# Making Experiences Count

## The proposed new arrangements for handling health and social care complaints

Detailed policy background

June 2007


# Making Experiences Count

## The proposed new arrangements for handling health and social care complaints

## Detailed policy background

June 2007

## DH INFORMATION READER BOX

| | |
|---|---|
| **Policy**<br>HR/Workforce<br>Management<br>Planning<br>Clinical | Estates<br>Performance<br>IM & T<br>Finance<br>Partnership working |
| **Document purpose** | Consultation/discussion |
| **Gateway reference** | 8288 |
| **Title** | Making Experiences Count |
| **Author** | DH: Experience and Involvement: IVI |
| **Publication date** | 18 Jun 2007 |
| **Target audience** | PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , NHS Trust Board Chairs, Communications Leads, Directors of Social Services |
| **Circulation list** | Allied Health Professionals, GPs, NDPBs, Voluntary Organisations |
| **Description** | A set of propsals to unify and reform the current arrangements for making complaints across health and social care. As well as fulfilling the commitment in "Our health, our care, our say", they propose a radical new approach to complaints handling which is more flexible and ensures organisational learning. |
| **Cross reference** | NHS (Complaints) Amendment Regulations 2006 & Guidance Learning from Complaints |
| **Superseded documents** | N/A |
| **Action required** | N/A |
| **Timing** | By 17 October 2007 |
| **Contact details** | Individual Voices for Improvement<br>Room 5E43<br>Department of Health<br>Quarry House, Quarry Hill<br>Leeds<br>West Yorkshire<br>LS2 7UE<br>makingexperiencescount@dh.gsi.gov.uk |
| **For recipient's use** | |

# Contents

# 1. Introduction

1.1 Currently, there are two different processes for handling complaints about health and social care services. These processes differ in stages and timescales. Investigations are also carried out in different ways.

1.2 Many people use services that cross health and social care boundaries. If a problem should arise, it is hard for people to know who to go to and difficult for different services to respond jointly.

1.3 The Government wishes to make it easier for people to complain about their experiences of using health and social care services. Recent changes to the current complaints regulations have aligned the two procedures more closely, but we need to go further.

1.4 In the White Paper, *Our health, our care, our say* [January 2006], the Department of Health set out its commitment to develop a single system across health and social care by 2009, that will 'focus on resolving complaints locally with a more personal and comprehensive approach to handling complaints' (Page 160).

# 2. Background

2.1 The current NHS complaints procedure is broadly the same across all health services. Complaints may be made about any matters connected with the provision of NHS services and are, in the first instance, directed to the providing organisation. The stages are:

1 – Local resolution

2 – Healthcare Commission

3 – Health Service Ombudsman

2.2 In the social care complaints procedure, a person is eligible to make a complaint where the local authority has a duty to provide, or to secure, the provision of a service. If someone is unhappy with the service they are receiving, they contact the local authority that provides or commissions the service. The stages are:

1 – Local resolution

2 – Investigation

3 – Review panel

Where a complainant is dissatisfied with the response to his complaint, he can approach the Local Government Ombudsman for independent consideration.

## NHS complaints procedure

2.3 In December 2003, the Department of Health consulted on draft regulations for the new NHS complaints procedure. The original intention was to implement the regulations on 1 June 2004. The regulations included proposals to enable:

- patients' complaints to be raised with any member of staff and resolved immediately, with no need for more formal consideration, thus cutting bureaucracy;
- the Healthcare Commission (formerly the Commission for Healthcare Audit and Inspection) to provide an independent review of complaints where complainants were unhappy with the local NHS response;
- patients to have a choice about the way they make a complaint about primary care services (e.g. directly to the practitioner or to the primary care trust if they prefer not to approach their GP directly);
- the time limit for making a complaint to be extended from six months to one year;
- improved liaison between services. The NHS and primary care practitioners would have a duty to work together when investigating complaints concerning multiple services. This would mean that complainants receive a single, comprehensive response.

2.4 However, it became apparent that the Shipman Inquiry's fifth report would address primary health care complaints handling in some detail later in 2004. Therefore abbreviated regulations, the *National Health Service (Complaints) Regulations 2004*, came into force on 30 July 2004. The Department of Health intended to introduce a more radical overhaul of complaints regulations following consideration of the recommendations from the Shipman Inquiry's fifth report.

2.5 Under the 2004 regulations, local resolution procedures remained unchanged but the Healthcare Commission took responsibility for independent review (the second stage of the complaints process). Other amendments, relating to secondary care, widened the scope of matters falling within the NHS complaints procedure and provided for a senior person to oversee the complaints process.

2.6 Where complainants are dissatisfied following the local resolution stage, they are able to ask the Healthcare Commission to review their case. The Healthcare Commission's primary function in relation to complaints is to assess how best to resolve each case, whether further action is required and by whom. The Healthcare Commission is able to:

- make recommendations for further action by the NHS organisation complained about, e.g. if there are shortcomings in the way a complaint has been dealt with;
- investigate cases in detail – either with the focus on resolving the individual complaint, or in the context of an inspection or inquiry about failures within the organisation complained about; or
- refer cases to the Parliamentary and Health Service Ombudsman, where the case is particularly complex.

