ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES

HEALTH NEWS BRIEFING

The Future of NHS Complaints

Report of a Seminar

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A REPORT OF THE SEMINAR: THE FUTURE OF NHS COMPLAINTS
HELD AT : THE NEW CONNAUGHT ROOMS, LONDON WC1
14 JUNE 1994

SUMMARY

In June 1993, the Secretary of State for Health, Virginia Bottomley, announced an independent review team was to be established to look at the way in which NHS complaints are handled and recommend how the various procedures can be improved. That review team has summarised its findings in the form of a report entitled *Being Heard*. This was published by the Department of Health on 11 May 1994 and the main recommendations can be found in Appendix 2 of this report.

The aim of the ACHCEW Complaints Seminar was to provide an opportunity for CHCs to learn more about the report's recommendations and to discuss their own views about the future of NHS complaints. It was also intended that the views expressed would contribute towards the development of the Association's policy on complaints. ACHCEW's formal response to the Department of Health on the proposals contained in *Being Heard* is attached at Appendix 3.

The Seminar was well attended, by nearly 200 delegates from CHCs in England and Wales. The Chair of ACHCEW, Eleanor Young, opened the morning session and introduced each speaker - the first of whom was Professor Alan Wilson under whose Chairmanship the Complaints Review Committee had drawn up its Report. A summary of the issues covered by Professor Wilson can be found overleaf.

Following this, the Minister for Health, Dr Brian Mawhinney, spoke about the government's perspective on the report - a full text of the speech is attached.

The final speaker in the morning session was Chris Dabbs from Salford CHC who discussed the possible implications for Community Health Councils. An article entitled "Been Heard?" summarises the main points made by Chris Dabbs.

The afternoon was given over to four break-up group sessions looking in more detail at various aspects of the current system. Brief summaries of each of these group sessions are included in this report.

Full details of the programme for the day can be found at Appendix 1 of this report.

RECOMMENDATIONS OF THE COMPLAINTS REVIEW COMMITTEE: Professor Alan Wilson - Review Committee Chair, Vice Chancellor of Leeds University

Professor Wilson outlined the main recommendations made by the Wilson Committee and published in the report *Being Heard* (see Appendix 2). These were discussed under the following headings:

- **the current situation**

    * FHSA procedures - informal/formal
    * hospital and community unit procedures - clinical/non clinical
    * health service Ombudsman
    * others (authorities, Ministers, MPs, professional regulators)

- **objectives**

  - for complainants

    * acknowledgement
    * apology
    * explanation
    * report on action
    * redress and compensation
    * punishment
    * voicing the complaint

  - for the NHS

    * complainant satisfaction
    * quality enhancement
    * fairness to practitioners and staff
    * avoidance of unnecessary litigation

- **critique of existing procedures**

    * too fragmented
    * not easy for people to use

        - poor access
        - often adversarial
        - can seem biased

* time consuming for the NHS to administer
    - very slow for all parties
    - practitioners may feel unfairly treated
* often not producing outcomes satisfactory to either party
* health service Ombudsman
    - currently excluded from FHSA service committees
    - and issues of clinical judgement

- **comparison with other organisations and countries**
    * main aims the same:
        - to satisfy complainants
        - to generate management information and improve quality
    * many lessons which can be built into our "principles"
    * other countries have varying levels of progress UK would be relatively advanced if the report is implemented

- **principles**

    the nine key principles recommended in the report are:

    * responsiveness
    * quality enhancement
    * cost effectiveness
    * accessibility
    * impartiality
    * simplicity
    * speed
    * confidentiality
    * accountability

- **features of effective procedures**
    * maximum commonality across all NHS services
    * separation of disciplinary elements
    * publicity and "branding"

* use of informal responses

* well-trained staff

* support for complainants and respondents

* investigation

* use of conciliation

* time limits

    - for making complaints

    - for responding to complaints

* confidentiality

* recording

* monitoring

* impartiality

- **procedures**

    * stage 1: providers have key responsibility to offer an effective procedure: they are the nearest point; they should be responsible; they should be the body which takes the appropriate action.

    * stage 2: independent panels more rarely, a greater degree of impartiality will be required; or the case has been handled badly by the provider; or it is in some sense "more serious" - then independent panels are called for.

    * health service Ombudsman

        - should always be there as the backstop

        - should therefore consider widening his remit to include FHSA service committee procedures and clinical judgement

- ***implementation***

    * emphasise the importance of *training* throughout

    * there should be *audit* and *monitoring* by purchasers

    * need for legislation, regulation and guidance

    * implementation groups in each of the four UK countries

    * a short annual review

ADDRESS GIVEN BY THE RT HON DR BRIAN MAWHINNEY MP, MINISTER FOR HEALTH

I thank you for inviting me to give the government's response, and that immediately poses a problem for me. It's a problem that were I to solve it this morning you would be among the first to [complain]. I can't respond in the middle of a consultation period without, by definition, aborting the consultation period and I have no plans to do that this morning. So I have to interpret my brief in a slightly more flexible way than otherwise you might have wished.

Let me leave you in no doubt that there will be a definitive government response and we will seek to use language that everybody will be able to understand. But I can't do that this morning. So what I want to do instead, is I want to reflect for a little while with you around some of the concerns which caused us to ask Professor Wilson to undertake this task and some of the issues which seem to us to be important as we decide how to move forward, because move forward we must. There is no question about that. We have got a system which has grown just a little bit like topsy since 1948 and there is, I think, widespread understanding that it now needs to be re-focused.

You will draw your own conclusions from the similarities between what I say, and what Professor Wilson has just said to you. This is the second time we have done this double act. I was sitting at the back wondering whether we were Abbott and Costello, Morecambe and Wise or Hale and Pace. Whatever we are, there will be certain common threads running through both presentations, and as I say you can draw your own conclusions from that.

I want to start as I started the last time we were together by saying very sincerely thank you to Professor Wilson and his colleagues for the very hard work and I think a very professional job which they have done in this report. It's comprehensive, it's thorough, it separates out the pertinent issues in a way in which I think most people find will be very helpful and it poses in our judgment exactly the right questions.

It's clearly apposite to your interests because part of the role of CHCs has been to stand alongside patients, as from time to time they bring complaints against the system and indeed to handle those complaints for many. And, if I may say so, I see this in the context of the wider role of the reforms, which as you know were given as a fundamental premise that decisions in the new health service should be taken as close to the patient as possible. That we ought to restructure our health service in ways that focused more intently on the patient and certainly less on the structure. There is no doubt in my mind that the handling of complaints falls very comfortably into that sort of philosophy. Indeed I would go further, I think it is almost a requirement of that sort of a philosophy that we need to clarify how we handle complaints.

The second thing I want to say by way of a preliminary was to put the concept of complaints in context. One of the joys of my life, is that for the most part, when the media bring something to my attention, it is very seldom from the 98, 99 or 99.9 per cent of the patients that we have treated and cared for in the health service year in and year out, who get a very good service and who are very content with the service that they get. I tend to get focused in my direction the odd case that doesn't work; that goes wrong. And let me tell you that if you are treating 45 million patients a year or interfering with 45 million patients a year, I - hope entirely constructively, then things will go wrong from time to time. That's not some great revelation, that's not "minister admits health service isn't perfect", that's a realistic assessment of a million employees who are dealing with 45 million patients a year. Things will go wrong. And when they go wrong, they tend to come to me, and one of the things I keep saying to the media is "you are bringing this to me because it is abnormal, not because it is normal, but because it is abnormal".

The difficulty the health service faces is that people too frequently keep trying to take that which is abnormal and make it appear like it is normal, which you know and I know is not the case.

So we do have these deviations from the norm, these unacceptable episodes. They do need to be addressed. Because when something goes wrong there are two things that must subsequently happen, initially. The first is that you put it right, and the second is that you then examine why it went wrong and try to learn the lesson which will prevent it from going wrong a second time. The third thing that needs to happen, sometimes in slightly slower time, is then to address the problems that the individual who has been at the receiving end of your service, and I have four S's which seem to me to be at the heart of what we are looking for in an effective complaints system.

