaint to be halted pending resolution of a claim (this was seen as providing a potential benefit in reducing the number of people who pursue litigation and reducing the dissatisfaction complainants and claimants currently feel);
- providing communication training for NHS staff within the context of complaint handling;
- introducing a duty of candour, together with exemption from disciplinary action when reporting incidents, with a view to improving patient safety.

Response of the Health Service Ombudsman to *Making amends*

22. In October 2003 the Ombudsman wrote to the Chief Medical Officer commenting on the paper and welcoming the review. Issues raised included the lack of clarity in the interface between the proposed scheme and the work of the Health Service Ombudsman's Office, and the narrow approach taken on the question of financial redress. (When the Ombudsman upholds a complaint about the NHS, an appropriate remedy is recommended, which may include an element of financial redress. If the operation of the scheme fell outside the Office's jurisdiction, complainants would potentially lose a right of access to an independent Ombudsman.) *Making amends* only recognised harm as a result of sub-standard care as eligible for possible financial redress, whilst *Making things right* referred only to apologies, explanations and practical measures. The Ombudsman expressed the view that the NHS needed to consider redress in a much wider sense if it wished to make amends for poor service and service failures as well as addressing clinical negligence.

Health and Social Care (Community Health and Standards) Act 2003

23. This Act received Royal assent in November 2003 and contained several elements relevant to reform of the NHS complaints procedure, most notably:

- providing for NHS Foundation Trusts to be established, and for an Independent Regulator (now known as Monitor) to be established for them;
- enabling the Commission for Healthcare Audit and Inspection (CHAI) and the Commission for Social Care Inspection (CSCI) to be set up, along with a duty for them to work together when appropriate;
- abolishing the National Care Standards Commission (only set up in April 2002) and the Commission for Health Improvement (CHI);
- making some provision on complaints about the NHS, e.g. giving the Secretary of State power to make relevant regulations and to give CHAI and independent panels the powers to consider them;
- making similar provision about complaints about social services and CSCI;
- imposing a duty on NHS bodies to have arrangements for monitoring and improving the quality of health care;
- providing for the Health Service Ombudsman to consider complaints about the handling of complaints by any person or body under the regulations.

Consultation on new draft regulations and guidance on the NHS complaints procedure

24. Draft regulations went out for consultation in **December 2003**, with responses due by March 2004, with a view to introduction of the regulations on 1 June 2004. The

Healthcare Commission also consulted on their proposals for the independent stage of the procedure. (The Health Service Ombudsman responded to both consultations on 30 March 2004, copying letters to each of the other consulting organisations.)

25. The Ombudsman's main concern about the regulations was that the timescale for effective introduction of the arrangements was too tight. As expected, CHAI was being given responsibility for the second stage of the NHS complaints procedure, and the Ombudsman expressed concern that it would be difficult, if not impossible, for them to deliver an effective complaints handling process from 1 June 2004. The Ombudsman suggested a three way discussion with the Department and CHAI.

26. The Ombudsman also had a range of other concerns. These included concern that focusing on process and timescales might provide a perverse incentive in terms of quality of response and that unrealistic timescales might jeopardise the credibility of the procedure. Other issues included the failure to include any specific mention of redress and the degree of ambiguity about the role of panels. The relevant Act and regulations seemed to suggest CHAI could investigate or set up a panel, whereas CHAI seemed to be proposing an investigation, followed by a panel if the complainant asked for one.

27. The Ombudsman raised a number of similar issues with CHAI, including the points about timescales, panels and redress, as well as raising additional issues around:

- delivering secure mechanisms for obtaining clinical advice;
- considering the proposal that complainants could pursue a complaint whilst taking legal action;
- ensuring sufficient patient focus;
- ensuring some of the detailed time targets were realistic.

28. The Health Service Ombudsman was given another opportunity to comment on further revisions to the regulations and did so in **May 2004** raising a number of further points.

