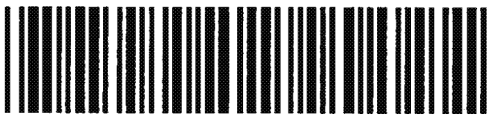
PATCH 2



Being heard

The report of a review committee on NHS complaints procedures

May 1994

The Government has invited comments on the proposals for new NHS complaints procedures contained in this document.

Please make your views known in writing to:

ENGLAND

Ms Elizabeth Connell
NHS Executive
Department of Health
Room GN35C
Quarry House
Quarry Hill
Leeds
LS2 7UE

SCOTLAND

Mrs Diane Thomson
NHS in Scotland
Management Executive
Room 51
St. Andrews House
Edinburgh
EH1 3DG

NORTHERN IRELAND

Mr Allan Gault
HP55 Management Executive
Room 116A
Dundonald House
Upper Newtownards Road
Belfast
BT4 3SF

WALES

Mr R.C. Williams
Welsh Office Health Department
Cathays Park
Cardiff
CF1 2NQ

Being heard

The report of a review committee on NHS complaints procedures

May 1994

CONTENTS

I. INTRODUCTION

Professor Alan Wilson (Committee Chairman)
Vice Chancellor, University of Leeds

1 Complaining is one of several ways in which patients, their families, friends, and carers, make their views known to the NHS. People generally have considerable trust in the services the NHS provides. They expect – and usually receive – care of the highest quality, and they offer gratitude and praise freely as a result. When they believe there is something wrong, it is by no means easy for them to raise their concerns. They are not in a powerful position and may feel vulnerable. The response they get when they make a complaint is a fundamental test of the NHS as a public service. The Citizen's Charter has emphasised that such effective complaints' handling is a key aspect of high quality public services.

2 However excellent the efforts of those who provide services directly, and of those who manage them, continue to be, there will always be causes for dissatisfaction in an area as complex as health care and in an organisation as large as the NHS. It is not feasible – or even desirable – to aim for complaint-free services.

3 The negative associations of complaints – that they happen when something has gone wrong and result in blame for practitioners and staff – must be overcome. More praise for good complaints handling and less blame for things going wrong could help in this respect. Individual practitioners and members of staff complained against can themselves feel vulnerable or isolated if complaints are badly handled.

4 Responding to complaints well is a positive act. It involves being heard and making good: responding to the dissatisfaction of complainants, and, where necessary, putting right what was wrong. The way in which the NHS responds to complaints is already changing. In many places, those responsible for complaints procedures, and those operating them, are responding to complaints in an exemplary way.

5 Our[1] responsibility was to review NHS complaints procedures to ensure that there are systems which are effective from the points of view of both users and providers of NHS services. The Secretary of State for Health gave us the following terms of reference:

> To review the procedures for the making and handling of complaints by NHS patients and their families in the United Kingdom, and the costs and benefits of alternatives to current procedures, and to make recommendations to the Secretary of State for Health and other Health Ministers.

There are particular aspects of these terms of reference which we have noted.

6 Firstly, it was clear that procedures for complaints by NHS patients – wherever they are treated – were the subject of our review. This therefore included all patients whether receiving NHS care from family health services, in hospital, or in the community. It also included patients who receive NHS care from the independent sector, whether private or voluntary. Our recommendations would not, however, be directly concerned with private patients.

[1] The membership of the Review Committee is listed at Annex A.

7 Secondly, our terms of reference excluded consideration of civil litigation and of professional regulation in themselves. Nevertheless, we have considered the important relationships between complaints systems and these areas (see Sections II.2 and II.3 respectively).

8 Thirdly, our review encompassed the whole of the United Kingdom. We have therefore sought to make sure that we had information ourselves about different procedures in England, Scotland, Wales, and Northern Ireland; that we had the benefit of the knowledge and experience of those operating or affected by these procedures; and that our recommendations might be considered for application in each of the countries concerned.

9 In arriving at our analysis and recommendations, we have met nine times to consider various aspects of NHS complaints procedures. In doing so, we have had the benefit of some 250 pieces of written evidence from the organisations and individuals who are listed in Annex B. We have referenced our report with respect to relevant points made in both evidence to us, and where we have used published sources. The keys to these references are at Annex C for our evidence and Annex D for other material.

10 In view of the relatively short time given to us by the Secretary of State for Health to complete our task, we decided not to take oral evidence in formal sessions. However, members of the Committee and of the Secretariat met a number of individuals and organisations to discuss ideas. We are enormously grateful for this help with our task. We would like to give particular thanks to Alan Bedford, Derek Day, Professor Liam Donaldson, Margaret Goose, Ken Jarrold, and Keith Pilcher who all made comments on earlier versions of this report. The Committee, of course, accepts full responsibility for this final version.

II. CURRENT SITUATION

II.1 NHS COMPLAINTS PROCEDURES

II.1.1 Introduction

11 Although the Patient's Charters for England, Scotland, Wales, and Northern Ireland include the right to have any complaint about NHS services – whoever provides them – investigated and to receive a full and prompt written reply, the essential elements of existing NHS complaints procedures were all designed before the health service reforms were introduced by *Working for Patients* [271]. Some remain largely unchanged since they were introduced decades ago.

12 This Chapter briefly describes current NHS complaints procedures, including the independent role of the Health Service Ombudsman and the Commissioner for Complaints in Northern Ireland. A more detailed account is provided in Annex E, which also describes differences in procedures in England, Scotland, Wales, and Northern Ireland. Relevant national statistics are provided in tables and graphs at Annex F. The interface with litigation and professional regulation is described in Sections II.2 and II.3 respectively.

13 In the NHS a general distinction is currently drawn between written and oral complaints. In most cases, an oral complaint will only be considered under formal complaints procedures if the patient remains dissatisfied or the matter is put in writing. Written complaints are handled in accordance with national and local guidance and receive a written response.

II.1.2 Family health service procedures

14 People's most frequent contact with the NHS is with GPs, dentists, pharmacists, and opticians, who provide services which are defined under contractual arrangements with a health authority or health board[2].

15 Complaints may be handled through informal mechanisms, which in England and Wales may involve a lay conciliator appointed by the family health services authority. A recent study suggested that on average 60% of complaints received about family health services are considered through such mechanisms in England [268]. Encouragement has also been given to the development of practice-based procedures, which are working well in some areas, although they are generally developing more slowly than envisaged [268].

16 People need to make their complaints known to the health authority or health board which has made contractual arrangements with the practitioner concerned, if they wish to take matters further (see Figure 1). If the complaint relates to the practitioner's terms of service, the health authority or health board must refer it as a formal complaint to a service committee, which the health authority or board operates according to detailed statutory regulations.

[2]Our use of 'health authority', 'health board', and other terms, is defined in Annex G.