The first is that it must be sensitive to the patient. And I agree with Professor Wilson when he says that there is increasing evidence of a change for the good in the health service. But, there are still too many who are dismissive of a complaint; who have slight overtones of "why aren't they just grateful that we are here", or "don't they understand that I am a professional and how dare they question my judgment" or "if they only realised how busy I am they wouldn't bother me with such trivialities". I think that is a diminishing tendency. I am convinced it is a diminishing tendency. And there needs to be put in place systems that are sensitive to the patient, and sensitive to the patient's perception of the treatment he or she has received.

Now, and I shall come back to this in a few moments, sensitive doesn't mean that the patient is always right. Sensitive means that the patient believes that he or she has a problem, and that should shift the type of response that the patient gets. So my first S is *Sensitive*.

My second S is *Simple*. The best political advice, the best organisational advice, the best of management advice is still this. Keep it simple, sucker. And one of our problems is that because our system has grown like Topsy it is no longer simple. I won't do any big test on you. It would be unfair having given you no opportunity to know about it in advance, but I would be interested to know how many people in this room feel that they are so on top of all the various complaints procedures in the health service that could pass a test were they to be asked to stand up and do so. It is too complicated. Professionals don't understand it. Professor Wilson and his committee took months to understand it. So it is hardly surprising that patients don't understand it. See it has got to be simple. It has got to be deliverable in easy to understand terms, in a chronology that makes sense, and that is as far as it's possible defined temporally. Which leads me to my third S. It's got to be *Speedy*.

We have a tendency at the moment to a leisurely pace which denotes, or could denote, a number of things. It could denote that the system doesn't take it all very seriously. My experience in life is that if there is something that is really important to you, you tend to get on with it. So a system that gets protracted further and further and further, may denote to the patient an organisation that is not taking their concern very seriously. Secondly, a system that gets protracted almost certainly reflects a management grip, which is not as tight and as efficient as it should be, and, if that is true, in this area of the activities of the organisation, then why ought I not to assume that it is true in other areas of the organisation? But I think probably the best and most cultured reason for having a speedy response is that the longer it takes to get an answer for the patient, the more uptight the patient gets. The more difficult it will be ultimately to satisfy the patient. Which leads me to my fourth S which is that the system, in the eyes of the patient must be *Satisfactory*, and by that I mean it must have credibility.

Satisfactory is not the same as giving the patient satisfaction. Which was the point that I meant to make at the beginning. In other words, a satisfactory system is not a system which says that the patient is always right; but it is a system which says "here is how we have investigated your complaint, here are the safeguards we have put into that system at each step of the way, and if the result comes out in a way that is not satisfactory to you, you may not have satisfaction, but you have got to accept that the system itself is satisfactory".

Now, Professor Wilson has just been telling you about the various stages that they propose and I make no definitive comment on what he and his committee have outlined, but I do very strongly endorse the emphasis that he has placed on simplicity, on speed, on safeguards, on credibility, on impartiality, because all of those are essential to confidence and we want to have a system in which people can have confidence. Now you will have noticed that in all four of my S's I talked about them in terms of the patient. They were my patient's four S's but let me backtrack for a moment and say that those four S's are just as important to the staff as they are to the patient. You do the staff no favours by having a system that is so complicated they can't understand it without swotting for an exam. Because, if you have a system that is that complicated, they who are at the receiving end of the complaint will take even more convincing that, should the patient's complaint be upheld, that they have been treated fairly. And we owe it to our staff, as well as to our patients, to have a system in which they too can have confidence. So they too want it simple, they too want it speedy, because they as other human beings don't like unresolved accusations hanging over their heads. Especially when, almost by definition they will feel that the accusation is unfair, or unfounded, and they too want a system that is satisfactory from their point of view so that if and when, as and when, it finds in support of the patient's complaint they will not be happy, but at least they will feel that they have been treated fairly.

So from both the patient point of view and the staff point of view we need to have those four S's. I heard Professor Wilson refer to the fact that I am reasonably well known as being in support of the concept of the patient's friend. I'll tell you why. It is my experience, and I think it is the experience of most Members of Parliament, that if you had a simple system where two people who grew up together and somebody said "Hey, listen, for whatever reason, emotional stress, too busy - something went wrong, why don't you just say sorry and it will all be over?" Most MPs will tell you that getting somebody to say sorry would solve nearly 85 to 90 per cent of the problems about complaints therein and if you look at those few hospitals in the country where the patient's friend concept is already working, you will find, I think, substantial support for that interpretation as one of the great tendencies that we have in public life and in the health service is that we tend to bureaucratise things that don't need to be bureaucratised and the very bureaucracy starts getting in the way. So while I am not here to give you a definitive response to the Wilson recommendations I would say that I am very excited by the concept of Patient's Charter, and so should you be, because in a very real sense that what CHC's are about. They are about being friends to patients and I would be surprised, were we to go down the route of patient's friends, were there not to develop, either at the trusts instigation or your instigation, relationships between CHCs and patient's friends which might make that system work even more efficiently than is envisaged in the Wilson report.

If I were to summarise what I have just been saying to you I would want to do it, in the words again which Professor Wilson used. What we are actually seeking to achieve is a "culture change" in the health service. For too long we had too many people believe first of all that there was no point in complaining because nobody listened. Secondly, we had too many people believe for too long that it was such a mammoth undertaking to lodge a complaint and so long to get it resolved, that frankly life was too short. Thirdly, there would be continually people who think for too long that a complaint by definition was a threat. And unless we break that culture then certain things cannot happen.

The first thing that cannot happen is we cannot offer a degree of satisfaction to our patients which they are entitled to have and which, frankly has got to flow naturally out of the reform process if it is to be a success.

Secondly, we cannot have a health service that is as good as you and I wish it to be because those complaints frequently address elements of service which could actually be improved. But if we cut ourselves off from that constructive criticism then our chances of effecting those improvements decrease.

And thirdly, if we do not effect that change, then we are going to continue to have a staff that feels unnecessarily threatened.

When Professor Wilson talked to me about his report, one of the points that I made to him, which I welcome and which we shall have to look to see how to implement should that be the ultimate decision - is that we wanted a complaints system where the crossover point between complaints and disciplinary procedures was as far down the line as it was possible to get. One of the great difficulties we have at the moment is that the cross-over point is almost immediate, or is perceived to be almost immediate. Now let's be sensible about this, every disciplinary action which takes place in the health service started out as a complaint. That is how it started out. So it is not possible to say that you will have a complaints system and a disciplinary system that run in parallel lines, there has to be a cross-over point at some point. What is important, however is that cross- over point should be as far down the line as is possible to make it, not as close to the patient as possible. Now that raises some very major issues, major issues that will be of importance to the professionals, and is one of the reasons why we were so strongly inclined to consult on the Wilson report, because we need to be able to take the professionals with us as well as the patients with us, if we are to have a system which carries credibility for the whole of the National Health Service.

Chairman, I have spoken for my allotted time. Let me try to sum up what I have been saying to you. I have been saying to you that change in my view is inevitable. I have been saying to you that I believe the Wilson report provides a basis, a good basis, when considering what change needs to be implemented. The change needs to be characterised by sensitivity, by simplicity, by speed and by satisfactory systems. It requires a change in attitude of all of us. I say all of us, because it would be fair to say that around the country from time to time, just occasionally, it would be possible to find even CHCs who in handling complaints had a slightly more confrontational attitude to the local hospital or Trust than was likely to be maximally beneficial to the patient as well as to the staff. I am looking for what I consider ought to be characterised by the term constructive criticism, rather than confrontation, and you have a role to play in that process. But, more broadly, you have a role to play in helping to develop systems which reinforce our common determination, increasingly and fundamentally, to put the interests of the patient at the heart of the health service and to develop structures which enable us to do that rather than to continue with some of the old thinking which says that patients must fit into structures.

That is the challenge of the Wilson Committee. We welcome it and we are confident about the future of the basis of it and I will listen carefully to what you say and others, before we come to a judgment. And incidentally, Chairman, above all the other things that I might have said to CHCs had I had a chance to say it here.

BEEN HEARD?

HEALTH COUNCILS AND THE N.H.S. COMPLAINTS REVIEW.