29. During the consultation period the Public Administration Select Committee took evidence on NHS complaints reform and associated matters (including *Making amends*) at a session on 29 January 2004. The Health Service Ombudsman also expressed concerns about the proposals in a memorandum to the Committee, as did the Consumer's Association (CA) and Action against Medical Accidents (AvMA), from whom evidence was taken. The two bodies suggested that:

- an opportunity to address adverse events in a joined-up way had not been grasped (AvMA) and that the proposals did not represent a comprehensive framework of patient-focused redress (CA);
- the NHS should offer compensation in straightforward cases where an internal investigation has identified a clear case for this;
- PCTs should see all complaints about primary care in their area (rather than just receiving retrospective reports) to enable them to manage clinical governance and protect patient safety;
- bodies have a duty to implement recommendations made by CHAI investigations (AvMA) or to take further measures to ensure they are implemented (CA);
- the role of the panel in the independent stage should be clarified;
- the proposals do not adequately recognise the complexity of issues, particularly the increasing diversity of different providers of NHS care and overlaps between these providers and between primary and secondary care.

30. In giving evidence about the relationship between complaints and claims for negligence the Chief Medical Officer said;

'I think we ... will have a single gateway. ... Ministers have not yet ... decided how they want to take forward the medical litigation proposals. The two systems must be very closely aligned. Whether they are completely integrated - I think there are arguments in a number of directions on that one ...

... Many people who are seeking compensation through the courts will do so after they progress the complaint to a certain stage, and they will often do so partly because of the inherent nature of the complaint but partly because the complaint has been handled badly, they have become more aggrieved during the process of handling the complaint. So the improvement in the complaints system will have a direct bearing, I think, on the way that redress, compensation, litigation is handled. The second thing is, I think there is a distinction between complaints which have to do with the diagnosis, treatment and care and complaints which have to do with the convenience of services. ... Finally I think there is the whole question of the threshold for offering compensation and indeed the fact that most surveys show that patients, on the whole, want an explanation, an apology and a reassurance that what had been learned from the complaint will be used to benefit future patients. Compensation is not top of their list. ...'

31. When asked about arrangements for training to support complaints handling the then Chief Nursing Officer said:

'... A lot of the issues around complaints have their roots in not communicating well. So we are at the moment working to look at the programme for training. We are working with higher education institutes to look at both pre-registration medical and non-medical training to see whether we can improve the component of communication training that goes into those programs. We are also working with the NHSU to look at introducing a common orientation programme to the NHS; and part of that component on day one will include, although basic, work around communication skills. We are also doing some more segregated work. For example, we are running programmes with front of house staff - medical receptionists, porters, reception desks - to get them to improve their communication skills. Then, specifically around the management of complaints, we have some pieces of work that are already on-going. For example, we are doing some work around developing national specifications for training in complaints and investigations. That specifically will be targeted at those front-line staff dealing with that - complaints managers, PALS services. We also are beginning to put together some work around training seminars specifically for primary care trusts, wards and staff around managing complaints, and we are in the very last stages of putting together a good practice tool kit which is around supporting improvements in local resolution. We have also had some other programmes going. For example, over the last three years we have put 40,000 ward team leaders - ward sisters, modern matrons, charge nurses - through leadership programmes; and a very specific component of that has been around communications skills and also resolution of issues and also about how you should proactively seek comments from patients and users.'

Beginning to implement the changes

32. On **1 April 2004** the Healthcare Commission became operational, having existed in shadow form for some time. On 9 July the NHS (Complaints) Regulations were laid before Parliament and came into force on **30 July 2004**. Although the intention had been to implement the Complaints Regulations in full from June 2004, Ministers decided on a phased implementation following an approach from the Shipman Inquiry. The Inquiry's 5th report was likely to address complaints handling in some detail and was due to be published later in 2004. Reports from the Ayling and Neale Inquiries (about doctors who had repeatedly failed to observe proper standards of care) were also expected. Therefore, the local resolution stage of the complaints procedure remained broadly unchanged. The 2004 Regulations consolidated and rationalised the statutory requirements for local resolution by NHS bodies and introduced the reformed independent review stage carried out by the Healthcare Commission. They do not require NHS Foundation Trusts to have a complaints procedure in line with the provision regarding local resolution in the regulations, although the independent review stage does apply to them and they are in the Health Service Ombudsman's jurisdiction. The Department intends to issue revised regulations in 2005.