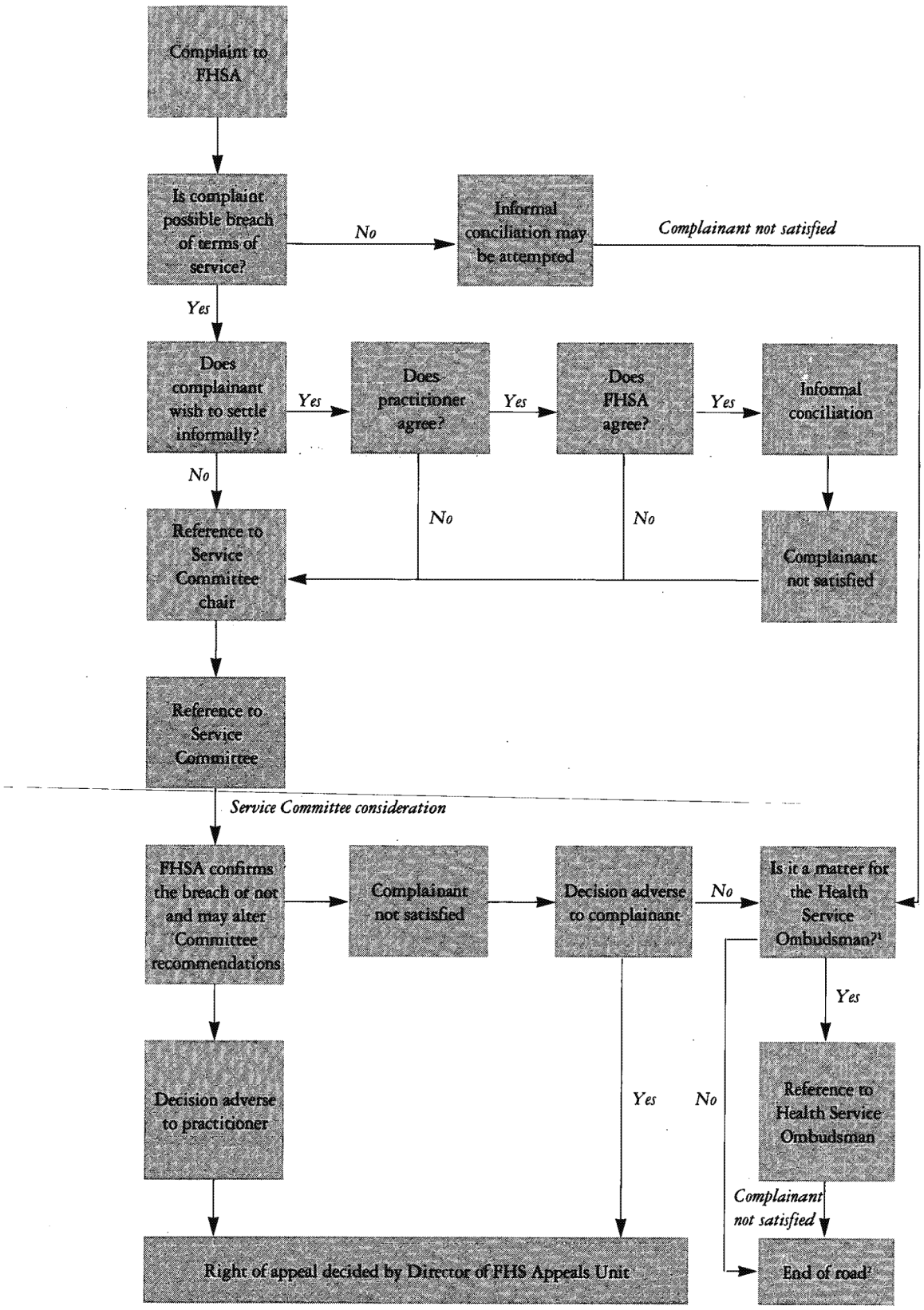


Figure 1: Family Health Service procedures

[1]Note the restrictions in the Health Service Commissioner's jurisdiction (ref. II.1.5).
[2]The only further options open may be to approach the relevant professional organisation and/or take legal advice.

17 Service committees have a lay chair and both lay and professional members. The committee may be known as a medical, dental, pharmaceutical, ophthalmic, or joint, service committee according to the profession(s) involved. Written evidence is provided to the service committee by both complainant and respondent. The service committee can hold a formal oral hearing at which both complainant and respondent make statements and are questioned. The committee considers whether the practitioner has breached the terms of service of his or her contractual arrangements, and makes recommendations – which may include withholding amounts from his or her income – to the authority or health board. The authority or health board decides whether the terms of service were breached and may accept or alter the service committee's recommendations.

18 Appeal may be made against the authority or health board's decision by the party to whom the decision was adverse to the relevant Secretary of State. In England, the Secretary of State has delegated this function to the Yorkshire Regional Health Authority who carry it out via the Family Health Services Appeal Unit; in Northern Ireland, the right of appeal is to the Department of Health and Social Services.

19 As they provide the bulk of family health services, general medical practitioners (GPs) receive the most complaints. A study of criticisms expressed in 1,000 such formal complaints about GPs [267] showed that they concerned such issues as:

failure to visit	25%
failure to diagnose	20%
error in prescription	8%
failure to arrange emergency admission	6%
delay in diagnosis	5%
failure to examine	5%
delay in visiting	5%
unsatisfactory attitude	5%
failure to refer for investigation/opinion	5%
poor administration	5%
other	11%

II.1.3 Hospital and community unit procedures

20 How complaints about hospital services are considered depends upon whether the clinical judgement of a doctor – or hospital dentist – is involved (see Figure 2). If they are about a non-clinical matter, formal complaints are investigated by a designated manager, and a written response is normally sent by the Chief Executive.

21 If the complaint concerns matters of clinical judgement, there is a three stage procedure agreed between the Health Departments and the professions (see Figure 3). In the first stage, the consultant in charge of the patient looks into the clinical aspects and tries to resolve the complaint, and may meet the patient to discuss the matter. In the second, the complaint would be referred to the Regional Director of Public Health in England or a similar figure elsewhere in the UK. If the complainant is not satisfied, and the Director of Public Health thinks it appropriate, the third stage may be used, which entails an independent professional review (IPR) by two "second opinions". These independent assessors make a confidential report to the Regional Director of Public Health on which the response to the complainant is based.

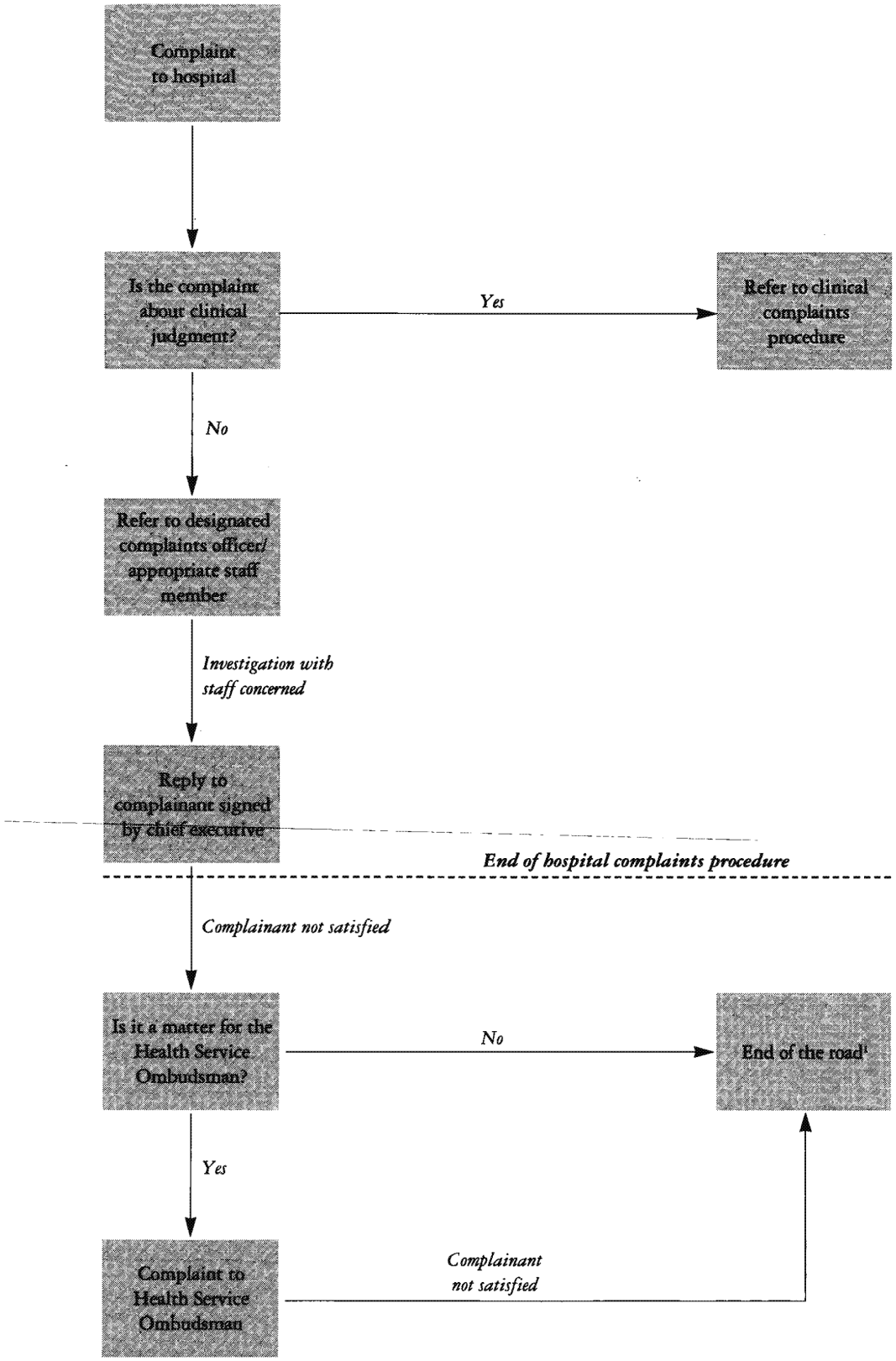


Figure 2: Outline of hospital complaints procedure

[1] The only further options open may be to approach the relevant professional organisation and/or to take legal advice