So, it's finally out, just in time to read on the beach and let the N.H.S. Executive have your comments! "Being Heard" is here in all of its 111-page glory. What might be the implications for health councils and their staff?

The recommendations are likely to lead to a better-publicised, more accessible and simpler single system. With less confusion and more publicity, there are likely to be greater numbers of complaints to deal with. With quicker responses demanded and greater emphasis on conciliation, however, complaints should be dealt with far more swiftly and with less bureaucracy.

These likely changes will probably alter the rôle of health councils (it is a U.K.-wide review) in complaints. There may be a shift to earlier contact with patients and carers and a shift away from formal confrontations, requiring a different balance of skills from health council staff. This might include getting more accustomed to supporting complainants directly within practice-based procedures.

The net for complaints will be formally widened to include purchasers, non-N.H.S. providers of services to the N.H.S., and possibly social services. By contrast, there should be a clear split between complaints and disciplinary procedures. These moves open up potential new areas for health council involvement in complaints while probably reducing or removing another for some.

The difficulties that complainants and health councils have faced in dealing with complaints about several agencies or organisations should be reduced if the recommendation about the organisation receiving such a complaint ensuring that it receives a full response is implemented.

Bureaucracy may, however, be nourished unless time limits are eradicated altogether. Existing time limits serve only to cause unnecessary paperwork, money and distress to all parties concerned. Hopefully, health councils will strongly argue for their complete abolition in any responses to the consultation.

The proposed Stage 2 procedure, and the screening process before it, will shift health council representation at hearings towards helping complainants to present information and away from the direct and adversarial presentation of a case. There will still be a need to ensure that cases meet relevant criteria to qualify for Stage 2.

The changes in the rôle of the Health Service Commissioner recommended by the Complaints Review Committee and the Parliamentary Select Committee on the Ombudsman should significantly alter his/her activity. This should also affect how health councils utilise the Commissioners/Ombudsmen for complainants, and perhaps also how cases are presented.

The emphasis on procedures being adapted to local circumstances, while meeting national criteria provide health councils with chances to improve complaints handling. Similarly, opportunities arise from the recommendations that organisations regularly assess the satisfaction of complainants with their handling of complaints, and that information from complaints is incorporated into quality review mechanisms. The experience and expertise of health councils (staff and members) in all of these areas should prove extremely valuable.

There are, of course, issues raised directly about health councils in "Being Heard". There is, at last, national recognition of the need for specific resources to be given to health councils to support complainants. The attached guidance on and monitoring of the use of these resources implies the introduction of standards into health council complaints work. Just as welcome is the recognition of the need for appropriate training for health council staff involved in supporting complainants.

Hopefully, the recognition of the need for resources and training for health council staff will mean that everyone everywhere in the U.K. will be able to expect the same minimum standard of service from their health council.

Two other issues directly impact on health councils. The introduction of a common system across the U.K. for complaints about N.H.S. services implies that <u>all</u> health councils will rightly have to develop and operate their own complaints procedures in line with national criteria, and also monitor the satisfaction of complainants with their own complaints services.

The second issue is the development of a U.K.-wide recording and classification system for complaints. This needs to be closely borne in mind in regard to the introduction of the Complaints Database for C.H.C.s in England and Wales. Health councils need to ensure that they are directly involved in any national discussions in the area of recording and classification.

"Being Heard" has been widely welcomed as a significant advance which should produce a system focused on the needs of complainants, but which is also beneficial to the N.H.S. Health councils and their staff have an important rôle to play in this, if they wish to take it.

The first step should be to ensure that all health councils submit their views on the report and its recommendations by 15 August. There will then be a great need for <u>all</u> health councils to review and improve their own complaints services, as well as being involved in improving those in the rest of the N.H.S.

Chris Dabbs,
Chief Officer,
Salford C.H.C.

13 June, 1994.

ACHCEW Complaints Seminar 14th June 1994

Workgroup One: Handling CHC Complaints

Chair: Joy Bennett, Chief Officer, South Buckingham CHC
Speaker: Martin Ford, Complaints Officer, Leeds CHC

Leeds CHC's approach to complaints

Martin Ford gave a short presentation about his work as complaints adviser in Leeds CHC - which was formed by the merger of Leeds East and Leeds West CHCs. It is now a full-time grade SMP 28 post.

He explained how complaints were handled. He deals with all complaints work. Initially he did everything for the complainant but the increasing number and complexity of complaints meant that this was impossible. Therefore he developed a new "layered" system which started in January 1994. A self help pack is sent to complainants and the CHC have found that many can now do their own complaints (making sure to send a copy to the CHC). There were questions from workgroup members about whether complainants were able to write their own letters. Leeds CHC have also produced a Directory of Solicitors from which clients make their own selection - they did this rather than go via AVMA because it was seen to be quicker. There was also concern about this.

In response to questions he said that the service was not publicised externally because of the fear of too many complaints, however there are leaflets in health centres, hospitals, libraries, etc. Most FHSA complaints get referred to the CHC but they only deal with 20 per cent of provider unit complaints.

Members of the workgroup were concerned that Leeds CHC makes almost no provision for patients for whom English is not their first language. Martin Ford said that there is an Ethnic Minority Linkworker post in the CHC (who speaks Chinese) but there is no service to other groups, although there is a local interpreting/ translation. He admitted that this was "a gap in our service". They do not carry out ethnic monitoring of complaints. Members of the audience were concerned about this, given that Leeds is a multicultural society.

Leeds CHC produce a quarterly statistical analysis and also a complaints digest. This latter has an anonymised short description of each complaint and only goes to CHC members - not open to public scutiny.

CHCs' Views of the Wilson Report

For the remaining time of the workgroup the Chair asked the audience (which included CHC staff and members) to suggest topics they were concerned about from so that two major topics could be identified to be taken back to the main plenary session. There was then a wide ranging discussion of a number of issues.

There was agreement that the fundamental issue was who "owns" CHCs ie what will be the establishing authority after the abolition of Regions.

There were doubts about how practical the Wilson Committee proposals were, for instance, the GP contract had only been changed in 1990 and this had had enormous repercussions. However there was agreement that there was a need to change the FHSA system. A member of the audience referred to the GMC performance review and its relevance to the discussion.

There was a lengthy discussion about time limits and an attempt to get agreement on whether members favoured no time limits, a one-year limit or a different period. In fact there was no consensus. Some felt strongly there should be no time limits, whilst others felt it could be three years from the time when the complaint was known about. It was pointed out that time limits are not user friendly. It was suggested that publicity should say that complaints be made "as soon as possible".

There was then discussion about to what extent CHCs should "do it" for the complainant, or "enable" complainants to do their own complaints.

There was disagreement about CHC members' role in complaints work. Some CHCs felt that members should have nothing to do with complaints because staff needed to have particular expertise. Others felt that members should have a monitoring role and some felt that indiviudal members could be involved in complaints work. The issue of legal liability was raised and how this might affect either staff or members.

There was general agreement that complaints should be part of the CHC statutory role but this would involve a recognition by members that staff have this role.

There was discussion about liaising with local voluntary organisations and getting them involved in complaints work, possibly CHCs could provide training to the staff of these organisations.

There was a lot of concern about the lack of training for staff dealing with complaints. The question of whether CHCs should have a separate complaints officers or whether the complaints work should be shared by CHC staff (CHC Chief Officers and Officers/Assistant Chief Officers) as part of their other monitoring work was raised.

There was discussion about the increasing number and type of providers that CHCs would need to monitor and deal with complaints from. This would include non-NHS service providers.

It was agreed to take forward two points to the plenary session:

1. **The future of CHCs (establishment issue)**
2. **The recognition of complaints as part of CHCs' statutory role.**

THE ROLE OF THE OMBUDSMAN
RICHARD OSWALD - DEPUTY HEALTH SERVICE COMMISSIONER.

Objective: To look at the Wilson Committee Report recommendations and to discuss issues of concern to CHCs in order to inform response to the report.

Health Authorities are often not good at handling complaints. From July 7th, the Ombudsman will make public the names of Health Authorities involved in his investigations which make provide a powerful incentive for change. Richard Oswald took an example of a complaint detailed in the forthcoming report from a female psychiatric patient who made allegations of sexual assault against a member of staff. These allegations were made over an extended period of time, four separate members of staff on at least five occasions, but no action has been taken. The member of staff concerned was eventually dismissed following a disciplinary hearing. The Chief Executive is quoted as saying staff had not reported the matter to him as he would have not considered it important.

