NAHAT/HSJ CONFERENCE - FRIDAY 29 SEPTEMBER 1995

"ACTING ON COMPLAINTS"

A FAIR HEARING? - THE PATIENT'S PERSPECTIVE

ADDRESS BY TOBY HARRIS, DIRECTOR OF ACHCEW

May I first of all say how delighted I am to have this opportunity to address what I consider to be an extremely important and timely conference. I am grateful as ever to NAHAT and the HSJ for the invitation to speak and want to thank them warmly for the unerring way in which at seminars such as this the address entitled "The Patient's Perspective" is always given the peak slot in the day - just after lunch - when those attending can be relied upon to be at their most alert, attentive and receptive.

I would like to start by giving you a quotation:

> "*There needs, therefore, to be a simple and well understood mechanism through which people who use the National Health Service can suggest how it can be improved and complain when things go wrong.*"

I don't know how many people recognise that quote. It comes not from "Acting on Complaints", nor from the Wilson Committee's report. It is actually sixteen years old and is from the report of the Royal Commission on the NHS. Thus, the concerns we are looking at today are by no means new. Nor for that matter are the objectives of the solutions that we are considering.

Since their inception in 1974, CHCs have been instrumental in helping users of the NHS (and their relatives and carers) to get the best possible service from the NHS. This has included advice and information about the availability of local services, campaigning for services tailored to meet the needs of individuals and helping to get the right sort of care for people with special needs. It has also included acting as "Patient's Friend" - explaining health service procedures and assisting at the inter-face between health service users and those responsible for the provision of health services.

Ironically, this continual involvement in advising and assisting those who feel they have a complaint about the way in which they or their relatives have been treated by the Health Service is not one of the statutory duties of CHCs and until recently the work that CHCs were doing in this field was not officially recognised.

However, the involvement has meant that CHCs collectively have built up considerable experience and expertise and they probably possess the most informed overview of the NHS complaints systems from the perspective of the patient.

In recent years, for example, CHCs have been leading the way with computerising their handling of complaints procedures. This has been substantially due to the ACHCEW Complaints Database developed for CHCs by AMS with the support of the NHS Executive. AMS has given CHCs considerable support over a period of time and will be producing an upgrade of the system to reflect the changes to the NHS complaints systems next April. The software is easy to use, but still allows very sophisticated analysis if required and will enable ACHCEW to make meaningful national

comparisons and also to identify possible "hot-spots" or areas of potential concern. I am pleased to see that AMS are represented here today and, if you have not seen their complaints database in operation I would urge you to have a look.

The experience of handling complaints over the last twenty years has led CHCs to reach a number of conclusions. First of these has been a general dissatisfaction with the systems that are currently in place in the NHS. It has long been our Association's view that the existing arrangements are unnecessarily complex and confusing, are much too long-winded, are unaccountable and either are or appear to be biased against the complainant.

One CHC, for example, conducted a survey aimed at revealing the level of satisfaction complainants experience with the complaints process itself. This found that over half the clients advised by the CHC during an eight month period were dissatisfied or very dissatisfied with the result of making their complaint. Arguably, those assisted by a CHC were more likely to be steered towards the best possible outcome than those who were not. So the levels of dissatisfaction identified may well be an understatement of the real position. That survey and others found that many complainants were frustrated by the scope of the systems available to them to pursue grievances. As a result, many complainants felt that they did not get an adequate opportunity to voice their concerns. Still more were frustrated by how long the whole process took and that when a conclusion was finally reached it did not accord with their expectations.

It was those experiences that meant that when we made our submission to the Wilson Committee we said that the existing systems needed to be scrapped and a new system planned starting as it were with a blank sheet of paper.

In this context, it is important to look at what consumers of the complaints system want and expect of that system. It is the overwhelming experience of CHCs (and this is borne out by other advice agencies) that when something goes wrong the three major concerns of either the person concerned or their relatives are to know:

- first, what happened
- second, why it happened and
- third, what action is going to be taken to try and ensure that whatever happened does not happen again

The desire to blame, the desire for retribution and any desire for compensation fall a long way behind the first three.

It has been ACHCEW's view that whatever complaints system you have it must meet the following five criteria:

- VISIBILITY. Complaints procedures must be widely publicised both within health care units and within the wider community, if potential complainants are to know that the systems exist.
- ACCESSIBILITY. Those with a grievance should be able to lodge it with some one in authority with the minimum of difficulty. The current NHS procedures are not only extremely complex, but are also fragmented. Different procedures apply to different professional staff depending on where they work and the nature of the complaint. These procedures are administered by different bodies which do not appear to be able to co-ordinate action when a complaint raises more than one

issue. That is why CHCs have supported the idea that the complaints systems should have a simple one-door point of access.