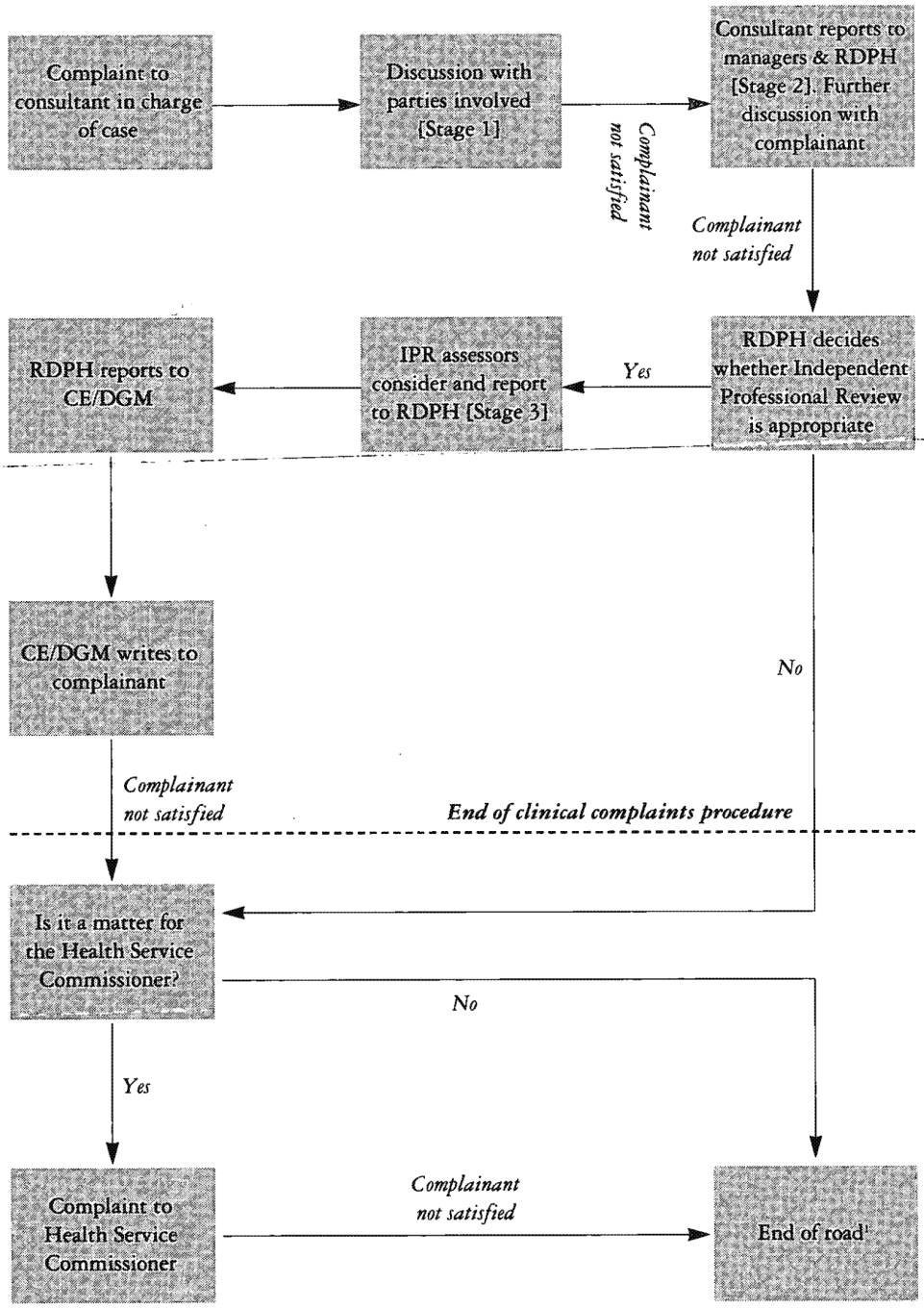


Figure 3: Outline of clinical complaints procedure

[1]The only further options open may be to approach the General Medical Council and/or to take legal advice.

22 Lloyd-Bostock and Mulcahy in a study of hospital complaints (clinical and non-clinical) [265] showed that they focus on issues relating to:

medical care	29%
communication, behaviour, and attitude	22%
hotel services	22%
access to treatment	19%
management policy and political issues	4%

23 Community trusts and units are instructed by the Health Departments to follow similar procedures to those in hospitals.

24 The Mental Health Act Commission and its equivalents can investigate complaints from detained patients who are dissatisfied with the response they have received from the manager of a hospital or mental nursing home.

11.1.4 Other complaints mechanisms

25 Ambulance services have their own local procedures, which are often based on those for hospital services.

26 Since the introduction of the NHS reforms, purchasers – health authorities and health boards, and fundholding GPs – have played a key role in acting as agents for their local population. The only centrally laid down procedure for responses to complaints about purchasing relates to appeals against a decision by a district health authority to refuse to fund treatment as an extra-contractual referral (ie for care which is not otherwise covered by the health authority's contracts with service providers), which must be considered by the district Director of Public Health.

27 Many written complaints about individual care, NHS policies and resource allocation, are sent to Government Ministers – either directly or via MPs – and to the Health Departments.

28 In recent years, separate complaints procedures have been introduced for community care and child protection. Since these procedures apply to services purchased or commissioned by local authorities, rather than by the NHS, they fall outside our terms of reference (although we believe that it would be helpful if they were re-examined in the light of our recommendations for NHS procedures).

11.1.5 The Health Service Ombudsman

29 The Health Service Ombudsman for England, Scotland, and Wales – formally known as the Health Service Commissioner – is appointed by the Crown and is responsible to Parliament. He is therefore independent of the NHS and of government. He can investigate complaints of alleged failures in a service provided by an NHS authority or action taken by, or on behalf of, one.

30 There are some important restrictions on the Ombudsman's jurisdiction. The Ombudsman cannot deal with complaints which, in his opinion, solely concern matters of clinical judgement (although he can investigate the administration of the hospital clinical complaints procedure), or complaints about family practitioner services. He can investigate other administrative actions of family health service authorities and health boards but he cannot examine their administration of the formal service committee procedures. The Ombudsman will not normally investigate any complaint that has been the subject of litigation or which is likely to be pursued through the courts.

31 In Northern Ireland, the Commissioner for Complaints combines in one office the roles of the Health Service Ombudsman and Parliamentary Commissioner for Administration.

11.1.6 Support for complainants and complaint respondents

32 Some help is available to people who may want to make a complaint. Hospitals and health authorities or health boards must make written information available about their complaints procedures. Health councils[3] provide an independent NHS source of information, advice, and sometimes advocacy, in relation to complaints. Annex H provides a fuller account of their important role. Patient representative officers in hospitals may provide more extensive support. Throughout the UK, the Health Information Services give information about how to complain on the freephone line 0800 66 55 44.

33 For complaint respondents, help is normally available from line management, representative committees, professional organisations and trade unions.

11.2 LITIGATION

34 Litigation is sometimes seen by NHS practitioners and staff as a possible threat behind the existing complaints procedures [138]. Although the rise in the rate of medical litigation has been seen as a reflection on the adequacy of NHS complaints procedures [220], there is evidence to suggest that the vast majority of cases of litigation in hospitals do not start out as complaints [265].

35 Whether many complaints develop into litigation or not, there is some evidence that fear of litigation can hamper handling of complaints. NHS complaints procedures require staff to make sure that litigation is not compromised by initial investigations, and to seek advice where litigation seems a likely development. Although the Health Departments have discouraged the practice, some hospitals have attempted to persuade complainants to waive their legal rights before a complaint will be investigated [135]. Ironically, such waivers have no legal status.

36 Fear of litigation should certainly not arise for the majority of complaints. These may cover such matters as attitude, hotel services, and so on, which the court system is not normally concerned with, although these matters may be mentioned in the course of litigation.

[3] That is Community Health Councils in England and Wales; Local Health Councils in Scotland; and Health and Social Services Councils in Northern Ireland.

37 Some complainants use the complaints procedures to find out information which might form the basis of a civil claim, if evidence of negligence comes to light. The Welsh Medical Officers for Complaints, who are the independent officers appointed to handle the clinical complaints procedure in Wales, believe that as many as 50% of the complainants they saw had consulted a solicitor. They believe that some solicitors now advise clients to use the complaints systems to obtain information with a view to subsequent litigation. Others take this view [135], including the Joint Consultants Committee [91]:

> Although no figures are published by RHAs on how many cases there have been of litigation following independent professional review, there is certainly an increasing perception among the assessors that their efforts have been part of a "fishing expedition".

38 We feel it is important to acknowledge the moral principle here: where complainants suffer compensatable harm as a result of NHS treatment, the NHS should not try to avoid its responsibilities towards them or to withhold information [135]. Indeed, there is anecdotal evidence to suggest that a defensive response to complaints of this nature is more likely to prompt recourse to litigation than to prevent it [71,135,167,172,210,239].

39 There are cases – sometimes the most serious [167] – in which compensation is offered to a potential litigant as an out-of-court settlement. NHS complaints procedures in themselves normally only offer compensation in limited circumstances which relate to the cost of treatment or remedial treatment in dentistry.

40 Litigation through civil action is only realistically available to those who have legal aid or significant disposable income [115], although greater use of contingency fees may enable some to use the courts who would not otherwise have done so. Recent changes have reduced the number of people who are eligible for legal aid and have therefore increased the number of people who will otherwise be required to make at least a contribution to the cost of their legal action [161].