The following issues, concerns and questions arose out of the general discussion which followed:

- **Chief Executive**'s involvement in serious complaints is particularly important. The Chief Executive must be seen to take complaints seriously and their role is to **take the lead** not to rubber-stamp.

- How will the Report be implemented/policed (given the 1985 Hospital Complaints' Act has still not been implemented)?

- How effective are **complaints officers** within Trusts? They have to be able to deliver which often needs bringing to heel recalcitrant consultants. Placatory responses are not adequate.

- Complaints investigations are about getting to the truth. Fairness **to both parties** is important - if staff are not on board, no system will work.

- Wilson Stage 1 calls for an **immediate response** from the ward, department. **Training** is a critical issue here. How realistic/ feasible is a positive response at this point?

- **Conciliation** is not what everybody wants.

- Is there an issue about **confidentiality** for practitioners in the proposed single door entry for multi-agency complaints.

- At what stage should a complaint passed from stage two to the Ombudsman?

- Complainants often feel their verbal evidence does not carry the credibility or weigh of written hospital records. Richard Oswald pointed out that 60% of complaints are upheld by the Ombudsman who displays a healthy scepticism towards medical records.

- The Report sees time limits as undesirable but:
  - the longer the time in delay the more difficult it will be to investigate a complaint properly.
  - how long should staff have a complaint hanging over them?
  - there is some responsibility on complainants to get round to complaining within a reasonable period.

- A quick "straw poll" indicated 7 members in favour of no time limit and 21 in favour of having some time limit on complaints. No agreement was reached on how long. Arguing for no time limit one member emphasised the importance of explaining to complainants that they shouldn't expect the best outcome beyond a certain time period.

- Complaints panels could end up being quite sizeable and therefore fairly intimidating for complainants. A lack of clarity about how independent panels would be constituted made comment on this difficult.

- It was widely agreed that FHSA complaints' procedure should be subject to the Ombudsman's investigations.

- It will be important for CHCs to **monitor** the implementation of the eventual outcome of the Wilson Report.

No firm resolution or conclusion was reached by the group but it was hoped that the issues highlighted would be helpful to individual CHCs in formulating a response to the consultation.

THE FUTURE OF NHS COMPLAINTS
Break-up Group 3 - FHSA COMPLAINTS

Fidelma Winkler, Chief Executive, Kent FHSA
Mary Creswell, Kent FHSA
Ross Thomson, ACHCEW, Chairing the Group

Fidelma Winkler asked the group what issues they would like to discuss. The following were identified:

Q. Is the Service Committee Procedure going to disappear? In the report it says there will be a procedure for breeches of conduct.

Q If it goes to disiplinary procedures will patients be brought in as witnesses?

Q Practice based complaints procedures - is anyone monitoring these practice based procedures and how are they doing it?

Q If patients make their complaint inhouse, they will not have the opportunity to go to the CHC

Q Will a change in the complaints procedure based in GP practices effect GP Contracts?

Q How does the FHSA view the impending Health Authorities amalgamation?

Practice based complaints procedure - has been adopted in Kent. Fedelma spoke about every complaint should be turned round so that lessons can be learnt. Hospital often find complaints an irritant.

<u>Points emerging from discussion</u>

A complete culture change is needed particularly within the profession. Wilson Report is about procedures, when procedures are amended who is going to change the culture at the very early stage. The FHSA has very little pressure so it has to rely on peer pressure.

Nowhere in the Wilson Report does it take account of constant offenders.

The service must be improved. The patient may not be satisfied by the outcome of the complaint but they must be satisfied that they have been heard and that it has been investigated properly.

Over valuing the protection of the professional, as FHSA starts to bring in better procedures care must be taken that they are not turned round in the interest of professionals.

Every complaint received is a lesson to be learnt.

Complaints are often as a result of bad management in the practice. Mary explained how the Kent FHSA would then go to the practice and discuss it e.g. problems with notes often go hand in hand with the type of care being received by the patient.

It was agreed that the Wilson Report was more about changing procedures it did not address change of culture which would have to be picked up a very early stage. Very little power in the document other than peer pressure. The professionals had to be taken along with any new procedures.

The patient may not be satisfied with the outcome of the complaint but might be happy with the process which the complaint has been investigated.

There was uncertainty as to whether Stage II in the Report would in due course replace Hearings as changes in legislation would be required. Amendments to GP contracts might have to be done. Should a practice based complaints system be in a GPs Contract? Is there a way of setting up something to monitor this system. Should CHCs have extra resources to enable them to monitor practice based complaints procedures?

Mary Cresswell explained how the Kent FHSA decided to look at a practice based complaints system. They talked first to the LMC and CHCs who were supportive.

Kent FHSA had a system of creditation for practice based systems. The FHSA had agreed that if the complaints system was going to be practice based.

a) staff must be trained to look at the complaint in depth; (changing attitudes)

b) patients should be advised to contact the CHC (giving out CHC name and address.) and advise of time limits.

c) there should be monitoring by FHSA allowed

d) there should be a designated person in each practice (e.g.practice manager) to deal with complaints

e) Agree that complaints are kept separately from patients' medical records.

If the inhouse procedures do not work then resolving the complaint should be referred to the CHC. The procedures should be advertised in surgery. Posters saying if they are not satisfied they should go to the CHC for help. Any concern spoken by a patient must be addressed by the patient.

Patients ask what guarantee is there that they don't lose their GP through making a complaint through the practice.

Fedelma felt that <u>some</u> CHCs use the patient to beat the system.

ACHCEW Conference 14th June 1994
The future of NHS Complaints
Break-up Group 4 - 'One Trust's Approach'
Dolly Daniel, Consumer Relations Manager
Hastings and Rother NHS Trust

Dolly Daniel asked the group to split into two and consider the feelings of staff or patients about complaints and then this was fed back to the whole group.

Patients	**Staff**
Isolated	Threatened
Frightened (of recrimination)	Frightened
Angry	
Vulnerable	Resentful
Guilty	
Emotional	
Confused	Ashamed
Vengeful	Defensive
Wanting compensation	Anxious
Aggressive	
Wanting to make a political point	Exposed
Wanting to feel better	Unsupported
OK to complain?	OK to request support?
Not wanting to get anyone into trouble	

It will be seen that many feelings are shared by both groups.

Dolly Daniel went through the system in operation in the Hastings and Rother NHS Trust; a population of 180,000 is served by 3,000 staff.

She mentioned

: the pack for managers, the leaflet for users and the quarterly and annual reports on complaints (available on request).

: that it is not always appropriate for the Chief Executive to respond to complainants eg. if the complaint is about ducks on the lake!

: that complaints are increasing in number and complexity, more are going to litigation, and two complaints have led to Internal Enquiries being set up.

: complaints can be costly in time and money

: their complaints standard is for complaints to be acknowledged in 2 days and responded to in 28 days (50% target achieved) The purchaser has the same target times

: the seniority of the manager with the complaints brief may affect the speed and/or quality of the response

continued.../

: Trust boards hold consultant contracts so can 'crack the whip'. It is sometimes difficult to pick up complaints which have gone direct to consultants.

: they get about 100 new complaints a month - there is a need to publicise the procedure to get feedback as soon as possible.

: two-thirds of the feedback is positive

: the quarterly report is reviewed by their Complaints Panel, which includes a CHC member, and is chaired by a non-executive member of the Board. The CHC member is assisting in a survey of patient opinion of the procedure (10% are being followed up by questionnaire and interview).

: there is a need to review how complaints information is used

: they have developed an in-house video about complaints and a logo for use with all Alzheimer's patients as a result of complaints.

: the Medical Director can be involved to ensure complaints are used effectively

Points made in questions were

: independent support (from the CHC) should be offered routinely
: it may be necessary to train laypeople to assess clinical advice
: if letters come from the Chief Executive it guarantees their standards.