2.7 On 1 September 2006, the National Health Service (Complaints) Amendment Regulations 2006 came into force. They:

- impose a reciprocal duty to cooperate on NHS organisations and local authorities; this provides for the transfer to the appropriate local authority of complaints made to NHS organisations that relate wholly or in part to concerns over social care services;
- allow NHS organisations to provide complaints handling services to one another and to designate people other than employees as complaints managers;
- increase the time limit for an NHS body to respond to a complaint from 20 to 25 days and provide for the complainant to agree to a longer period. This allows for a more thorough investigation of complex complaints rather than insisting on a fixed time period for all complaints;
- place a duty to cooperate on the local authority and the NHS body, and to provide a coordinated response to the complainant.

## Social care complaints procedure

2.8 In October 2004, the Department of Health consulted on proposals to make the adult social services complaints system simpler, faster and more effective in improving services by learning from complaints. The consultation paper included proposals to enable:

- simpler and faster complaints resolution: service users being able to complain to any member of staff and get a resolution immediately, with no need to deal with the complaint more formally than that, unless the complainant wished;
- independent review: the Commission for Social Care Inspection (CSCI) to provide independent review of complaints referred to them by people who are unhappy with the response made by the local authority;
- feedback to be used to improve the service – as part of its inspection and review role CSCI would use the feedback from complaints to improve the delivery of services.

2.9 The Government wished to ensure that social care has the needs of the user at its centre, that it is able to listen, learn, and respond, with the complaints process being seen as a lever to improve services. It was envisaged that modernisation would ensure a user-focused service, with those needing to complain finding it a straightforward process with a swift, clear and fair response.

2.10 The proposal to involve CSCI in the process was put on hold in the May 2005 budget announcement that the Commission would be merged with the Healthcare Commission into a single body.

2.11 Revised regulations, the Local Authority Social Services Complaints (England) Regulations 2006, came into effect in September 2006. These:

- introduced a 12 month time limit to make a complaint;
- required local authorities to appoint a complaints manager; and
- retained Review Panels, but with a more precise and focused brief on constituting and running them.

## The role of the Healthcare Commission and CSCI

2.12 The Health and Social Care (Community Health and Standards) Act 2003 made provision for similar health and social care complaints procedures at the independent stage. The Healthcare Commission took responsibility for the independent review stage in July 2004, but this responsibility was not extended to CSCI for adult social care. Similarly, Ofsted has no direct role in children's social care.

## Patient Advice and Liaison Services (PALS)

2.13 PALS were set up in the NHS in 2002 and their core function is to provide confidential advice and support to patients, their families and carers and to resolve problems and concerns quickly. They also monitor trends and gaps in services and report these to the trust management for action, acting as an early warning system for NHS trusts, foundation trusts and PCTs. PALS liaise with staff, managers and other relevant organisations, to negotiate speedy solutions and to bring about changes to the way that services are delivered. However, not every trust is committed to providing a PALS function.

## Independent Complaints Advocacy Service (ICAS)

2.14 Section 12 of the Health and Social Care Act 2001 places a duty on the Secretary of State for Health to make arrangements to provide Independent Complaints Advocacy Services to assist individuals making complaints against the NHS.

2.15 ICAS was established to support patients and the public wishing to make a complaint about their NHS care or treatment. This statutory, national service was launched on 1 September 2003 and is delivered to agreed quality standards. It is patient-centred, delivering support ranging from provision of self-help information, through to the assignment of a dedicated advocate to assist individuals with letter writing, form filling and attendance at meetings. ICAS aims to ensure complainants have access to the support they need to articulate their concerns and navigate the complaints system, maximising the chances of their complaints being resolved quickly and effectively

# 3. Problems with the current complaints processes

## Difficulties experienced by complainants

3.1 Recent research commissioned by the Department of Health in 2005 suggests that the processes in both health and social care are not easy to understand. People have difficulty in identifying the options available and understanding what each organisation can and cannot do at each stage of the process. People also want the opportunity to resolve a concern locally and, if there is a need to take it further, to know how to make a formal complaint.

3.2 The Department of Health's Individual Voices for Improvement (IVI) project commissioned an academic literature review of existing research. IVI also initiated a qualitative research study to explore the views of service users and professionals on complaints and feedback systems in health and social care. The research explored:

- people's understanding of the current complaints and feedback systems;
- how satisfied they are with these systems;
- the barriers that prevent people from providing feedback on health and social care services, and
- people's thoughts on a single arrangement for handling complaints about health and social care services.