41 In the vast majority of cases, a well-structured complaints system has considerable advantages for both sides over the use of litigation [161,175], particularly in terms of ease of access, informality, speed, and costs. The option of seeking compensation through the courts will remain to those willing and able to choose it, but, as the Association for Victims of Medical Accidents stated in their evidence to us [210]:

> it is essential that any new complaints procedure should be able to investigate the complaint fully without being concerned as to whether issues of negligence are involved.

II.3 DISCIPLINARY PROCEDURES AND PROFESSIONAL REGULATION

42 The NHS has procedures through which practitioners and staff may be disciplined in relation to their contractual arrangements. For family health services, these come together with complaints procedure through consideration of terms of service issues by service committees. In hospitals, there are separate disciplinary procedures which are initiated by hospital management.

43 The various professional regulatory bodies – such as the General Medical Council, the General Dental Council, and the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting – deal with complaints about their members, but only in so far as they reveal matters of professional concern such as serious misconduct. The jurisdiction of these bodies is designed for the purpose of professional self-regulation, and so to protect patients, but not to provide specific redress or explanation [7].

44 Both family health service authorities and the Family Health Services Appeal Unit in England have responsibilities for referring appropriate cases to professional regulatory bodies.

II.4 CONCLUDING COMMENTS

45 Complaints by NHS patients may be considered under a large number of different procedures (we have identified nine in this Chapter). In Chapter IV we analyse these procedures, and how they are operated, but we first consider what NHS complaints procedures should aim to do.

III. OBJECTIVES

III.1 INTRODUCTION

46 The objectives or goals both of patients in making complaints, and of the NHS in responding to them, must be identified in order to consider whether and how NHS complaints procedures might be improved. While following the complaints procedure may not necessarily satisfy the objectives of either party, the objectives are more likely to be met if procedures are designed positively to encourage resolution.

III.2. OBJECTIVES OF COMPLAINANTS

47 Complainants have a variety of objectives in making their grievances known. These objectives need to be at least partially met if the complainant is to be satisfied with the response he or she receives.

48 Who are complainants? Studies show that, compared to the users of the NHS generally, complainants are more likely to be female than male, and under rather than over 45. The reasons for this have not been explored in detail, but it seems likely that younger women are more likely to take a general responsibility for the health of their families (both younger and older relatives), and that a greater sense of entitlement and greater confidence makes younger people more willing to complain. As many as half of those making a complaint [265] may be acting on behalf of someone else, usually a relative.

49 It is rare for a complainant to be motivated by prejudice or malice [7]. There are some complainants who show signs of severe mental disorder [7], and there are those whose complaints are made out of feelings of grief [7] or guilt [135]. This does not mean that their complaints are unjustified, but it can mean that it may not be possible for action under complaints procedures to satisfy them [7]. The proportion of complaints which follows bereavement is high [262].

III.2.1 Acknowledgement

50 Complainants want to be taken seriously. They want their views – and the fact that they had reason to complain [15] – to be acknowledged [52,69] and for the individual or organisation (whether practice, trust, or the NHS generally) they hold responsible to be prepared to take action [30,175].

51 People expressing dissatisfaction sometimes do not intend to make "a complaint" although practitioners or staff interpret their comments in this way. Their intention may have been to suggest how things could be improved, and a response which assumes a grievance exists can provoke further concern.

III.2.2 Apology

52 A simple apology can be a very important objective for complainants [35,52,69,72, 79,98,128,147,166,217,220,237,239,247]. If an apology is not provided, or is delayed, the complainant is less likely to be satisfied:

> all too often a failure or unwillingness to say "sorry" at an early stage is the reason for complaints proceeding further through the system than is really necessary or appropriate [166].

53 Apologies can be given without an admission of blame or liability in relation to the substance of the complaint. At the same time, apologies should not be used simply to brush complainants off:

> An apology, however gracious, without answers or follow-up action and information, is not going to be sufficient response to the most serious complaints, and can too easily be used as an attempt to get everyone off the hook [167].

III.2.3 Explanation

54 Complainants usually also want information [12,72,79]: an explanation [4,15,91,115, 147,156,166,217,236,237,247] of what happened [7,210,239] and why [210,220]. This explanation must be in language which the patient can understand.

55 If an explanation attempts to deny the complainant's experience of events, it is unlikely to be accepted. Explanations can also degenerate into a form of making excuses.

III.2.4 Report on action

56 Complainants often ask for something to be done to prevent the same thing happening again [12,37,48,52,72,91,116,137]. This is frequently expressed altruistically in terms of others not having the same problems [15,135,166,167,190,233], for example:

> Neither myself or my husband wanted money as no money could ever change the events, however, we did want the hospital to admit they had made a mistake and a reassurance that they had reviewed their procedures to ensure that this did not happen again to anyone else as I would not wish anyone to experience a similar nightmare [149].

The other side of the coin is that dissatisfied people may not complain if they feel nothing will happen as a result.

57 Many complainants say that getting a commitment to action is their main objective. They are much more likely to be satisfied if information is given about specific measures which have been, or will be, taken [15,210].

III.2.5 Redress and compensation

58 Complainants can also want action to take place which has a more direct bearing on the care provided to them, or to the patient about whose care they are complaining. This may include redress [7], such as faster or additional treatment, or financial compensation [12,196], particularly in cases such as dentistry where charges may have been incurred.

59 Complainants, even in cases relating to clinical judgement, do not often have financial compensation as a primary goal [1,72,137,175]. It is also apparent [72,161] that some who take legal action to obtain compensation do so because other goals are not being met.

60 The situation can be different where a charge has been made for a service (eg in relation to dental treatment [268]), other expenditure has been incurred (eg parking charges), or there has been a loss of personal effects.

III.2.6 Punishment

61 Complainants do not usually want retribution [137,210,237], but in some cases, they can want steps taken against individual practitioners and members of staff for what they have done, or against managers where they feel mistakes have been covered up [166]. The motive may be a desire to have justice [167,175], to help tackle the cause of the complaint [167,210], or for professionals to be seen to be accountable [15,115,220].

III.2.7 Voicing the complaint

62 Finally, a complaint may – at least partially – be an end in itself. This is sometimes overlooked, but the expression of a complaint can provide an outlet for feelings of dissatisfaction, frustration, anger, or grief [12,135].

III.3 NHS OBJECTIVES

63 The NHS considers complaints procedures in two ways: firstly, in responding to complainants; and secondly, as the employer or contractor of individual practitioners and staff about whom complaints may be made.

64 From these perspectives, the NHS has several distinct and important objectives: complainant satisfaction; quality enhancement; fairness to practitioners and staff; and avoidance of unnecessary litigation.

III.3.1 Complainant satisfaction

65 The NHS needs effective complaints procedures so that complainants can be given a response to their complaints [99] which aims to satisfy them [190]. This may seem obvious, but it has important consequences for how the Service seeks to meet complainants' objectives.

66 Put at its most basic level, the Service has an interest in satisfying complaints to avoid protracted correspondence and unnecessary litigation (see III.3.4 below). While this can encourage standard apologetic responses, these may not meet other objectives of the complainants or of the NHS itself.

67 By providing effective responses to complaints, service providers – both individuals and organisations – can also maintain and enhance their reputation, a factor of increasing importance following the NHS reforms. The damage done to the reputation of providers by not responding adequately to complainants has been demonstrated in other service sectors, as have the positive views generated by good complaints handling [8]. Satisfying a complainant can also enable the relationship between patient and practitioner to be restored.

III.3.2 Quality enhancement

68 Complaints can be used positively to improve services [12,43,56,99,142,145,162,190, 237,249]. The contribution that complaints can make in this way is now part of the conventional wisdom of quality management within the NHS and elsewhere (see Chapter V). Complaints can help identify or confirm individual or system problems. For example, they can reveal a need for training in communications skills. Complaints can play a part in purchasers' monitoring of the performance of provider units [145].

III.3.3 Fairness to practitioners and staff

69 The NHS must have complaints procedures which practitioners and staff believe to be fair [162,210]. This is particularly so as the work undertaken by NHS practitioners and staff involves the care of ill health where outcomes are uncertain. Procedures should allow the views of both sides to be expressed. Otherwise the approach to complaints handling by practitioners and staff may become negative and defensive.

70 We discuss further in Chapter VII the necessary links between complaints and disciplinary procedures, but we simply note here that fairness requires a balance between treating practitioners and staff appropriately and maintaining proper accountability for their actions.

III.3.4 Avoidance of unnecessary litigation

71 Complaints procedures have sometimes been presented as an alternative to, or way of avoiding, civil litigation [231]. This motivation has affected how the procedures themselves have developed and how complaints are handled under them.