The group agreed that issues which ACHCEW should take up with the DOH concerning the Wilson Report were recommendations for Trust Board action concerning complaints, as follows

: Trust Boards should routinely offer complainants independent support from the CHC in connection with their complaints

: the Medical Director on the Board should be involved in all consultant complaints

: Consultants should be asked at appointment interview what their attitude to complaints is and how they would handle them

: Trust Boards should have a policy on what to do with staff who do not comply with the Board's agreed complaints procedures.

APPENDIX 1

ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES

14 June 1994
The Future of NHS Complaints

PROGRAMME

9.45 -	Coffee and Registration	
10.30 -	Welcome and Introduction from the Chair	
10.35 -	**Professor Alan Wilson:** (Review Committee Chair. Vice Chancellor, Leeds University)	*Recommendations of the Complaints Review Committee*
11.00 -	**Rt Hon Dr Brian Mawhinney MP:**	*The Government's Response*
11.45-	**Chris Dabbs:** (Chief Officer, Salford CHC. Review Committee Member)	*Implications for CHCs*
12.10-	Followed by questions from the floor and debate	
1.00 -	----- *Lunch* -----	
2.00 -	Break-up Groups:	
	1. Handling CHC Complaints: ***In the Warwick Room, 2nd Floor***	**Martin Ford** (Complaints Officer, Leeds CHC)
	2. The Role of the Ombudsman ***In the Cornwall Room (main hall)***	**Richard Oswald** (Deputy Health Service Commissioner)
	3. FHSA Complaints: ***In the Denby Room, 3rd Floor***	**Fedelma Winkler** (Chief Executive, Kent FHSA. Chair, Complaints Consortium)
	4. One Trust's Approach: ***In the Oxford Room, 2nd Floor***	**Dolly Daniel** (Consumer Relations Officer, Hastings & Rother NHS Trust)
3.00 -	Report back & Plenary session	
4.00 -	Tea	

APPENDIX 2

Extract from: *Being Heard - The report of a review committee on NHS complaints procedures*

X. LIST OF RECOMMENDATIONS

GENERAL PRINCIPLES

1 We recommend that the following principles should be incorporated into any NHS complaints procedure:

* responsiveness
* quality enhancement
* cost effectiveness
* accessibility
* impartiality
* simplicity
* speed
* confidentiality
* accountability (Para 161).

MAXIMUM COMMONALITY

2 We recommend that there should be a common system for complaints by NHS patients so that they can exercise the same rights whichever part of – or provider of services to – the NHS is involved (Para 179).

3 We recommend that NHS practitioners and staff at all levels should make sure that, with the patient's permission, complaints which do not concern matters within their responsibility or involve more than one organisation are quickly passed on so that the complainant will receive a full response (Para 181).

DISCIPLINE

4 We recommend that complaints procedures should be concerned only with resolving complaints, and not with disciplining practitioners or staff (Para 182).

5 We recommend that the Health Departments re-examine existing disciplinary procedures, particularly those for family practitioners, in the light of our other recommendations and our analysis of the shortcomings of existing procedures (Para 183).

6 We recommend that there is an unrestricted flow of information from procedures for handling complaints to management and/or professional bodies, so that they may take any appropriate disciplinary action (Para 186).

PUBLICITY

7 We recommend that every purchaser and provider of NHS services should have simple, readily available written information about how to complain. A short general leaflet on "how to complain about NHS care" should be produced and disseminated. We also recommend that greater publicity should be given to the availability of general information on how to complain from the freephone Health Information Services (Para 187).

8 We recommend that "branding" should be considered as part of the implementation of any new NHS complaints procedures (Para 188).

INFORMAL RESPONSES

9 We recommend that complaints procedures empower NHS staff to give a rapid, often oral, response when a complaint is made about a service within their responsibility, and to initiate appropriate action as a result of the information received (Para 190).

10 We recommend that complaints procedures should encourage those handling complaints, including senior staff, to make early personal contact with complainants (Para 191).

TRAINING

11 We recommend that training in complaints handling should be extended to all NHS practitioners and staff who are, or are likely to be, in contact with patients (Para 192).

12 We recommend that appropriate training is offered jointly to health council staff and others who may be asked to support complainants and respondents (Para 195).

SUPPORT FOR COMPLAINANTS AND RESPONDENTS

13 We recommend that specific resources, including staff, are provided to health councils for their role in supporting complainants, accompanied by guidance from the Health Departments as to the use of these resources and monitoring arrangements (Para 196).

14 We recommend that all NHS practitioners and staff should be made aware of the support available when a complaint is made against them (Para 197).

INVESTIGATION

15 We recommend that the degree of investigation carried out within complaints procedures relates to the complainant's required degree of response. Further investigation by management may also be needed into individual, or patterns of, complaints (Para 201).

CONCILIATION

16 We recommend that conciliation is more widely available throughout NHS complaints procedures, and that those attempting conciliation receive appropriate training (Para 203).

TIME LIMITS

17 We recommend that information given out about complaints procedures should encourage people to make complaints known as soon as possible after they become aware of a problem (Para 208).

18 We recommend that the Health Departments examine the desirability of time limits for making complaints in the light of the arguments we have outlined (Para 210).

DEADLINES

19 We recommend that written complaints are acknowledged within two working days (Para 213).

20 We recommend that, if an investigation or conciliation is required, the response to the complainant should normally be made within three weeks of the complaint being received. If this is not possible, the reasons should be explained and a new date given which should be no more than two weeks ahead. Where the complainant is dissatisfied and further action is required by the complaints or chief executive, we recommend that a further two weeks should normally be allowed for this (Para 214).

21 We recommend that all stages of a complaints procedure should normally be completed within three months (Para 215).

CONFIDENTIALITY

22 We recommend that complaints should normally be filed separately from health records (Para 216).

RECORDING AND MONITORING

23 We recommend that a system for the recording and classification of complaints should be developed and implemented on a United Kingdom basis (Para 218).

24 We recommend that non-executive directors should take a key role in monitoring performance on complaints (Para 221).

25 We recommend that all practices and trusts review their complaints handling on at least a quarterly basis, and make an annual published report on these reviews to the relevant health authority or health board, trust board, and main purchaser(s) (Para 222).

26 We recommend that organisations regularly establish what their users think about their handling of complaints (Para 223).

27 We recommend that information derived from complaints is incorporated into quality review mechanisms (Para 224).

28 We recommend that each of the Health Departments publish an annual complaints bulletin on the current quarterly Scottish model (Para 225).

IMPARTIALITY

29 We recommend that all NHS complaints procedures should include at some stage the possibility of complaints being considered by impartial lay people (Para 230).

DESIGNING PROCEDURES

30 We recommend that the broad features of handling and response we describe should be followed. Key aspects should be required by the Health Departments, but detailed implementation and operation should be left to individual organisations (Para 234).

STAGE 1 PROCEDURES

31 We recommend there should be a three-fold approach to complaints in Stage 1: an immediate first-line response; secondly, investigation and/or conciliation; and thirdly, action by an officer of the family health services authority (or equivalent) for family health services or by the Chief Executive for trusts (Para 238).

32 We recommend that there must be well-publicised access for complainants to a named person such as a complaints officer (Para 243).

33 We recommend that special attention should be paid to the needs of vulnerable groups for support and representation in making complaints (Para 244).

34 We recommend that most complaints should receive an appropriate response either immediately or within 48 hours from front-line staff, their immediate managers, or senior clinical staff, or the named person or complaints officer (Para 247).

TRAINING IN COMMUNICATION SKILLS

35 We recommend that NHS practitioners and staff in all disciplines and professions receive thorough training in communications skills and that should this be incorporated at an early stage into training for professional qualification, staff induction courses, and basic training at all levels (Para 250).

36 We recommend that everyone who is likely to receive oral complaints should be trained in active listening skills (Para 251).

ORAL AND WRITTEN COMPLAINTS

37 We recommend that oral and written complaints should receive the same consideration and sensitive treatment (Para 254).

INVESTIGATION AND CONCILIATION

38 We recommend the use of investigation and the offer of conciliation, where an immediate oral response seems inappropriate or where the complainant remains dissatisfied following an earlier response (Para 255).

39 We recommend that the conciliator might be a practitioner or member of staff within the practice or trust, or lay person, specially trained for this role (Para 258).