3.3 In summary, the qualitative research found that in health care:

- the nature of patients' relationships with the NHS meant that an experience has to be either very good or very bad to prompt formal criticism or praise;
- there was ignorance about the complaints process;
- assumptions were often made about what the process may be like – for example, lengthy and bureaucratic;
- some people felt awkward at the prospect of complaining direct to their GP practice and were concerned that raising a problem could have serious consequences for their ongoing relationship with their GP;
- the perceived size and bureaucracy of the hospital structure made the system feel impenetrable, and once an experience was over the temptation was for people to forget it and move on;

3.4 In social care, the research found that:

- service users tended to feel they have a relationship with individual professionals rather than a service, and as a result many saw 'no point' in making a complaint;

- some felt they would not be treated fairly if they complained;
- many did not know who to complain to or felt uncomfortable complaining directly to their carer or social worker, and most doubted whether anything would change as a result;
- there is more uncertainty about who to complain to and this is made worse by the involvement of contractors.

3.5 More generally, the research also identified that:

- many health professionals welcomed the idea of a single feedback system because they thought there would be significant benefits to patients and service users and that it would be helpful in the case of a complaint overlapping health and social care, when patients and service users are often unsure who to complain to;
- members of the public have little awareness of the current three-stage complaints procedure for health services and are often surprised that the NHS has a system like this in place;
- there was strong approval for giving people the opportunity to resolve a problem informally without lodging a complaint, if this was their preferred route;
- members of the public appeared to have little awareness of the Patient Advice and Liaison Service (PALS), although they liked the idea of the service when it was described to them, but many thought that if more people knew about PALS, it would encourage more people to lodge complaints.

3.6 Within social care:

- understanding of the complaints system varies considerably – some know the procedure very well while others know little about it;
- staff who work directly for social services tend to have a better grasp of the system than those employed by contractors;
- the range and number of providers of services across social care is itself a problem when it comes to taking forward a complaint.

## Findings from *'Making things better?'*

3.7 In the 2005 report *Making things better? A report on reform of the NHS complaints procedure in England*, the Health Service Ombudsman highlighted the five key weaknesses in the current approach to complaints handling in health and social care:

- complaints systems are fragmented within the NHS, between the NHS and private health care systems, and between health and social care;

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

3.8 In a joint letter to the Department of Health in October 2006, the Health Service Ombudsman and the Local Government Ombudsman welcomed the commitment in *Our health, our care, our say* to the development of an integrated health and social care complaints arrangements. They believed that it would represent a significant step towards the delivery of a patient and user led complaints system.

## Poor performance in complaints handling

3.10 The majority of NHS complaints are resolved at local level, and among the cases referred for independent review, the Healthcare Commission has seen some very good practice in the way that complaints are handled [*Spotlight on Complaints;* Healthcare Commission; 2006]. However, it receives approximately 8,000 requests for independent review each year, and in 33% of these cases it has found that the health care provider could have done more to resolve the complaint. In its opinion relatively straightforward measures would often have resolved these complaints and, in 85% of cases, referring back to the provider for further action appeared to have been successful in resolving the complaint.

3.11 Complainants have mostly sought a better explanation of the care they have received or of a decision taken by the health care provider.

3.12 Frequent problems seen in the way complaints have been handled at a local level include:

- failure to acknowledge that a complaint is valid;
- failure to apologise, even where local shortcomings are identified;
- responses which do not explain what steps have been taken to prevent the recurrence of an event, which has given rise to a complaint;
- responses which contain technical or medical terms, which the complainant may not understand; and
- failure to involve staff directly concerned in the complaint in the local investigation.

3.13 The Healthcare Commission would like chief executives of NHS organisations to confirm that there is no further action that can be taken at a local level to respond to a complaint. It also considers that it is important that there is leadership at an appropriate

level to handle complaints in NHS organisations and that these complaints' leads make sure that complaints are seen as avenues for learning and service improvement.

3.14 Common and recurring themes in complaints must be tackled at every point so there is also a role for leaders of local clinical teams to review complaints and identify ways to improve care.

3.15 There must therefore also be appropriate leadership in complaints handling within social care. The relationship between users and the social care system is complex and service users tend to feel that they have a relationship with individual professionals rather than with 'the service'. Uncertainty about who to complain to was greater in social care than in health; the involvement of a range of providers and contractors complicated the picture.

## Fragmentation and complexity

3.16 Most people see the NHS as essentially one organisation delivering one-off or ongoing packages of health care. The underpinning principle is that an NHS patient is an NHS patient, regardless of where they are treated.

3.17 However, over time the complaints procedures have become increasingly fragmented and complex. This follows the changing pattern in service delivery of both NHS care and social care. Both types of service are increasingly being delivered in a wide range of settings, by a wide range of providers. Local authorities and health organisations are often not the direct provider of services as they are reliant on private, voluntary and third sector bodies who deliver services on their behalf (e.g. where endoscopic services are secured by private providers in an NHS setting by the NHS, or private home care services for people in their own homes).

3.18 The current complaints procedures have evolved from a time when the NHS and local authorities directly provided services.

3.19 Social care complaints regulations apply to all local authorities and include both their directly provided services and those that are delivered on their behalf.