72 One effect of this has been a reluctance, particularly by doctors, to provide any statement which might be taken as an admission of liability [41,196]. Although an apology need not be such an admission, this has sometimes meant apologies have been delayed or denied to complainants. In fact, the policies of the medical defence organisations now encourage apologies to be made [137,170].

IV. ANALYSIS OF EXISTING PROCEDURES

IV.1 INTRODUCTION

73 Current NHS complaints procedures were the subject of considerable critical comment in the period leading up to our review. In *Complaints do matter* [2], the National Association of Health Authorities and Trusts summed up the views of many, both inside and outside the NHS:

> The arrangements are seen as being over complex, failing to be user-friendly, taking too long, often over defensive and often failing to give any satisfactory explanation of the conclusion reached.

The following analysis considers current procedures in the light of such published reports [such as 1-4] and of the extensive evidence submitted to us.

74 We have taken particular note where our evidence suggested that there are features of existing national procedures which should be kept or developed, or where providers have produced effective arrangements of their own within these procedures. Individual members of staff currently make a very positive contribution within the existing framework:

> there are many examples of good work being done...this is more likely to be because of the excellence of staff, and courage of the complainant...than qualities inherent in the system [37].

We have also had to consider whether it is the operation of the procedures, rather than the systems themselves, which is faulty [47,195].

IV.2 GENERAL

75 Complainants can face an uphill struggle when using NHS complaints procedures: firstly, in making their views known; and secondly, in receiving the sort of response they would wish for [58,105].

76 A recent survey for the Scottish Management Executive suggests that the accessibility of NHS complaints procedures is poor: only one in three of those who had felt the need to complain had done so, while only one in four NHS users knew who to complain to. A more recent National Consumer Council survey [241] has confirmed this lack of knowledge, with only one person in three knowing where to complain. Some of the evidence we have received also makes reference to this difficulty [86,246].

77 Part of the reason for not knowing where to complain is the bewildering array of procedures in existence. At least nine different procedures are described in Chapter II of this report. If someone decides to make his or her views known, it can be difficult to know where to start. There are simply too many different procedures and players – primary care, formal, informal, hospital, clinical, Health Service Ombudsman, General Medical Council, and so on [1,128,162]. A single complaint may need to be pursued in a variety of ways and the nature of the response provided will depend upon the procedure under which the complaint is considered. Each distinct procedure will not address grievances that may have been expressed about care received from other parts of the NHS [85,214].

78 The Scottish survey referred to above also showed that people may be deterred from complaining even if they know how to do so. They believed that complaining would not make a difference or they did not want to cause trouble. However, complaining might make a difference to their own or others' future treatment [154,178,237,243]. The National Consumer Council has also pointed to other psychological barriers to complaining: gratitude; powerlessness; medical language; the erosion of a sense of entitlement; lack of information on procedures, standards, and outcomes [241]. The Audit Commission has described further barriers:

> Patients who have difficulty expressing themselves on paper; who cannot write or cannot write English are disadvantaged in most complaints systems [99].

79 If successful in making a complaint, the chances of obtaining a satisfactory response can appear to be poor. Despite evidence of some good practice, NHS procedures often seem to be ineffective in meeting complainants' objectives. In the Scottish survey, only one of those who complained was satisfied with the response they received. Professor Donaldson's study of the hospital clinical complaints procedure [260] showed that only half of those whose complaint progresses to the third stage of the clinical complaints procedure were satisfied with the outcome (although this proportion has also been interpreted as a measure of the procedure's success by the Joint Consultants Committee [91]).

80 Furthermore, the processes through which their complaint is handled can appear to *increase* the dissatisfaction of NHS complainants [209]. Adversarial systems may find fault and allocate blame without resolving problems [241]. Procedures can seem confusing and complex [154,239], or impersonal and unhelpful [116].

81 The handling of complaints can itself be the cause of further complaint. The Health Service Ombudsman has received an increasing number of complaints about the actual handling of an original complaint. His latest Annual Report observes:

> The way in which an authority handles a complaint is of vital importance. Poor handling is at the very least irritating. At worst it can destroy the credibility of a reply with the result that the complainant is not prepared to accept anything that is said [261].

Some of the evidence submitted to us from individuals based on their own personal experience has demonstrated the frustration and anger that can be generated by poor, or even hostile, initial responses [57,61,63,69,106]. Delays in dealing with complaints [31,54,61,69,109,227,247] and the absence of deadlines can also cause dissatisfaction [14].

82 In the evidence given to us by NHS and other bodies who are party to the complaints procedure, the expressions of dissatisfaction with current procedures are legion eg:

> professionals and management within the NHS find the present arrangements confusing and unsatisfactory [185]
>
> It is our view that NHS complaints procedures...are no longer adequate or appropriate...to resolve the majority of complaints about medical services [137].

83 There are some dissenting voices. Elements in current systems have their supporters: for example, the Joint Consultants Committee [91] believes the clinical complaints procedure in hospital can be used to meet patients' concerns. Some fears have been expressed that the Patient's Charters, by increasing consumer awareness, may have encouraged frivolous as well as genuine complaints, and time-wasting correspondence [215].

84 However, the overall verdict of the Scottish Consumer Council [190] is more typical:

> the current system neither resolves patients' problems to their satisfaction, nor produces information for management.

IV.3 FAMILY HEALTH SERVICE PROCEDURES

IV.3.1 Informal procedures

85 Some feel that the existing informal conciliation procedures work well [125]. Others have expressed more critical views. While informal meetings may be helpful for some complainants, this does not apply to all [37,227]. Informal meetings may not satisfy the complainant [86]. They can be seen simply as a way of smoothing over problems and closing the case, with no proper investigation [175] or formal written record [227]. This can be seen as an effort to divert the complainant away from a formal hearing [167,214], which might lead to disciplinary action or referral to the General Medical Council [167].

86 Too many complaints may be dealt with under the formal procedure without first having gone through informal conciliation [42,44,103,211]. Although the use of the informal procedure varies substantially [167,268], the use of conciliation is sometimes seen as not sufficiently flexible [141]: encouragement is not given to informal exploration of complaints by GPs, or for them to resolve the issues without fear of disciplinary action [46]. Inadequate time (48 hours in one example given to us [70]) can be given to doctors to agree to the use of the informal procedure. While some feel that practitioners should not be able to block the use of informal procedures for conciliation [185], clearly their co-operation is required. Equally, others consider that the decision on whether a complaint is dismissed or investigated under informal or formal procedures should not be left to a health authority officer [70] simply on the basis of a complainant's statement [171].

IV.3.2 Formal procedures

87 The existing formal complaints procedure in relation to family health services has been heavily criticised in our evidence and elsewhere. The criticism comes from all quarters: the Medical Defence Union says that:

> Complainants appear to find the procedure lengthy, cumbersome and over-regulated, and understandably they cannot relate the substance of their complaint to the narrower considerations of the terms of service imposed by the regulations. [137];

while Action for Victims of Medical Accidents states:

> [it] is almost universally accepted that insofar as General Practitioners are concerned, the confusion of breach of terms of service with the complaint of the patient is unacceptable and unworkable [210];

finally, in the words of the Health Service Ombudsman, the procedure is:

> an amalgam of terms of service and complaints procedures, resulting in confusion and misunderstanding, and promotion of an adversarial approach [47].

The system is seen neither to address nor to satisfy the needs of patients [64,69,82,186,214] nor to deal adequately with perceived shortcomings in service [64,227].

88 To patients and their representatives the system can seem biased towards the respondent [3,37,62,102,135,161,175,187,218] and lacking any appeal to an independent authority [17,167] such as the Health Service Ombudsman [47,175]. Patients face the possibility of being struck off their practitioner's list without explanation as a result of making a complaint [47,157,232], which is a particular dilemma for patients in rural areas [232]. On occasion, the whole of an extended family may be removed in this way [37]. Doctors can even refuse to acknowledge a complaint [187].

89 Practitioners also consider that they can be treated unfairly [170] and that the process is threatening [51,170] and stressful [4,46,51]. Health authority and health council staff are sometimes alleged to behave irresponsibly without fear of retribution [94]. Practitioners can feel that employing authorities are led by complainants into dealing inappropriately with issues raised [45,46] and that minor breaches of service are taken to full formal hearings [95].

90 Health authorities and health boards find the formal procedure difficult to administer [196]. The procedure is seen by them, and by others, to be complex [124,171,196]; bureaucratic [64,166,187]; cumbersome [137,196]; and having in-built delays [171]. Investigations are considered to be costly [215]. There is varying local interpretation of the complex regulations, with no source of consistent national advice [124]. The powers of health authorities and service committees are limited in certain respects [64,171,220].

91 The main obstacle to the procedure being of use to the public is that it is essentially a disciplinary mechanism [37]. Only complaints about issues defined in the practitioner's contractual arrangements are addressed by the procedures [47,86,113,117,185, 214,236,238]. These issues do not normally take account of poor manner or attitude [37,139,167,238]. Not surprisingly, the distinction is poorly understood by the public [64].