Further changes - abolition of the Commission for Patient and Public Involvement in Health (CPPIH)

33. On **22 July 2004** the Secretary of State for Health announced the outcome of a review of the Department of Health's arm's length bodies. The aim was said to be to streamline them, reduce bureaucracy and release resources to frontline NHS care. Among those to be abolished is the CPPIH. Patients' Forums will continue and the Department said that 'stronger, more efficient arrangements to provide administrative support and advice' to them would be set up. A clear quality framework for Forum activities would be established and communicated to Forums. The best body to do that would be identified in discussion with the Healthcare Commission and stakeholders.

Responsibility for appointing Forum members would move to the NHS Appointments Commission.

Neale and Ayling Inquiry reports

34. The inquiries into how the NHS handled allegations relating to the performance and conduct of these two doctors reported on **9 September 2004**. Recommendations from the Neale Inquiry included:

- *Doctors should spend time observing the Patient Advocacy and Liaison Service (PALS) process and be familiar with the process. ...*
- *All PALS appointees should be of middle/senior grade. ...*
- *Unified and centralised training should be provided for all PALS officers.*
- *Complaints handling should be aligned to quality management and patient services rather than claims management. ...*
- *The head of the unit dealing with complaints should be an appropriately trained middle manager. ...*
- *Complaints handling should be mandatory for all levels of clinical, nursing and administrative staff. ...*
- *Complaints statistics should be included in the Profiles of Trusts and used by the Healthcare Commission in routine audit procedures. ...'*

35. The recommendations from the Ayling Inquiry included:

- providing accredited training for all PALS officers in dealing with sensitive and intimate concerns - Strategic Health Authorities (SHAs) should require confirmation from NHS Trusts of the completion of such training within the next 12 months;
- addressing the emerging issue of visibility and accessibility of PALS in primary care settings by getting the Modernisation Agency to develop a model of best practice - if appropriate, patients' forums could monitor the effectiveness of service provision against this model. The implementation of this model and associated performance measures should be a formal component of CHAI's reviews of PCTs;
- providing ICAS staff with the same training in handling concerns and complaints of an intimate and sensitive nature as that recommended for PALS staff, with this forming part of the service specification for ICAS. Satisfaction surveys should be built into the work of ICAS on completion of their work with each complaint so that their performance can be routinely monitored and a cycle of continuous improvement be established;
- requiring all NHS Trusts and health care organisations, such as deputising services, directly employing staff to make a formal declaration of any other concurrent employment, not only for health and safety reasons but also to ensure a record is kept of other organisations with an interest in the individual's performance. Failure to make such a declaration should be a disciplinary matter. This requirement should be appropriately adapted for PCTs to be kept informed of other professional employment undertaken by general practitioners (GPs);
- ensuring that copies of any written records regarding complaints and concerns which name an individual practitioner are placed on that practitioner's personnel file, to be kept for the length of their contract with that organisation. This should be made known to the practitioner;
- ensuring that the regular reports on patient complaints and concerns, made to NHS Trust Boards and other corporate governance bodies, not only analyse trends in subject matter and clinical area but also indicate whether a named practitioner has been the subject of previous complaints.

Changing the social services complaints procedures

36. In **September 2004** the CSCI consulted on their proposals for the independent review stage of the social services complaints procedures. That consultation said that capacity for joint reviews with the Healthcare Commission would be developed in 2005-2006. Two separate consultations by the Department for Education and Skills and the Department of Health respectively, on the children's and adults' parts of the social services complaints regulations, were issued in **October 2004**. The intention was to introduce the new procedure in April 2005 (but it is now likely to be implemented later in the year).