3.20 The current NHS complaints regulations apply only to designated NHS organisations – strategic health authorities, NHS trusts operating from premises wholly or mainly in England, primary care trusts, and special health authorities to which section 2 of the Health Service Commissioners Act 2003 apply.

3.21 Even within NHS complaints regulations, the local resolution aspects do not apply to foundation trusts. As an increasing number of trusts achieve foundation trust status, fewer NHS providers will fall within the scope of the regulations.

3.22 NHS foundation trusts are subject to the independent review stage carried out by the Healthcare Commission but only in relation to complaints by or on behalf of patients – it does not, for example, deal with complaints about financial probity. The Healthcare Commission has agreed a protocol with the independent regulator of NHS foundation trusts (known as Monitor) about the circumstances in which it will refer a complaint to the regulator. Foundation trusts come within the jurisdiction of the Health Service Ombudsman.

3.24 Independent providers of NHS services are under an obligation to have in place NHS complaints arrangements as if the regulations applied, but the obligation is contractual rather than being on the same legislative basis as NHS trusts.

3.25 Complaints arrangements in primary health care are also contractual. The overall framework for complaints handling is the same as in secondary care (local resolution, Healthcare Commission, Ombudsman), but there are differences in emphasis and detail. For example, although both the GP contract and the 2006 NHS complaints regulations provide for a 'duty to cooperate', the duty on NHS trusts covers only cooperation with the local authority, whereas the GP duty goes wider and includes cooperation with other NHS providers, commissioners and local authorities. Details also differ in primary care between medical, dental, ophthalmic and pharmaceutical.

3.26 The differences between health and social care vary, not only in the procedures to be followed but also in the circumstances in which a complaint may be made. In modern day care, there are increasing numbers of cases crossing the boundaries between types of health care provision and between health and social care. It is important that any system is effective and efficient across all these boundaries and that it is simple for patients and social care users to understand and to navigate. Where the boundary is between health and social care, many of those affected will be elderly, frail or suffering from long-term conditions. The current mechanisms are unnecessarily complex.

3.27 With regard to social care, the Local Government Ombudsman has previously identified recommendations that reflect similar complexity. Local Government recommendations have included making monitoring of contracts more rigorous; and improved links between care managers and agencies.

## The role of the Healthcare Commission

3.28 The Healthcare Commission has encountered high numbers of requests for independent review with up to one third of requests made inappropriately as trusts have not made every effort to complete a successful local resolution. It is arguable that providing an independent stage through a separate organisation has worked against effective resolution of complaints at local level because NHS organisations are aware that the Healthcare Commission will undertake the work. This approach also duplicates the investigation function, with the Healthcare Commission tending to carry out its own

# 4. Drivers for Change

## Standards for Better Health

4.1 *Standards for Better Health* [Department of Health; 2004] signalled a shift in the way improvements in people's health and care are planned and delivered, moving away from a system mainly driven by national targets to one in which:

- standards are the main driver for continuous improvements in quality;
- there are fewer national targets;
- there is greater scope for addressing local priorities;
- incentives are in place to support this system; and
- all organisations locally play their part in service modernisation.

4.2 *Standards for Better Health* puts quality at the forefront of the agenda for the NHS and for private and voluntary sector providers of NHS care. The standards describe the level of quality that health care organisations, including NHS foundation trusts, and private and voluntary providers of NHS care are expected to meet in terms of safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health. A key aim of these standards is to underpin the delivery of high quality services that are fair, personal and responsive to patients' needs and wishes, which are provided equitably and which deliver improvements in the health and wellbeing of the population.

4.3 The Health and Social Care (Community Health and Standards) Act 2003 established the Healthcare Commission and set out its functions. These include undertaking an annual review of the provision of health care by (and for) each NHS body in England, including foundation trusts. In undertaking its reviews, the Commission focuses on achievement against the developmental standards, although it also needs to be satisfied that all trusts are meeting the core standards. The outcome of the Healthcare Commission's review enables the public to identify progress against the standards by individual organisations.

4.4 NHS Standards for Better Health core standard (C14) requires health care organisations to have systems in place to ensure that patients, their relatives, and carers:

- have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;
- are not discriminated against when complaints are made; and
- are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

4.5 Currently, the standard does not explicitly set out the quality standard expected to be met by organisations providing health or social care, or provide a driver for local improvement in complaints handling.

## Shipman, Ayling, Neale and Kerr/Haslam Inquiries

4.6 The Shipman Inquiry's fifth report, 'Safeguarding patients: lessons from the past, proposals for the future', was published in December 2004. It is the last of three reports that between them seek to answer the questions, how was it possible for Harold Shipman to continue to murder patients for so many years without detection and what needs to be done to protect patients in the future? The report looks more generally at the arrangements for safeguarding patients from incompetent or aberrant performance by health professionals. Amongst other issues, it reviews the handling of complaints from patients and expressions of concern from fellow professionals.