92 As operated, the procedure is too lengthy both for complainants and practitioners [4,23,39,42,51,54,46,70,137,161,187,236], with inadequate explanation of delays [17]. It is time consuming to administer [64,141], so that many health authorities are unable to meet the time targets set under the Patient's Charter [129,140,208,83,268]. Although they are not imposed on health authority staff [137], the targets may be counter-productive in putting pressure on the parties involved [208], are difficult to interpret [83], and are not known by complainants [141].

93 The slowness of the procedure can also delay a complainant pursuing other avenues of complaint, such as the General Medical Council [187], and can hinder the Council in its investigations [7].

94 The 13 week time limit for making a complaint is seen as restrictive [37,86,139,187,227,236], and can pass without the complainant ever having been aware of it [167]. An example was given to us of a GP's failure to act on a symptom during pregnancy which may have resulted in problems with the birth, the mother not making the link between the two events until much later [227]. Such concerns are exacerbated by: the doctor's ability to veto consideration outside these limits [214] or request an extension for their reply [167]; the requirement for the complainant to account for every day of the delay [124]; and the lack of time limits for those administering the system [17,82].

95 The formal oral hearing and its lay element can be valued [214], but hearings can be run like a court, with complainant and respondent on separate "sides", which can be unnecessarily adversarial [46,135,161,171,186,211], intimidating [82,86,171,205,247], or 'cold' [246] and therefore discouraging satisfactory resolution [137]. The onus is on complainants to show that there is a case to be answered [102,113,185,214,246], which may make them appear vindictive and make practitioners appear victims of persecution [175]. Many service committee members do not receive adequate training [124]. Professional members of the panels practise in the same area as the respondent, and may not be seen to be impartial [175,220].

96 There is an imbalance in the representation at hearings available to complainant and respondent [135,161,185]: the GP's "friend" is often a representative of a medical defence organisation [236] or someone else who is expert in the complaints procedures, whereas patients may have no support at all or be supported by health council staff who may be inexperienced [17,97,139,214,244] and generally lack medical knowledge [167]. The Council on Tribunals has expressed concern at the exclusion of paid lawyers [214]. However, others consider that legal representation would only be available to those on very high or low incomes and should therefore not be permitted [81]. There is an imbalance in the provision for a medical but not a lay observer [167,214]. Hearings may be taped by those servicing the committee, but the complainant and respondent have no right to a copy [17]. Recording the proceedings can be denied to complainants [167].

97 It is not felt that the procedures satisfactorily cover locums [7]; deputising doctors [7,83,171]; doctors in private practice [7]; or doctors who resign before NHS procedures can be completed [7]. In particular, it can seem discouraging [141,167] or even "bizarre" [227] that complaints about treatment by deputising doctors or locums must be directed against the employing GP. There is confusion over complaints about services provided by GP Fundholders [124].

98 Information for patients about the procedures themselves [14,246], how they are conducted, and the basis on which decisions are taken, may be lacking [3,82]. Health authorities may not ensure access to records for complainants [22,139]. Information they provide to practitioners [23] and patients [167] can be misunderstood.

99 For dental complaints, current time limits do not take account of how long it may take for certain problems to come to light (such as those arising from complex restorations) [189].

100 Ophthalmic service committees meet very infrequently and are said to lack knowledge of the relevant regulations [180]. Greater impartiality could be achieved by having only one professional member where optometric complaints were considered [173].

101 It was argued in some submissions that the service committee procedure is in itself satisfactory, but should be used as an end point [44]. It can involve the whole authority in facing up to quality issues [140], although some consider monitoring to be poor [3].

IV.3.3 Appeals

102 Appeals lead to further delays [17,135,141,153,208,215,224] and are not subject to any time limits for completion. It seems contrary to natural justice that the Appeal Unit can decide cases without an oral hearing [215] or lay member [167]. There is no requirement to indicate why a Service Committee's findings have been overturned [39]. The result of an upheld appeal may be out of proportion with the substance of the complaint itself [39].

IV.4 HOSPITAL AND COMMUNITY UNIT PROCEDURES

IV.4.1 Standard procedure

103 In relation to hospital and community unit procedures, we have received evidence from several trusts describing how they have been able to operate their own systems successfully within existing procedures [9,107,234,251,253,254].

104 There are some reservations about the extent to which the hospital system offers independent investigation [99,179,210,236]: staff investigating complaints, even when not responsible for the service complained against, are employees of the organisation against which the complaint is made [186], and the thoroughness of the investigation depends on their co-operation [236]. Some feel the Chief Executive is likely to be biased [213].

105 Views are expressed that complainants prefer the formal, if adversarial, family health service procedure over that for hospital complaints [153,210]. The hospital system is too complicated [239] or adversarial [75], with patients unsure of who to complain to [179]. Publicity may be poor: an Audit Commission study found 45% of wards visited did not have any posted or written information about the system [256]. Responses from hospitals may not answer questions, but offer alternative descriptions of the patient's experience [227]. There is no visible disciplinary procedure for complaints against managers to be pursued [167,227]. Investigation of the complaint may be discontinued where the police have decided to pursue a criminal investigation [236]. Oral complaints are not usually recorded [179].

IV.4.2 Clinical complaints procedure

106 The majority of criticisms made of the hospital procedure concern the separate procedure for clinical complaints. The procedure pre-dates and does not take account of the recent NHS reforms [185]. The existence of a separate system in itself is confusing [239] and does not encourage access [127,239]. There is no clear cut distinction between a clinical complaint and a general one about treatment [161,184,190]: many complaints are a mixture of clinical and non-clinical issues [135,239].

107 It can seem to complainants that little or no investigation takes place, and that the process is an exercise in damage limitation [135,159]. The doctor's own notes may be used as the major evidence [37] with an assumption that the records describe all relevant events adequately [13], despite evidence that they cannot necessarily be relied upon [227]. The complainant has no opportunity to investigate or interrogate [13]. Information may be presented selectively, or even be incorrect [13]. The response may be defensive, evasive, and partial [13]. Too much power may also be seen to lie with the complainant [135], who may wish to take things as far as possible [18].

108 Complainants can face a long drawn-out process [135,147,179,227], particularly before an Independent Professional Review can take place [91], sometimes "several years" [147]. There is a lack of time limits [236]. The procedure does not include any specific mechanism for reference to the General Medical Council or General Dental Council in appropriate cases [7,167,227]. Clinical judgement may be made by GPs [236] or by other professions, such as nurses, who are excluded from the procedure [47,185,236].

109 At Stage 1 of the procedure, an initial informal meeting can be intimidating or be viewed by the complainant as a waste of time [227]. There is no compulsion on the individual complained against to be present: while this may be welcomed by the complainant, it can be a cause for anger [227]. If hospitals do not supply the names of those who care for patients, complainants are unable to raise the matter with the professional regulatory bodies [227]. The status of the staff involved may also be important in judging the seriousness of the complaint [227].

110 Decisions taken at the second stage are discretionary [167,236,239], and it does not include a non-medical element [239]. Its purpose is not always clear [135,184], and it can be seen to be slow, secret, and not truly independent [239]. Assessors frequently comment to the Joint Consultants Committee that had Stages 1 and 2 been properly and rapidly addressed, the complaint need have gone no further [91,159].

111 At the Independent Professional Review in stage 3, the nature of the procedure makes delays seem inevitable [91,177,227]. Complainants may be kept poorly informed about progress [177]. Trusts are increasingly reluctant to release consultants to participate [91,135], seeing the procedures as cumbersome, and of doubtful efficiency [138].

112 The review may not be seen as impartial [135,177] or truly independent [161]. The second opinions are chosen without reference to the complainant [37,167,236] or any other interested party [37]. There is no lay representation [161,167,220,227], contributing to 'understandable suspicion of "doctors sticking together"' in the words of one doctor [147]. There is also no non-medical input, even where, as in the case of maternity services, a component of care provided may have been from another profession [227].

113 As Professor Donaldson's study [260] showed, professional peers are more likely to uphold grievances concerning failure in communication than errors of clinical judgement [227]. Neither the complainant [135,177,227,236], nor the trust, necessarily sees the assessors' report. Meetings may be used as a substitute for a written response [167]. Complainants are often not satisfied with the outcome [105,135,184]. AIMS goes so far as not recommending the use of the procedure [227].

IV.5 THE HEALTH SERVICE OMBUDSMAN

114 The Health Service Ombudsman is generally praised very highly for being independent and thorough, although some concern has been expressed about the length of time his investigations take [126,161]. The normal time limit of twelve months for making complaints is considered restrictive by some [104,167,236]. Rare allegations are made that the Ombudsman is biased [132] or that his Office is "paternalistic" [15]. Concern is occasionally expressed about a lack of appeal against his judgements [132].