40 We recommend that, following investigation and/or conciliation, a written response is sent from the senior partner, practice manager, general or clinical managers within the trust, or health authority or health board director (Para 259).

ACTION BY THE COMPLAINTS EXECUTIVE OR CHIEF EXECUTIVE

41 We recommend that in particularly serious cases or where the complainant remains dissatisfied, the complaint should be considered at the most senior level available (Para 261).

42 We recommend that authorities and health boards responsible for family health services – in consultation with local practices and local representative committees – employ "Complaints Executives" (Para 263).

43 We recommend there should be a full range of options at the discretion of the Complaints Executive or Chief Executive: conciliation; detailed investigation of the complaint – which might include obtaining independent advice or establishing an independent inquiry (Para 264).

44 We recommend appropriate professional advice is always sought where complaints concern clinical judgement (Para 264).

45 We recommend that whenever a response is sent, the complaint respondent should check whether the complainant is satisfied and inform him or her what further action might be taken (Para 267).

46 We recommend that the Unit General Manager of a directly managed unit should take chief executive action where this is required for complaints (Para 269).

COMMUNITY SERVICES

47 We recommend that community service staff should have particular training in responding to complaints because they may not have immediate access to advice from more senior managers or specialist staff, when they are visiting patients in their own homes (Para 271).

NON-NHS PROVIDERS

48 We recommend that purchasers specify complaints requirements in their contracts with non-NHS providers (Para 272).

PURCHASERS AND COMPLAINTS ABOUT POLICY DECISIONS

49 We recommend that purchasers should give proper consideration to complainants' views on their policies, including deciding whether the original policy decision should be changed in the light of the complaint (Para 274).

50 We recommend that, if complaints about purchasing decisions and policy matters cannot be resolved locally, complainants should ask the Health Service Ombudsman to investigate (Para 275).

51 We recommend that complaints about policy decisions are handled on the same basis as those about purchasing (Para 276).

COMPLAINTS INVOLVING MORE THAN ONE ORGANISATION

52 Where a complaint concerns more than one organisation involved in providing or purchasing NHS services, we recommend that the organisation receiving the complaint should make sure that it receives a full response (Para 277).

COMMUNITY CARE

53 We recommend that the NHS and social services departments liaise closely to develop complaints procedures for community care and other areas which embody the principles and characteristics we have described. We recommend that the Government should consider further integration of NHS and local authority complaints procedures (Para 278).

STAGE 2 PROCEDURES

54 We recommend that arrangements are put in place for those complaints which are not adequately dealt with under "internal" procedures. These arrangements should take the form of screening followed by panel consideration (Para 295).

55 We recommend that whoever operates the Stage 2 procedure must start with *screening* each complaint to establish:

- firstly, the issues the complainant wishes to be addressed;
- secondly, whether these issues could be appropriately considered within Stage 1 procedures but have not been;
- thirdly, what sort of further response is appropriate (including whether the matter is more appropriately dealt with under disciplinary procedures) (Para 298).

56 We recommend that the decision to proceed to a Stage 2 panel should rest with the screening officer and, in problematic cases, a panel chairman (Para 300).

57 We recommend that panels should normally have three members. If the complaint raises issues of professional judgement or requires particular specialist knowledge, two additional members might be appointed (Para 301).

58 We recommend that panels should always have a lay majority (including a lay Chairman), and vary their members according to the nature of the complaint. If the complaint concerns issues relating to clinical judgement, two members should be included from the relevant profession acting as independent assessors (other professional reports might also be commissioned if necessary). Where the complaint is from a patient detained under the Mental Health Act, a commissioner from the Mental Health Act Commission (and its equivalents) should normally be co-opted onto the panel. Where the complaint involves community care, the panel should include representatives from social services. The appointing body should ensure that the list of those available to serve on panels respects equal opportunities principles (Para 302).

59 We recommend that the body appointing panels should be responsible for ensuring that Chairmen and panel members receive adequate training (Para 303).

60 We recommend that the panels should make a report with any appropriate recommendations to be sent to the complainant, and copied to the person(s) against whom the complaint had been made and to the relevant chief executive(s) to judge what management action should follow. If there was an indication that professional codes of practice might have been breached, a copy should also be sent to the relevant regulatory body. We recommend that panels should normally complete their consideration of a complaint within five weeks (Para 305).

ORGANISATIONAL OPTIONS

61 We recommend that the Secretary of State for Health and other UK Health Ministers consider the options for the organisation of the Stage 2 procedures in the light of our recommended principles and features of effective procedures (Para 320).

HEALTH SERVICE OMBUDSMAN

62 We support the recommendations made by the Select Committee on the Parliamentary Commissioner for Administration to extend the Health Service Ombudsman's jurisdiction to GPs and to the operation by family health services authorities of the current service committee procedure. We also suggest that the Government should carefully examine whether the practical difficulties might be overcome which the Select Committee believes prevent the Ombudsman considering complaints about clinical judgement (Para 322).

IMPLEMENTATION

63 We recommend that the introduction of new complaints procedures for family health services should also be accompanied by changes to the national contractual arrangements for family health service practitioners to require practice procedures to be introduced, and co-operation with other aspects of NHS complaints procedures (Para 328).

64 We recommend that purchasers, with guidance from the Health Departments, are made responsible for auditing the complaints procedures operated by those providing services, as part of their contractual monitoring of service quality (Para 331).

65 If general accreditation systems are introduced on a comprehensive basis, we would recommend that complaints procedures should feature in them, and that this should then become the primary means of ensuring complaints procedures are operating effectively (Para 335).

66 We recommend that implementation should be managed through four Implementation Groups within the Management Executives of the four UK countries (Para 340).

67 We recommend that a short annual review of NHS complaints handling in each of the four UK countries should be carried out reporting to the relevant Secretary of State (Para 341).

APPENDIX 3

BEING HEARD

A RESPONSE BY THE ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND & WALES

1.1 The Association welcomes the opportunity of responding to this important and long-awaited report on the future of NHS complaints procedures.

1.2 ACHCEW's views on the current procedures for dealing with complaints in the NHS, and our recommendations for change, are well-documented and submitted in the form of written evidence to the Wilson Committee. It is not the intention of this response to re-state those views but we have enclosed the following supporting papers for ease of reference:

A Health Standards Inspectorate. ACHCEW/AVMA. 1992.

NHS Complaints Procedures: A Submission to the Complaints Review Committee. ACHCEW. 1993.

1.3 ACHCEW believes that the Wilson Committee has clearly recognised the elements of the current procedures most in need of change and their list of principles - upon which any new system must be based - cannot be faulted. However, we also believe that, in seeking to deliver both a broad and sweeping set of recommendations, the Committee has failed in some parts to focus on the mechanisms which would be required to implement the new systems which they have proposed. Although this is hardly surprising, considering the length of timescale to which they were working, it unfortunately means that some of the important practical implications of their broad proposals have been overlooked. Our main concerns relate to the following areas:

* the proposed separation of disciplinary issues and complaints issues, as opposed to focusing on the complainant's needs as being central;

* design and ownership of the screening system used before progression to stage 2 procedures;

* ownership of stage 2 procedures and the need for impartiality and independence from the NHS;

* lack of detail on the role of stage 2 panels and the lack of emphasis on oral hearings - over-reliance on written evidence can result in stage 2 being more limited than current FHS procedures and possibly less effective;

* absence of a formal recommendation for additional resources, despite the recognition of the need for "resource-reliant" improvements (eg training for front-line staff, use of lay conciliators).

1.4 Were these issues to be addressed in the same spirit in which the report makes its broad recommendations, Professor Wilson's system would lead to vast improvements both for patients and the NHS in the way that complaints are handled. If, however, they are neglected and a (perhaps immediately cheaper) "quick fix" remedy is chosen, it will not be long before the confidence of the patient disappears and we are looking for another independent review committee to find out what went wrong. We have every hope that this will not become necessary.

Comments on the individual recommendations of the report

General principles

2.1 Recommendation 1: ACHCEW has long advocated a list of similar principles which should be considered essential to an effective system. We welcome each of the nine principles on the Wilson Committee's list and hope that the future system genuinely adheres to each of these.