4.7 Three other inquiries have also recently published their findings, the inquiries into the cases of Clifford Ayling, Richard Neale, and William Kerr and Michael Haslam. Although each of these has its particular features, there is a common thread running through all four inquiries: the failure of those in positions of authority in the NHS or in the regulators to detect signs of unacceptable or incompetent professional behaviour and to take effective and timely action to protect patients.

4.8 The Department of Health has considered the common aspects of all four sets of recommendations together. We agree that complaints and concerns must play an important role as an integral part of an effective structure of clinical governance. Complaints from patients and concerns from fellow professionals may be the first signals drawing attention to deficient care or abuse of patients. Those handling complaints must strike a careful balance – seeking to resolve the complaint, as far as possible, to the satisfaction of the complainant, but also being alert to the possible wider implications for patient safety.

4.9 The Shipman Inquiry's terms of reference were limited to primary care. We accept that there may be particular issues over the handling of complaints in primary care, where complaints staff may be working in greater isolation than their colleagues in secondary care. An effective complaints system needs to be easy for patients to understand and to navigate, to be fully integrated across primary and secondary care, and across the boundary between health and social care. We therefore believe that many of the principles behind the recommendations in the Inquiry's fifth report should be extended to secondary and social care. We believe it is important to:

- support people who want to make complaints or raise concerns, so that they know where to go and can be assured that their story will be listened to and acted upon, and

- ensure that health care organisations have the procedures and skills to act effectively on what they hear.

4.10 In *Safeguarding Patients*, the Government proposes to:

- introduce a right for patients with a complaint against a GP to go directly to the PCT rather than to the GP practice;
- consider a parallel arrangement for patients with a complaint against a local hospital
- agree a concordat between organisations likely to receive complaints to make sure that they are speedily routed to the most appropriate body;
- develop good practice on the need to keep complainants informed about the process which will be adopted to investigate the complaint, and about the subsequent progress of the investigation – and we now believe complainants should be 'involved' rather than just 'informed';
- make sure the new arrangements are widely disseminated;
- place a responsibility on PCTs to maintain an overview of complaints against GPs, including where necessary taking over the investigation of complaints even where they were lodged with the practice in the first instance;
- work with the NHS to build capacity and skills in practices, PCTs and hospital trusts to investigate serious allegations, including collaboration between PCTs where this would help to concentrate skills and experience;
- develop more robust arrangements for the performance management of complaints handling in health care organisations.

4.11 In social care, we propose to build on the 2006 reforms to:

- make sure there is consistency across local authorities;
- make sure there are highly skilled, motivated and supported staff;
- make sure there is performance management for complaints handling;
- make sure there is oversight of complaints handling by regulators;
- provide guidance on the complaints procedure; and
- develop the way organisations learn from complaints.

## NHS Redress Act 2006

4.12 The proposed NHS Redress Scheme, which covers lower financial value clinical negligence cases, will help local organisations respond better to their patients as it makes provision for investigation, explanation and, where appropriate, apologies in each case.

Those receiving redress under the redress scheme will also ordinarily be entitled to receive a report of the investigation and a summary of action being taken to prevent similar mistakes occurring in future.

4.13 The NHS Redress Act 2006 provides for a more consistent and open response to patients when things go wrong with their NHS hospital care, placing the emphasis on putting things right for them. It also provides the impetus for wider service improvement.

4.14 The approach offers the complainant an honest, timely and open response from the organisation concerned if something does go wrong. It gives them a say in how things are put right, and a say in how their care is delivered. Complainants will be assured that the organisation will learn from their experience and that it will try to make sure that other patients have a better outcome because of what has happened to them. The framework behind the scheme will help local organisations to deliver this improved response to their patients and users. Staff will be encouraged to speak out and to provide open explanations and, where appropriate an apology. The focus given by the NHS Redress Scheme will help make sure organisations provide a more consistent approach to NHS patients.

## Regulatory Reform (Collaboration etc between Ombudsmen) Order 2007

4.15 The Government and the Ombudsmen are to modernise the Ombudsman system to enable the Ombudsmen to provide a more accessible, flexible and responsive complaints handling service to the users of public services as an integral component of improving public service delivery. The policy aim of the Order, which comes into effect in June 2007, is to increase the scope for collaborative working amongst the three Ombudsmen (Parliamentary Ombudsman, the Health Service Ombudsman and the Local Government Ombudsman).

4.16 In particular, the Order allows the Ombudsmen to:

- undertake joint investigations of complaints (consult with each other, share information and produce joint reports);
- delegate functions to each other's staff if required for the purpose of a joint investigation;
- appoint and pay a mediator or other appropriate person to assist in relation to any complaint they are investigating; and
- (in the case of the Local Government Ombudsman) investigate a complaint that had not previously been notified to the authority concerned where the Local Government Ombudsman is convinced that no benefit would be achieved in requiring that the case first be considered by the authority.