- SPEED. A speedy resolution to complaints is in the interests of not only the complainant but also those against whom the complaint is made. Moreover, for some people the satisfactory resolution of a complaint is part of the healing process that follows a traumatic or upsetting event. If this procedure is protracted, it is more difficult for complainants to recover from their experience. That is why speedy procedures with firmly fixed response times are so important.
- IMPARTIALITY. It is the view of many of those that have been through them that the existing complaints procedures are beholden to the medical profession. Serious allegations are investigated and judged either by other medical professionals, often by those working in close proximity with those against whom the complaint is made, or by others with a responsibility for the institution or organisation concerned.
- EFFECTIVENESS. The outcomes of the different complaints procedures are unclear and often unsatisfactory as far as the complainants are concerned. Most complainants are looking for an explanation, an apology and a reassurance that a similar incident will not happen again either to them or to someone else. At present, complainants rarely receive a full explanation of what went wrong. Apologies are often cursory and phrased in bureaucratic jargon and often the tone is "We are sorry you found it necessary to complain". Frequently, little indication is given as to what changes or improvements have been made as a result. Any new system needs to remedy this.

ACHCEW welcomed the Wilson Committee's report. Almost any new arrangements would have to be better than the present slow, unsatisfactory, unfair, and desperately complicated complaints system that we have in the NHS at present.

However, the strength of the Wilson Committee's report was that it took a broad brush approach to the problem, setting out some basic principles and leaving the details to be filled in later. This was fine for a Committee inquiry into the problems, but the assumption was that when the Government responded the details would be filled in.

"Acting on Complaints" filled in some of the details, but by no means all of them. And even in terms of those details which were filled in, ACHCEW has been concerned about some aspects of what the Government said. For example:

- the stage two procedure is likely to be perceived as unfair by complainants screened out by non-executive directors perhaps seen as too close to local management (the NHS Executive concedes that they will not be independent, but suggests that in some mysterious way he or she should distance him or herself from those involved, while at the same time being reliant for any clinical advice needed from within the Trust or Health Authority which is being complained against itself - it is not clear to me that any complainant will feel that the screening process is unbiased under such circumstances);
- the dangers of overload on the Health Service Commissioner with his new broader remit and in particular in relation to complaints by people who feel they have been unfairly screened out of the stage two procedures: and

- the failure to recognise that complaints and disciplinary procedures are inextricably linked. This is still not satisfactorily resolved. The complaints process is to be suspended if disciplinary action is to be invoked, so that the patient loses whatever guarantees they may otherwise have had about the time-table for resolving the matter and even about how much information they will get about the outcome of the process. The guiding principle should be that the complainant should receive the same level of information at the end of any disciplinary investigation as they would have had if the matter had been dealt with through the complaints process.

However, most of the details were not filled in by "Acting on Complaints". Most of the practical arrangements are to follow in Guidance from the NHS Executive. Now, to reuse that over-worn phrase, "The Devil is in the detail". The details are only now beginning to emerge and there are only six months to go.

Some of the reason for the lack of detail - for the lack of Guidance from the NHS Executive - is that much of it is dependent on negotiations with the professional groups within the Health Service. During the summer, the BMA was in almost as febrile a state as the Parliamentary Conservative Party, so I can understand that this was not the easiest moment to sit down with the GMSC to rewrite the GPs' terms of service relating to complaints, particularly while issues of night cover were unresolved. And even with the doctors now being as co-operative as I am sure they are, a similar exercise has to be conducted with the dentists (and we all know how quickly discussions have proceeded with them following the Bloomfield report) - to say nothing of the opticians and the pharmacists. And then there are the hospital doctors to be dealt with.

Anyway, if all of that is out of the way in the next couple of weeks, this will allow the NHS Executive to bring out interim guidance by the end of next month, leaving them a few more weeks to knock out the final guidance (and we all know how quickly they move) in time for Christmas - leaving January, February, and March to set up the new arrangements at local level and to train all of those who will be responsible for stages one and two in every health authority, in every trust, in every GP practice, in every pharmacy and so on.

And just in case you think three months will be sufficient, just remember that the Directions and Regulations will not be finalised until February and there is no guarantee that the legislation changing the Health Service Commissioner's powers will be enacted by April. Moreover, legislation does not permit Directions to be given to community Trusts, so the new arrangements will have to be enforced through the contractual process via Health Authorities and GP Fundholders.

This should all present no problems at all - and if you listen carefully you can just hear the flapping of pigs' wings. And, of course, with that attention to the public finances that we have all got to know and love, there is virtually no new money involved and all the training is to conducted using existing resources.

I have to say - with only the slightest hint of irony - that this is an ambitious target.

I have two major worries. The first is about all of those negotiations, which all incidentally have to reach a common outcome if the objective of simplicity is to be achieved. Those negotiations are going to be effectively between the Government on one hand and the professions on the other.

When I asked at the Acting on Complaints Implementation Advisory Group (ACIAG as it is known, which makes it sound rather more like a particularly distressing skin disease, than a talking shop) who would be representing the patients in all of these negotiations, I was told - with that pitying look only civil service mandarins can produce - that of course the NHS Executive would be looking after the interests of the public.