37. Both the Health Service Ombudsman and the Local Government Ombudsmen for England responded to the consultations. Both expressed concern about the complexity of the process, the lack of clarity for complainants and the lack of alignment between CSCI and the Healthcare Commission in relation to health and social care complaints.

The fifth report of the Shipman Inquiry

38. This report, *Safeguarding patients: Lessons from the past - proposals for the future* was published in December 2004. It considered the handling of complaints against and the raising of concerns about GPs, General Medical Council procedures and its proposal for revalidation of doctors. The report proposed a significantly different system for handling complaints about GPs. The recommendations included:

- extending the time limit for lodging a complaint to 12 months;
- ensuring all complaints about GPs are reported to the PCT within two days of receipt and giving patients the option to lodge complaints directly with the PCT;
- ensuring a member of PCT staff conducts a triage (initial assessment) of all complaints to decide whether they are 'private grievances' or if they raise clinical governance issues. Private grievances should be dealt with by the PCT staff (or the GP, if lodged there). Clinical governance complaints should be called in by the PCT if lodged with the GP, and all such complaints should receive a second triage by a group of two or three senior people from the PCT. The aim of that would be to decide whether the PCT should arrange an investigation or whether the complaint should be referred instead to some other body such as the police, the General Medical Council or the National Clinical Assessment Authority (NCAA);
- setting up joint teams of investigators from across PCTs to investigate clinical governance complaints. They should be properly trained in investigation. The aim of the investigation should be decide what happened and report to the PCT;
- ensuring that the group which conducted the second triage considers what action to take, either itself or by referring the matter elsewhere. If the investigation team's report is inconclusive then the complaint should be referred to the Healthcare Commission;
- ensuring that intended or actual legal proceedings are not a bar to an NHS body investigating a complaint. If the NHS body is taking disciplinary proceedings relating to the subject matter of the complaint against the person complained of, a complainant should be entitled to see the substance of the report of the investigation on which the disciplinary proceedings are to be based;
- allowing, in some circumstances, an NHS body to defer or discontinue its own investigation if the matter is being investigated by the police, a regulatory body, a statutory inquiry or some other process. However, an NHS body should never lose sight of its duty to find out what has happened and to take whatever action is necessary for the protection of the patients of the doctor concerned. It should also provide such information to the complainant as is consistent with the need, if any, for confidentiality in the public interest;
- allowing PCTs to refer a complaint to the Healthcare Commission at any point during the first stage of the complaints procedures. Cases raising difficult or complex issues or involving issues relating to both primary and secondary care might be referred to the Healthcare Commission for investigation at the time of the second triage, or later if the investigation raises more complex issues than were initially apparent. Referral to the Healthcare Commission should also take place in cases where an investigation has found that it cannot reach a conclusion because there remain unresolved disputes of fact. The referral would be so that the Healthcare Commission could carry out any further necessary investigation and, if appropriate, set up a panel to hear oral evidence about the facts in dispute and decide where the truth lay;
- establishing objective standards, by reference to which complaints can be judged, as a matter of urgency. These standards should be applied by those making the decision whether to uphold or reject a complaint and by PCTs and other NHS bodies when deciding what action to take in respect of a doctor against whom a complaint has been upheld. Those standards must fit together with the threshold by reference to which the GMC will accept and act upon allegations, so as to form a comprehensive framework;

- ensuring there is a 'single portal' by which complaints or concerns can be directed or redirected to the appropriate quarter. This service should also provide information about the various advice services available to persons who are considering whether and/or how to complain or raise a concern, including advice services for people concerned about the legal implications of raising a concern;
- dealing with concerns raised by someone other than a patient or patient's representative (e.g. a fellow healthcare professional) in the same way as patient complaints.

Annex B

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