## E.748/05

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

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

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

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

# 5. Proposals

## Underlying principles

5.1 The fundamental aim of a complaints process is to:

- respond promptly to complaints;
- inspire user confidence;
- facilitate effective handling at local level to the user's satisfaction,
- encourage organisational learning to prevent similar occurrences in future; and
- provide a unified approach across all providers – from public, private, voluntary and charitable sectors – to the handling of peoples' complaints.

5.2 *NHS Complaints Reform – Making Things Right* [2003] described the vision of a new complaints procedure:

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

5.3 Unfortunately, and as described earlier, the revised NHS complaints process has not delivered this vision.

5.4 As care services become increasingly community-based, with a greater plurality of providers, it is important to make sure there is a more integrated approach that crosses boundaries, in particular those between primary and secondary care and, more generally, between health and social care. This will provide people with a responsive and less obstructive procedure, and facilitate cross-organisational learning. People can understandably become frustrated when they have to deal with two separate organisations (for example, an NHS trust and a local authority) when they are seeking a resolution to a complaint, particularly if there is little or no cooperation between those organisations.

5.5 Early resolution of a complaint is important, but should not be the only factor considered. Less prescription around timescales would allow organisations to assess and deal appropriately with all complaints, allowing for proper consideration of learning and service development issues. There may be instances where a provider chooses to investigate a case even though the complaint has been resolved to a persons'

satisfaction as it considers an investigation may be helpful to identify ways to improve service delivery.

5.6 By increasing the role of the complainant in the complaints procedure, providers will become more responsive to their needs and preferences. Appropriate links to clinical governance and risk management processes will assist in delivering better quality care. Involving complainants throughout the local process will help to make sure their views are taken into account and make the system more responsive. It will also make sure the investigation of a complaint is robust and proportionate and that the findings are justified by the evidence.

5.7 We see this as a vast improvement on the current system, where complainants are effectively presented with a decision and invited to challenge it. This type of adversarial approach is outdated and works against the organisation's ability to learn from the complaint. It is in a provider's best interests to work with people who use its services in order to identify where and how services might be improved.

5.8 The complaints framework would therefore become:

- Local resolution
- Ombudsman

## Links to service improvement

5.9 We believe the principles enshrined in the NHS Redress Act 2006 are equally applicable to the effective handling of complaints:

- if something does go wrong with a patient's care there should be an honest and open response from the organisation concerned, as soon as possible;
- people should have a say in how the case is handled and how things are to be put right; and
- people should be reassured that the organisation will learn from their experience and that other patients will have a better outcome.

5.10 To support this process at local level, we believe the role of complaints manager should be accorded greater authority than is the case currently. In line with the Redress Act principles, we would see a minimum skillset established for complaints managers in both social care and health. As now organisations would continue to be able to contract in these people and, where more practical, have one complaints manager responsible to a number of providers.

5.11 It is also important that all staff who have direct contact with people who use services or their relatives are appropriately trained in how to respond to someone who wishes to

raise a complaint and that they are fully aware of the organisation's procedure for handling complaints.

5.12 Providers of health and social care will investigate when a complaint is received, with a view to putting things right for that individual and learning from their experience to improve the quality and safety of future care. The focus of the new complaints framework will help to ensure organisations provide a more consistent approach.

5.13 Overall, the aim is to create a cultural shift within the NHS and social care, with the emphasis towards preventing harm, reducing risks and learning from complaints. The new framework will require the thorough and proper investigation of incidents. This will provide not only benefits for people using services, but help to protect against the possibility of unjust criticism of health and social care professionals.

5.14 The new complaints process will deliver a better and more responsive service to all users. It will give a focus to how social care and health providers respond in the future to people who are unhappy with their care and it will support organisations in their drive to improve the quality and safety of services.

## Meeting these aims

5.15 In terms of the overall framework, we see the development of health and social care complaints handling standards as playing an important role. This development would make explicit the quality expected to be met by organisations providing health or social care, and may be seen as providing a driver for the local improvement necessary to take forward the reform agenda effectively. Providers of health and social care services would then be accountable, not only to their commissioning bodies (in terms of performance management), but also to the Regulatory Body as part of its inspection programme. The specific areas to be covered by the standards would be:

- accessibility;
- integration;
- resources; and
- governance and management.

5.16 The Department of Health, the Health Service and Local Government Ombudsmen, the Commission for Social Care Inspection and the Healthcare Commission agree that it is difficult to articulate a single core standard for complaints handling. Nonetheless, organisations should be able to demonstrate that complaints handling forms part of a wider strategic approach to user care. We agree that the current standards need to be developed, with the new approach being:

- simple, integrated and consistent across organisations and agencies;

- supported by accountable, local management structures;
- based on an understanding of the needs of users and staff;
- staffed by well trained people; and
- genuinely intended to deliver specific and systemic changes.

5.17 In some organisations, this approach represents a significant shift in the underlying culture not only of complaints handling but also of performance management. The underlying principles will not be rigidly laid down in statute. Provider organisations will be judged on outcomes, and the judgement will rest with both commissioning bodies and the regulatory bodies.