2.2 Whilst considering general principles, we feel it would have been useful for the Committee to formally recommend exactly what constitutes a complaint. We are not aware of a satisfactory definition and this has caused problems in the past.

Maximum commonality

2.3 Recommendation 2: A "common system for complaints by NHS patients" is clearly necessary to avoid the maze of bureaucracy and confusion which currently exists. This should mean that complaints will be dealt with using the same set of rules and conventions, irrespective of the circumstances under which they are first lodged. It is important that these rules and conventions are made known to patients and staff throughout the NHS to ensure there is no confusion on either part about the way in which the complaint will be handled.

2.4 Recommendation 3: We agree it is not for the complainant to find "the correct organisational doorbell to ring" and that, where appropriate, staff should refer a complaint on to the correct body/authority without delay. This will clearly require protocols to be established but as long as patients perceive there to be a single, easily recognisable point of access to the system and are not dissuaded by administrative hurdles or forced to recount the details of their complaint several times, ACHCEW's concerns about a *single front door* will have been satisfied.

Discipline

2.5 Recommendation 4, Recommendation 5 and Recommendation 6: Whilst we understand that discipline is an issue in its own right, we are extremely concerned that in the process of attempting to cleave complaints and disciplinary issues, the system for dealing with complaints will lose credibility and be seen by many simply as a "talking shop".

2.6 A parallel can be drawn between the proposed complaints/disciplinary split and the separation of clinical and non-clinical complaints. There originally appeared to be good reason to separate these two elements of a complaint and deal with them through different procedures. But most commentators now agree that the two elements are inextricably linked and efforts to deal with them separately have resulted in a piecemeal approach to complaints handling generally and yet another unnecessary administrative hurdle.

2.7 According to the experience of CHCs[1], three of the five fundamental concerns of complainants are: to know whether anyone is to blame, what action (if any) will be taken against that person, and what action will be taken to ensure a similar incident does not occur. These are surely also of fundamental concern to any disciplinary body.

2.8 The minority of complaints which result in disciplinary action being taken by the GMC or other professional bodies will usually be stressful and traumatic for the complainants involved. It is therefore important (paragraph 184) that these complainants should not be expected to go through the details of the incident on two separate occasions on the basis that both a complaint and a disciplinary issue must be dealt with.

2.9 We believe, therefore, that the link between disciplinary and complaints systems needs to be stronger and more formal than "an unrestricted flow of information". There will be (as there are now) cases where a complaint which is upheld will specifically relate to a disciplinary matter, or the investigation of a complaint will clearly point to the need for disciplinary action. In these cases, appropriate action should be taken, the complainant should be fully informed of this, and an independent appeal mechanism should be available if the complainant is not satisfied.

Publicity

2.10 Recommendation 7: Whilst we agree that every purchaser and provider of NHS services should provide "simple written information on how to complain", it is important to bear in mind that this should already be available yet in many cases is clearly not[1].

2.11 If information is to be disseminated effectively, it should be available in formats understood by the wider community. This includes people whose first language is not English, those who are not fully literate, people with physical, sensory or learning disabilities, and people with mental health difficulties. It should be clear which individuals/organisations are responsible for updating the information when necessary and for ensuring that outdated information is removed from circulation.

Informal responses

2.12 Recommendation 9 and Recommendation 10: We would support the use of the type of informal responses described where this is appropriate to the situation and/or the type of complaint. If this is to be successful, the type of training described in recommendation 11 should be considered essential. We are unclear as to how training to this extent can be achieved without additional resources.

Training

2.13 Recommendation 11: To reiterate the points above, we are extremely pleased to see the Committee recommending that "all NHS practitioners and staff who are, or are likely to be, in contact with patients" should receive training in complaints handling. However, this major task will not realistically be achieved by the incorporation of "communication and interpersonal skills" into the syllabus of study for health professionals or into induction training programmes (even though these measures should prove helpful in the long run). If we are to effect the sort of culture change advocated so firmly by the Minister for Health[2], requirements for this training must be built into contracts and resources ringfenced for the purpose.

2.14 Although communication skills are of course important, training will also need to be focused on the process of conducting investigations. A competent investigation and evaluation of the evidence at an early stage will help to reduce the number of complaints unnecessarily referred on to a subsequent stage.

Support for complainants and respondents

2.15 Recommendation 12 and Recommendation 13: Many CHC Officers spend more time supporting individual complainants than they do on any other activity. We wholeheartedly support the recommendation that "appropriate training" is provided for these staff and that "**specific resources, including staff, are provided to health councils for their role in supporting complainants,** accompanied by guidance from the Health Departments as to the use of these resources and monitoring resources".

Investigation

2.16 Recommendation 15: Few would dispute that the degree of investigation should be appropriate to the situation (or "the complainant's required degree of response") but this should not be left to the discretion of the staff handling the complaint. The complainant should have the opportunity to state whether he or she believes that (further) investigation is necessary: this decision should not be made by NHS staff on his/her behalf.

Conciliation

2.17 Recommendation 16: The use of conciliation is an important option in the resolution of a complaint. However, if it is to become more widely available, those staff dealing with complaints must continue to see it as just an option. ACHCEW is becoming increasingly aware that, in relation to family health services, some patients feel they are almost "forced" into conciliation inappropriately in an attempt to avoid their complaint going forward to a Service Committee. Both parties in a complaint obviously need to be willing to undergo conciliation if it is to have any chance of success. Those complainants who are unwilling to take part in the process, for their own reasons, should not be treated any less favourably.

Time Limits

2.18 Recommendation 17: We agree that complaints information should encourage patients to make a complaint as soon as possible after they become aware of a problem. NHS staff and advice agencies should do likewise.

2.19 Recommendation 18: We are disappointed that, despite a majority agreement, the Committee was not able to formally recommend the abolition of time limits as a cause of unnecessary frustration and bureaucracy. We urge the Department of Health to look beyond the predictably reactionary views of those who would retain time limits, to the examples of where they have already been abolished with few or no adverse consequences.

Deadlines

2.20 Recommendation 19, Recommendation 20 and Recommendation 21: The proposed deadlines are in line with ACHCEW's previous recommendations and we support them in full. The deadlines should apply nationally and the actual response times should be published locally.

Confidentiality

2.21 Recommendation 22: We agree, for the reasons stated in the report, that complaints should normally be filed separately from health records, unless the complainant requests otherwise.

Recording and monitoring

2.22 Recommendation 23: Over the last year, ACHCEW has commissioned and been involved in the design of a computerised recording system for complaints. This has now been circulated to all the Associations' members throughout England and Wales. If a national system for the recording and classification of complaints is to be developed on a UK basis, we would be interested to participate in its design.

2.23 Recommendation 25: A review of purchaser/provider complaints handling, along with the publication of an annual report, would be welcome. The review process should certainly involve the CHC Chief Officer or Chairperson (paragraph 222).

2.24 Recommendations 26, 27 and 28: ACHCEW considers these recommendations (about involving users, incorporating complaints information into quality review mechanisms and publishing an annual complaints bulletin) to be positive and useful.

Impartiality

2.25 Recommendation 29: Impartiality is fundamental to any complaints system. Whilst we understand the report stating (paragraph 226) that: "Impartiality is achieved by care and accuracy on the part of the investigator", we would stress that, in practice, it is often the status of that investigator which will determine whether the complaint is considered impartially.

2.26 This does not mean to say that internal investigations cannot have a legitimate role in complaints handling. It means that, if a system is to be satisfactory to patients, it should provide, at some stage, every complainant with access to an investigation which is both impartial and independent of the NHS. "Providing access" to complainants includes informing them of any alternatives open to them if they are dissatisfied.

2.27 Finally, we reiterate our concerns, expressed on several occasions in the past, about GPs removing patients from their lists, without having to give reasons for doing so. Patients will continue to be reluctant to make a complaint about their doctor in the knowledge that, simply by lodging that complaint, they risk being branded as a "troublemaker" and as a consequence, being removed from the GP's list. If the new system is to be truly impartial, GPs must be required to give a satisfactory reason before removing a patient from their list.