115 More are concerned about the limitations on the Commissioner's jurisdiction [126,161,221,236,239], particularly in relation to complaints about clinical judgement [186,220,227,236] when clinical and non-clinical issues may both be involved [140,227]. These restrictions have recently been considered in an inquiry by the Select Committee on the Parliamentary Commissioner for Administration [270], which has oversight over the work of the Ombudsman. We discuss the Committee's conclusions later.

V. COMPARISONS WITH OTHER ORGANISATIONS AND COUNTRIES

V.1 INTRODUCTION

116 To enable us to take into account what was considered to be good practice in other organisations, we commissioned Peter Gibson Associates to carry out a short review of complaints handling systems in both the public and private sectors and have used their analysis [263] in sections V.2 and V.3. The organisations contacted in respect of this review are listed at Annex I.

117 We also obtained information from the Department of Health's International Relations Unit and elsewhere concerning health service complaints procedures in some countries as a further point of comparison. This information is provided in Section V.4.

V.2 DIFFERENCES BETWEEN THE UK PRIVATE AND PUBLIC SECTORS

118 Over the past decade, the perceived importance of customer service and such concepts as total quality management have grown in both the private and the public sectors. The emphasis on effective complaint handling has increased as part of that wider development, as has the understanding that well handled complaints bring benefits to the organisation in addition to the individual.

119 The two main aims of complaint handling seem to be broadly shared, namely:

(a) to satisfy those who complain, turning them from being potentially dissatisfied into satisfied customers or service users;

(b) to generate management information about aspects of the organisation's service or products which cause customers problems, to enable these problems to be addressed and levels of customer service improved.

120 There are, however, some differences. The main difference between the public and the private sector examples studied lies in the amount of investment that the private sector has put into information technology, in the form of sophisticated Automated Call Distribution (ACD) telephone systems, computer networks and customer contact software, into staff training and into customer research. Companies report increased volume of work, lower staffing levels, improved customer service and customer retention, and increased profits as the benefits.

121 Public sector organisations, while generally sharing a commitment to deal satisfactorily with a complaint at the first point of contact thereby maximising customer satisfaction and minimising cost, tend to stress and publicise a formal escalation procedure, with various stages of appeal up to an ombudsman or tribunal. This no doubt reflects the public sector's commitment to fairness and adherence to published rules. Actual usage of the later stages of complaints procedures is in practice very low. Escalation is also generally available in the private sector, but it is rarely emphasised.

122 Private sector companies, on the other hand, tend to stress the importance of customer retention as a third major aim in complaint handling. Since it is cheaper to keep old customers than to win new ones, customer retention strategies can contribute significantly to company profits. Increasingly, however, parts of the public sector are open to competition, and with the advent of trusts and other consequences of recent reforms, the NHS is no exception. Increasing competition in the health sector and managerial initiatives have resulted in much greater emphasis being placed on the quality of services delivered and the satisfaction of users of those services.

V.3 LESSONS FROM THE PUBLIC AND PRIVATE SECTORS

123 The lessons on complaint handling that can be learned by the NHS from other public sector organisations and from the private sector are summarised here. However, it should be borne in mind that the NHS is different from other public and private sector organisations both in its structure and in the services it provides. The prime concern of the NHS has to be the well being of patients. In most cases those patients, unlike customers in the private sector, do not have any choice as to who provides their health care needs. Therefore the lessons below may need some adaptation in application, to take account of the differences between the NHS and other sectors.

V.3.1 Satisfying complainants

Lesson 1

124 It is necessary to carry out research to find out how many customers or service users have problems with a service, whether they complain or not, and how they would like their complaint to be handled. Too many organisations handle complaints on the basis of what their managers think their customers want, or on the basis of what other services' customers want. As TARP Europe, the European arm of a US consultancy with wide experience in complaints systems, states in one of its working papers on the aspects of service important to customers:

> A number of key dimensions are counter-intuitive, therefore, management cannot and should not rely on its own intuition to select them. Moreover, the important dimensions vary by type of transaction. In short, these cannot be generalised.

However, research has shown in a number of industries that it is possible to generalise about how customers want complaints to be handled.

125 Avis Europe, British Airways, British Gas, British Telecom, Nissan, Polaroid UK, and Shell UK all carried out research on customers' expectations of service, including expectations of complaint handling. Surveys of recent contacts, including those which involved complaints, revealed how levels of satisfaction were affected by the time and the number of contacts taken to close a complaint.

Lesson 2

126 Complainants do want:

(a) an apology, even if the company/organisation was not at fault; British Airways have shown that customer satisfaction increases when an apology is offered to a complainant and that this can be done without the company accepting responsibility for the cause of the complaint;

(b) a speedy response (though precise speeds are service specific) – customer satisfaction has been found to be linked with speed of resolution of complaints;

(c) reassurance that the company is taking the matter seriously, to prevent recurrence.

Lesson 3

127 Complainants do not want to be told:

(d) that the rules were followed, so the organisation was right all along;

(e) that they made a mistake, so it is their own fault;

(f) detailed explanations of why a problem arose which come across like an excuse for poor services.

Lesson 4

128 It is wrong to assume that complainants always want problems to be investigated thoroughly. Sometimes they do, but often they do not. Research can give guidance on the types of issues that customers in a service are likely to wish to see investigated. There may be complex matters to be investigated, but if this is handled inappropriately, complainants may be dissatisfied with the way their complaints have been handled rather than with the original problem. According to OFTEL, many of the complaints that it used to receive about British Telecom concerned British Telecom's complaint handling rather than the original problem. These escalated complaints have now dropped by 40% or 50%.

Lesson 5

129 Those receiving complaints from customers must have contracts, or "service level agreements", with other departments to whom they refer certain complaints for investigation or help in preparing responses, to ensure that response time targets are met.

Lesson 6

130 Customer satisfaction with how a complaint is handled goes down dramatically the more contacts the complainant has with the organisation. It should therefore be an objective to resolve as many complaints as possible at the first point of contact. This is also cost effective for the organisation. In one organisation, research showed that satisfaction with those who made only one contact was nearly 80%, whereas a second contact brought satisfaction down to just over 30%, (though this may also be related to the complexity of the complaint). Some organisations are therefore laying down targets for percentages of complaints to be "closed" at the first contact.

Lesson 7

131 To avoid the customer even having to take the initiative about a problem some organisations solicit complaints during or towards the end of a transaction, or immediately afterwards. If done before a transaction is completed, staff may be able to correct the problem there and then. Speedy resolution increases satisfaction, and to do this during a transaction is the speediest way possible. In the case of First Direct, the telephone banking subsidiary of Midland Bank, the banking representative asks if they can help with anything else, giving customers an opportunity to complain.

Lesson 8

132 Contacting customers by telephone, even where they have made contact by letter, tends to increase satisfaction. It is an indication of tangible concern, as well as a way of exploring details of the problem and possible forms of resolution which may be acceptable to the customer. Some organisations confirm telephone responses with a standard letter, especially if compensation is being sent. J Sainsbury plc respond to around 10% of written contacts by telephone. Staff obtain the numbers from directory enquiries and make two or three attempts to contact the customer at different times. Most customers are very pleased to be contacted in this way.

Lesson 9

133 It is not a good idea to solicit customer complaints actively until the organisation has a clear idea of how many contacts are likely to be generated and is geared up to handle them well. People who have a problem with a service, but who do not report it, tend to be dissatisfied customers who may not buy again and will tend to tell others about their problem. If they can be encouraged to make contact and their complaint is handled well, research suggests that they may become satisfied customers, who tell others about their good experience. On the other hand, if their contact is badly handled, they will become even more dissatisfied. Complaint solicitation is an important part of any strategy, but it must be planned carefully if it is to increase and not decrease satisfaction.

134 Shell UK, which established a freephone customer service centre in 1989, reported that it was "a nerve wracking procedure to open the organisation up to complaints. People did not know what level of response to expect". Shell's advice is to pilot such a service first, in a geographic area or for certain brands, to estimate the likely level of demand.

Lesson 10

135 Telephone helplines, especially freephones, are an effective means of encouraging direct contact by customers. They can be advertised on products, at point of service and in correspondence or bills, as well as in the media. Levels of satisfaction amongst users tend to be high. Some of the companies studied had well publicised freefone services and one claimed 80% of those using their service were satisfied with the response.

Lesson 11

136 Staff training on customer contact handling, defusing anger, and telephone techniques, and "empowerment" of frontline staff to satisfy complainants, all improve satisfaction. Many of the companies studied provide staff with training on customer contact handling giving staff greater freedom to satisfy customers on the spot. Avis Europe is promoting the approach that "what frontline staff feel is right". This is an expression of confidence in the staff of Avis, who have been working to improve complaint handling for six years now and are considered expert in assessing what is necessary to satisfy a customer.