5.18 To be meaningful, the approach has to apply to all providers of NHS health care and publicly funded social care.

5.19 By involving the complainant throughout the consideration of their complaints, there should be a flexible approach to each individual case. Complex cases, particularly those crossing various boundaries of care, may take significantly longer to resolve than cases that are more straightforward or relate to only a single issue of complaint. We wish to see complaints staff discussing individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation.

5.20 We propose that the core standards for complaints handling will provide a requirement for individual cases to be dealt with efficiently and effectively. Additionally, for performance management purposes, we may also lay down overall targets in terms of percentages of cases, based on advice from the regulators and the Ombudsmen, expected to be cleared within certain timescales.

## Handling of cases

5.21 The current regulatory frameworks place too much focus on process. They are too complex and inflexible, with every complaint having to go through the same stages and processes, regardless of complainants' wishes or needs or the nature and implications of the complaint.

5.22 To encourage more effective handling at local level, we believe the new framework should encourage appropriate, initial handling at local level. It should focus on facilitating quality outcomes in terms of patient satisfaction and learning. Overall, this might best be seen as a matrix model, rather than the current linear model. Rather than just focus on resolution to the complainant's satisfaction, local organisations will be expected to also consider clinical governance, risk management, service improvement and, if appropriate,

internal disciplinary action. The new framework will open up the options for handling each case, with decisions taken locally in discussion with users.

## Complaints to commissioning organisations

5.24 In line with the recommendation in the Shipman Inquiry (Fifth Report), we accept that complainants should have the choice as to whether they make a complaint to the provider *or* directly to the commissioning body. There will be instances, perhaps most noticeably in NHS primary care, where a user will feel uncomfortable about complaining to the organisation providing the service. They may feel that a complaint will harm the future standard of care they receive. It is important that fear does not discourage people from making a complaint. An effective system must make sure there is no disincentive for people to complain as there may be wider issues around patient safety. While the new system will retain the emphasis on local resolution (indeed, it will strengthen it), we consider it is essential that everything possible is done to make sure that people are not deterred from lodging a complaint.

5.25 Where a complaint is made to the commissioning organisation, it will be for that body to determine how best to handle it. In some instances, it may be recorded and passed to the provider to handle the complaint. In others, the commissioning organisation may wish to take over the handling of the complaint. In making this decision, we expect the commissioning organisation to take into account a number of factors, for example: complainants' wishes, their vulnerability and any safety issues.

## Department of Health action

5.26 The Department of Health has started what might be seen as a process to introduce a more proficient approach to the complaints process through the development of the Voices for Improvement Action Network (VIAN) – a developing, facilitated network for NHS and social care complaints staff. VIAN groups fulfil two objectives. Firstly, they bring together health and social care colleagues locally and nationally in a unique manner. Secondly, VIAN will explore the groundwork that is essential to deliver the new arrangements in 2009.

5.27 We also intend to work to improve management of, and leadership for, those working on complaints at a local level.

## Making sure complaints are not lost within the system

5.28 A fundamental concern for all involved with the handling of health and social care complaints is to make sure that no concern or complaint gets lost. This is a particular worry in health where the system has a wide range of providers and regulatory bodies, and there is often confusion as to the role of each body. In the past, complaints have

been made to the wrong person or the wrong organisation and subsequently been lost by not being redirected.

5.29 We are proposing a concordat between the different NHS and local government bodies involved in a complaint, which sets out the aims, objectives and principles behind effective collaborative working. The concordat would establish the requirements and expectations of effective joint working, particularly how disputes between agencies will be resolved.

5.30 There will also be clear governance arrangements across the different agencies. The responsibilities and accountabilities about service provision and complaints handling need to be made clear, with decision-making arrangements being open and transparent.

5.31 Included within this will be commitment from each organisation to make sure that any misdirected concerns that are raised with it are correctly redirected, subject to the complainant's permission.

## Support for more vulnerable users

5.32 The principle of providing advice and advocacy to people making complaints is essential. In particular, vulnerable people find these services of vital importance when making their complaints. A significant proportion of people who use NHS and social care services are vulnerable. The Shipman, Ayling, Neale and Kerr/Haslam inquiries have shown that individuals working within health and social care can endanger peoples' lives. When they do not receive the services they are entitlement to expect we must make sure their concerns are heard and acted upon. We see PALS and ICAS as integral and essential components of effective complaints handling although, currently, their remit is limited to health issues. To this end, we are exploring the possibility of either developing parallel services in social care, or extending the availability of PALS and ICAS to local authority complainants.

5.33 In social care, complaints handling by local authorities must be child and young person friendly, and appropriate to the age and understanding of the person. If a child or young person wishes to make a complaint, local authorities are required to provide him with information about advocacy services and offer help to obtain an advocate. We believe this is a sound principle that could be extended to other vulnerable people, for example, adults with learning disabilities. A strengthened policy around advocacy and advice will help to protect the more vulnerable people who use services, assist the speed at which an organisation can respond to a complaint and make sure that the organisation learns from their experiences.