So that's OK then. I wish I could have been so confident. My fear has been that in the detailed discussions all the improvements that "Acting on Complaints" should bring to patients will be lost. Already there are some worrying indications: the time limit for lodging complaints has dropped from twelve months to six months from the point at which the complainant first became aware of the issue. Twelve months was reasonable for circumstances in which the complainant was having to recover from a traumatic event - six months is too short for some people and the shortening of the limit from what was originally proposed is a retrograde step.

The second concern is that the whole thing is being run on the cheap. The training costs themselves should be substantial. What in essence is required is a huge change of culture within the NHS about complaints. Large numbers of staff at many levels within the Service need to acquire new attitudes towards complaints and complainants. It is a lot more than simply saying to them this is how the new arrangements work - we are - for many staff - talking about a full attitude transplant.

Moreover, at an organisational level, with the cull of staff at RHAs, and now at Quarry House and Richmond House, in full swing, can we say with any certainty that enough resource commitment is being put in at these levels to make it all happen?

None of this should be taken as defeatism. None of this should be interpreted as saying that the implementation date should be delayed. I am sure that faint-hearts within Government may be saying: "there is too much to be done, like community care, it must be put off for a year or two." Likewise there will be those in the professions - perhaps those in whose interests the current unfairnesses work - will see that the difficulties of the next six months provide an excuse for delay, for postponement, and perhaps even for shelving the whole project.

- That must not be allowed to happen. Patients have waited too long already for improved complaints mechanisms. Delay - or watering down - would be unacceptable.

Massive effort and huge sums were put into the introduction of the internal market, the launch of the Patient's Charter produced a plethora of glossy booklets and acres of newsprint, and we are told that the new out-of-hours arrangements for GPs are to be greeted by a similar splurge of publicity telling patients not to bother their doctors after

7.00pm. Now that we have a change that should unequivocally benefit patients, we expect no less in relation to the new complaints system.

But, of course, as I have indicated the benefits are no longer quite as unequivocally beneficial as they might originally have seemed. Earlier I set out ACHCEW's five criteria for assessing the new arrangements: visibility, accessibility, speed, impartiality, and effectiveness.

I have already talked about visibility: the new arrangements must be given the same publicity treatment as the other favoured aspects of Government policy.

But the concerns about accessibility are more significant. ACHCEW wanted to see simple one-door access without the current problems whereby procedures are administered by different bodies and are not co-ordinated. In fact, it is now clear that complaints about purchasing will have to go through a different procedural channel from those about the provision of services. We all, of course, know that the so-called seamless web, linking health and social care is anything but seamless (if, indeed, webs can have seams). But as far as the service user is concerned, it is all one package of care and if there is a complaint it will be viewed by the user as a single complaint. Yet, there will be no linkage of the complaints systems.

We are also told that the existing legislation means that stage two panels cannot consider complaints which concern more than one NHS sector (so the hospital and community health services and the family health services cannot be considered together). However, for many complainants, what to them is a single complaint will involve different NHS sectors and will enmesh them in a variety of complaints processes and hearings - not far removed from the mess we have at present.

As far as speed is concerned, the time-scales suggested are welcome, but as the NHS Executive acknowledges they are also challenging. The worrying feature is that nothing has yet been said about how the time-scales are to be monitored and enforced.

The fourth of the ACHCEW criteria was impartiality. I have already commented how patients are likely to perceive the screening arrangements. And whilst what is proposed, as far as Stages One and Two are concerned, is a substantial improvement on the current arrangements, it is unfortunate that the opportunity is not being taken to make Stage Two and its screening process wholly independent of the unit involved.

Finally, we come to effectiveness. What is proposed will lead to clearer outcomes and should prove more relevant to the concerns of many patients than, for example, the present requirement to prove a breach in terms of service. We will have to see how it works in practice.

The changes to the complaints system are a tremendous opportunity. The present arrangements are an unfair shambles that do a disservice to patients and reflect no credit on those who preside over them.

A good effective complaints system would not be there simply to right wrongs, nor simply to provide redress to grievances, nor to massage the egos of those with

imagined problems. Such a system would be there to improve the quality of service for all NHS users.

The Health Service must not be frightened of complaints. They are an essential input into the quality process. Unless people know what is going wrong they cannot put it right. And when it is put right, it benefits everybody, not merely those who have complained.

Good managers and good clinicians should always see complaints as a means to providing a better quality, more effective, service. If that improves general patient satisfaction, then that can only be to the good.

These are not easy times for the public services. The NHS has always rightly had huge public support. A good complaints system, which makes the NHS itself more responsive to the people who use it, can only bolster and enhance that public support and that must be in the interests of all who work in the service.

The NHS owes it to the public to get the changes right. We have six months left to do it. Let us all do what is in our power to make sure it happens.

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