DESIGNING PROCEDURES

Stage 1 procedures

3.1 We support the basic philosophy that front line staff should be encouraged to respond to complaints immediately, where this is possible (Recommendation 34). There is a danger, however, with this approach that some complaints may be trivialised and/or the complainant dissuaded from taking further action - despite the fact that the complaint has not been satisfactorily resolved. To prevent this problem arising, we believe that (in line with 45) all front line staff should inform complainants that they have an option of taking their complaint further. As stated earlier, <u>if a system is to be satisfactory to patients, every complainant must, at some stage, have the right of access to an investigation which is both impartial and independent of the NHS</u>. If a complainant is not informed that he or she has this right of access, it might as well not exist.

3.2 There can be little doubt that poor communication at this stage exacerbates many complaints, and so sensitivity on the part of staff will be even more important in the proposed stage 1 procedures. Recommendations 35, 36 and 37 should go some way towards improving communication skills and the sensitive handling of complaints.

3.3 The second element of the "three-fold approach" is investigation and/or conciliation, typically carried out within a trust or practice. As an additional measure to attempt to resolve certain types of complaint, this can be welcomed. There are, however, many complaints for which it will not be suitable. Take as an example, a typical complaint that a GP acted in a rude and offensive manner, ignoring the concerns of a patient that he/she considered to be making unreasonable requests. The GP concerned happens to be the senior partner in the practice, and conciliation has been attempted but to no avail. If after investigation it turns out that the complaint is justified, how likely is it that the practice manager will take stern action in favour of the complainant? Alternatively, how likely is it that a placatory letter will be sent but no further action taken against the GP?

3.4 The third element is for "particularly serious cases or where the complainant remains dissatisfied" and involves action typically by the "Complaints Executive" in an FHSA or the Chief Executive of a trust. We understand and support the need to appoint a Complaints Executive at a senior level within the FHSA (Recommendation 42); this responsibility should certainly not rest with the senior partner of the practice concerned.

Non-NHS providers

3.5 Recommendation 48: We fully support the requirement for complaints requirements to be spelt out in contracts between purchasers and non-NHS providers. In practice, this should ensure that independent or voluntary sector providers have complaints systems which are *fully equivalent* to those in the NHS, rather than merely being "similar".

Purchasers and complaints about policy decisions

3.6 Recommendations 49, 50 and 51: We agree that complaints about purchasing and policy issues are best resolved by an established internal system or, failing that, referred to the Ombudsman who would judge whether the decision-making process had been followed correctly. Complaints about purchasing should be handled no less seriously than other complaints relating to NHS treatment and care.

Complaints involving more than one organisation and complaints relating to community care

3.7 Recommendation 52 and Recommendation 53: ACHCEW has long stood by the guiding principle that complaints arrangements should apply equally and fairly to *all* NHS-initiated care. We agree that, in the event that a complaint has to be referred on from one body to another, it should be the responsibility of the body which initially receives the complaint to ensure that the complainant receives a full response <u>and is aware of any further steps which can be taken if he/she remains dissatisfied</u>.

3.8 As community care is a particularly important and growing area where problems have already been identified, we believe that the government should look towards establishing more formal links between NHS and local authority complaints procedures - we are not convinced that these two systems can, or should be, integrated.

3.9 The role of the CHC in complaints involving social services has still not been fully clarified. We would welcome further guidance on this issue.

Stage 2 procedures

3.10 Recommendation 54: Although it would deal with a much smaller volume of complaints, we believe that an external "stage 2" procedure would become the focus of the new system: it is essential not only in its own right but also because it is a means of giving patients the confidence to use the internal stage 1 procedures *knowing that, if their complaint is not dealt with satisfactorily, they can opt for a fully independent investigation*. This will only happen if patients perceive the stage 2 procedures as being accessible (the screening process must not exclude any legitimate complaints from consideration) and totally impartial.

3.11 Recommendation 55 and Recommendation 56: The main purpose of screening should be to establish whether the complaint in question could be more appropriately dealt with within the stage 1 procedures. If this is not the case and it is clear that there exists an issue of complaint, the stage 2 procedure should be invoked automatically. Although we agree that it is appropriate that the Health Service Ombudsman should deal with cases where complainants are dissatisfied with a screening decision, this should be a rare occurrence.

3.12 It would, of course, be unsatisfactory to employ a screening system which "chose" between the merits of different complaints to ensure that only what it considered to be sufficiently "serious" matter were allowed through. Apart from being inappropriate and against the spirit of treating complaints positively, this approach would cause the office of the Health Service Ombudsman to be deluged with appeals - all of which using resources and causing avoidable administrative delays.

3.13 We do not consider it appropriate for the complaint to be referred to disciplinary procedures at this stage without a formal link between the stage 2 panel and the disciplinary body. The purpose of this link would be to ensure that the original complaint continues to be the focus of the investigation and the complainant does not get "pushed to the sidelines".

3.14 In the situation above, the panel would be responsible for making sure the complainant was fully informed of the process and outcome of the disciplinary procedure, and that the complaint had been adequately addressed. Any element of the complaint that would not, or could not, be addressed would then be passed to the panel for their consideration. This should ensure that a complaint would be dealt with in a similar manner, from the complainant's perspective, irrespective of whether it raised disciplinary issues or not.

3.15 Recommendations 58, 59 and 60: Whilst we welcome the proposed constitution of the panels, with a lay majority and a lay Chair, the variable nature of their membership and the importance placed on equal opportunities principles, we are disappointed at the lack of detail on how the stage 2 panels are meant to conduct themselves.

3.16 Paragraph 304 states that "it would be for the panel to decide how they would consider each case". This, surely, is fundamental to the nature of the new system and formal guidance will have to be issued to the panels at some stage to indicate how they are expected to operate. Assuming this to be the case, we very much hope that the importance of oral hearings is stressed as the appropriate way of dealing with complaints where there is a conflict between the written evidence of the complainant and that of the respondent. This does not necessarily mean that the hearing must be of an adversarial nature, as is sometimes the case with FHS Service Committee hearings. It is, however, the only fair and practical way of resolving certain complaints where both sides have deeply entrenched positions.

3.17 On the basis that the use of oral hearings is to be encouraged, and certainly in no way restricted, we support the remaining proposals (Recommendation 60) for the operation of stage 2 panels.

Organisational options

3.18 The lack of firm agreement on the "organisational home" for the stage 2 procedures is perhaps the most disappointing aspect of the Committee's report. Independence and impartiality are more crucial to a complaints system than anything else, particularly one which relies on internal investigation throughout its early stages. We firmly believe that it is only the fourth "option" suggested by the Committee - an independent body such as a national complaints Commission - which is in any way acceptable as an organisational base for the stage 2 procedures. Unlike the Wilson Committee (paragraph 320) we believe that this issue is crucial to the success of the system as a whole and whether it is accepted or rejected by patients. Any of the other three suggestions for ownership of stage 2 would weaken the system to such a degree as to make it unacceptable and possibly unworkable.

3.19 A complaints Commission would also have a key role in promoting high standards and disseminating good practice throughout the NHS. It should also have a role in determining any sanctions on bodies which fail to fulfil their responsibilities under the new system.

Health Service Ombudsman

3.20 Recommendation 62: We support and applaud the Committee's call for an extension of the remit of the Health Service Ombudsman into family health service matters and complaints relating to clinical judgement.

Implementation

3.21 Recommendation 63, 64, 65, 66 and 67: We support the proposed changes to the terms of service of FHS practitioners, the responsibility of audit to be placed with purchasers the featuring of complaints procedures in accreditation systems, the use of separate implementation groups and the introduction of an annual review of NHS complaints handling.

3.22 We agree with the recognition (paragraph 39) that "some increase in resources for complaints handling is likely to be required, although this should be offset against savings from quality enhancement" but are disappointed that the Committee has not felt it appropriate to make a formal recommendation to this effect. Investing in a high quality complaints system will yield immediate benefits to patients and long-term benefits to the NHS but without the allocation of additional resources where necessary, this cannot happen.

References

1. NHS Complaints Procedures: A Submission to the Complaints Review Committee. ACHCEW. 1993.

2. The Future of NHS Complaints: Report of a Seminar held on 14 June 1994. ACHCEW. 1994.