# Appendix 1: Consultation Criteria

This consultation follows the revised Cabinet Office code of practice which is available from the Cabinet Office website at http://www.cabinetoffice.gov.uk/regulation/consultation/code/index.asp. This requires government departments to:

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of policy

2. Be clear about what proposals are, who may be affected, what questions are being asked and the timescale for responses.

3. Ensure that consultations are clear, concise and widely accessible.

4. Give feedback regarding the responses received and how the consultation process influenced the policy.

5. Monitor their effectiveness at consultation, including through the use of a designated consultation co-ordinator.

6. Ensure consultations follow better regulation best practice, including carrying out a regulatory Impact Assessment if appropriate.

The Code also invites respondents to "comment on the extent to which the criteria have been adhered to and to suggest ways of further improving the consultation process". For DH consultation, comments or complaints (but not your response to this consultation) should be sent to:

Consultations Coordinator
Department of Health
Skipton House
80 London Road
London SE1 6LD

Email: (mb-dh-consultations-coordinator@dh.gsi.gov.uk)

**Please do not send consultation responses to this address**

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in the majority of circumstances; this will mean that your personal data will not be disclosed to third parties.

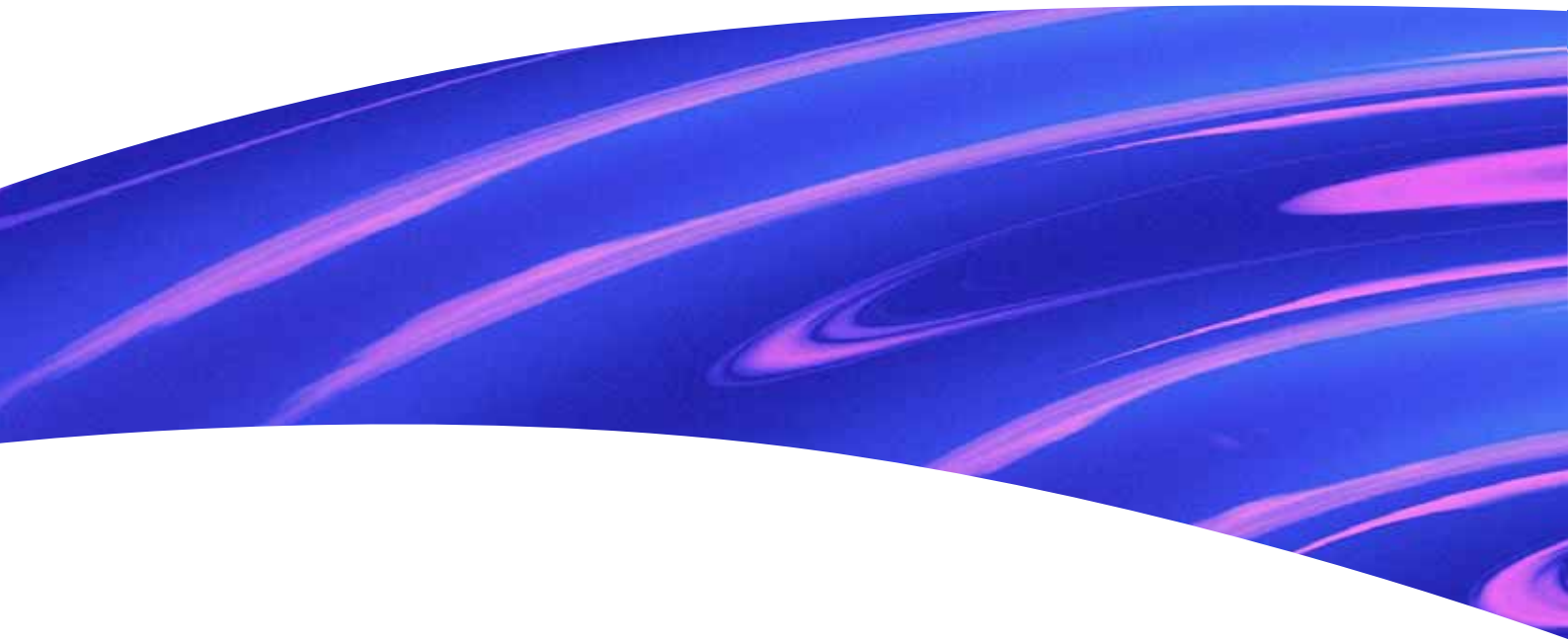
## Where to send your response to the consultation

Completed responses and comments should be sent by Wednesday 17th October either by email to:

makingexperiencescount@dh.gsi.gov.uk

or by post to:

Individual Voices for Improvement
Room 5E43
Department of Health
Quarry House
Quarry Hill,
Leeds,
West Yorkshire
LS2 7UE




281506 1P June 07
www.dh.gov.uk/publications