V.3.2 Generating management information about customer problems

Lesson 12

137 Integrate customer complaints with other forms of customer contacts, such as enquiries, comments, suggestions, and log all contacts whether they are made by telephone, in writing or in person. Many organisations discard valuable customer information for a range of reasons: "it is not a complaint, it is really a request for service/criticism of policy" or "we do not record verbal complaints, please put it in writing". By integrating customer

data from a range of sources, many organisations are able to produce management statistics which facilitate analysis. If data is not pooled in this way, systematic analysis may not be possible, because the numbers may be too small. British Gas, which has several hundred million customer contacts a year, is seeking to integrate data from comments and enquiries with complaint data, because it is convinced that the full range of customer contact information benefits the company.

Lesson 13

138 Log customer contact/complaint data on to computers, to facilitate analysis. Manual systems do not readily allow systematic management information to be generated in the same way computerised systems will. Some organisations log all customer contact information straight onto a PC, whether at a local service outlet or at a central customer service helpline, which avoids double entering of data. There are several tried and tested versions of customer contact software on the market, which can be customised to meet one organisation's needs, and which can provide regular management reports and generate mail. Development of in-house systems can be successful, but can also led to expensive failure. A number of organisations which were successfully generating management information (British Gas, British Telecom, Sainsbury, and British Airways) all developed their own software.

Lesson 14

139 Measure satisfaction with customer contact/complaint handling on a regular basis, by carrying out post-complaint tracking. The most successful method, which achieves up to and over 50% response rates, employs short postal questionnaires which ask about salient aspects of the complaint experience.

Lesson 15

140 The number of complaints received is not necessarily a good indicator of the quality of the service. A rise in complaints may simply be a result of a complaints procedure being well publicised, or of growing confidence amongst customers in management's willingness to hear about problems. Shell UK reports that it has been able to eradicate certain problem areas but "customers are always bringing new things to our attention". Where products, technologies, competition and customer expectations are always changing, reducing the total number of complaints may not be feasible or desirable.

V.3.3 Costs and benefits in customer retention/resource maximisation

Lesson 16

141 In the private sector, effective complaint handling is increasingly seen as the key to customer retention. It is generally much cheaper to keep an existing customer than to win a new one. Depending on the market sector, the existing levels of investment in IT, computers and ACD telephone systems, and previous investment in staff training, each organisation must carry out its own cost-benefit analysis of various approaches to complaints handling.

142 A number of companies report a positive "return on investment", even though very substantial sums have been spent in improving systems. British Airways reports that a year ago only 40% of those who approached customer relations would fly with them again because of how their complaint had been handled. Now that is 73%. British Telecom reports a 17% increase in satisfaction with how complaints have been handled. At Avis Europe satisfaction has increased from 60% to 75%.

Lesson 17

143 Other reported benefits from effective complaint handling and data collection include:

* targeting of current spending and investment in response to customer information;
* quick reporting of serious problems;
* offering new or expanded service (such as extended opening hours);
* significant saving in staff inspection time, through higher levels of customers reporting faults;
* provision of feedback reports on changes to customers;
* public recognition of this role in making changes;
* raising customer confidence;
* very significant increase in satisfaction amongst complainants (up to 94.5% in one case);
* reduction in reports to regulators or ombudsmen or in litigation;
* identification of the small number of customers who are "trying it on";
* public awards in recognition of high service performance, which boost staff morale.

Lesson 18

144 The introduction of effective complaint handling takes several years, especially in large organisations. Many staff and managers will be very sceptical at first of the benefits. Organisations introducing change must therefore have high level support, and a clear strategy to start with, and must aim for some "early wins" which will give credibility for the process. Later gains, however, are less spectacular. As Bob Fraser, Chairman of British Gas Eastern Region, who has had a major involvement in complaint handling, puts it, "Stay focused. Stay with it. It is a long haul".

V.4 OTHER COUNTRIES' PROCEDURES

145 We felt it would also be useful to look at the complaints procedures operated in other countries. The information summarised below was supplied by the International Relations Unit of the Department of Health. Initially we looked at the procedures of the countries within the European Union as these, like the United Kingdom, are increasingly subject to directives from the European Commission in Brussels. We then looked at other countries, with particular interest in Commonwealth countries which have a similar legal framework to our own.

146 Of the countries approached, several were found to have no formal national system for dealing with complaints, including Japan, Luxembourg, and the Netherlands.

147 In the Republic of Ireland, in the absence of a body dealing particularly with complaints, any complaint about a patient's treatment must be addressed to the Local Health Authority. It will then take the complaint up with the hospital concerned. Where patients remain dissatisfied, further complaint can be made to the Ombudsman for the Department of Health or their local government representative.

148 In France, there is no centrally-prescribed procedure and each hospital can choose its own way of dealing with complaints. The vast majority of French hospitals are nevertheless insured against claims for damages. When a complaint is received, the insurance company appoints an investigator to decide whether the hospital was at fault, and if so, how much should be offered in damages. If dissatisfied with the outcome of these investigations, the complainant can take the matter to a Tribunal Administratif. However, cases are considered inadmissible if complainants cannot show that they attempted to seek satisfaction directly from the hospital concerned. The role of the Tribunal Administratif is similar to that of the Health Service Ombudsman. However, the Tribunal Administratif can look into any grievance against a hospital whether about administrative or medical matters.

149 The Italian government has put forward proposals for ministries to provide Information and Complaints Offices which will deal directly with the public in an attempt to improve the levels of service in the public sector. The measure most specifically addressing complaints is the "First Intervention" service. This is a special telephone and fax service where the public is offered the opportunity to present complaints about delays, inefficiency, and general malfunctioning of public hospitals. The authorities claim all reports sent in by the public will be considered and passed onto the relevant body for action.

150 Italian legislation in the form of Law 502 of 30 December 1992 opened the way for a system of reviews and quality control for staff performance and the protection of patients' rights. This law delegates to Regions the responsibility for carrying out inspections to ensure that minimum standards are observed. It also states that Local Health Units, with local public input, should provide information/public relations offices for the collection and analysis of complaints. The director generals of each Local Health Unit and the hospitals in its area should meet at least once a year to examine complaints data and consider ways in which services could be improved.

151 Denmark has a Patients' Board of Complaints, established in 1988. However, this has the authority to consider only complaints about allegations of incorrect medical treatment which are referred to it by the Danish National Board for Health, Health Inspectors, or municipal authorities. It cannot handle complaints about impolite behaviour, compensation, or waiting time. The Board will not hear complaints outside a two-year time limit and there is no right of appeal against its decision. The decision of the Board on any complaint is likely to take from 6 to 18 months. The only course of redress left to complainants dissatisfied with the Board's decision is to bring the case before a civil court. The Patients' Complaints Board is an independent agency within the Danish Ministry of Health.

152 In Portugal, the Regional Health Authorities are responsible only for complaints about non-hospital treatment. Where these are considered to be sufficiently serious, they may be referred on to the Directorate General for Health, who may in turn refer the complaint to the Health Inspectorate. Where a complaint is about hospital treatment, there is immediate direct referral to the Directorate General for Health.

153 The Greek legislation providing official Patients' Rights includes "..the right to present or file objections and complaints".

154 In Finland, legislation has been passed which gives patients the right to complain to the director of the health care unit in which they are being treated if they are dissatisfied with that treatment. It also gives patients the right to take their complaint to the controlling authorities for health care provision if the complaint remains unresolved.

155 Several countries, at the time of writing, were in the process of preparing legislation for the introduction of new health complaints procedures. In The Netherlands, every doctor and hospital will be required to deal with complaints. In Luxembourg, similar legislation will result in patients having the right to complain to the director of the hospital concerned who will be obliged to respond.

156 New Zealand is also in the process of introducing new legislation covering complaints about health services. The New Zealand Medical Association (NZMA) already produces information leaflets for patients titled "When Things Go Wrong". The leaflet explains in neutral terms problems which may be encountered by patients. It then explains how to attempt to resolve these problems directly with the doctor concerned. If patients are still not satisfied, they are informed how to pursue their complaints further and what to expect at each stage of the procedure. The NZMA has also established Complaints Officers around the country who can investigate any matters concerning fees or services.

157 In Australia, the New South Wales Department of Health has established a Complaints Unit as a mechanism to respond to consumer complaints about poor health care delivery. The Unit consists of a Preliminary Inquiry Section, an Investigation Section, and a Legal Section.

158 The Preliminary Inquiry Section was introduced in 1990 because of delays in resolving minor complaints and an increase in complex cases. The Section is responsible for:

- screening complaints, referring those which are outside the jurisdiction of the unit to the relevant outside body, notifying complainants where complaints are not suitable for investigation by the unit, and referring complaints to the Investigation/Legal Sections of the Unit where they are not resolved within 28 days and further action is appropriate;
- initiating contact between the complainant and the health service provider with a view to resolving the complaint informally and to provide information.

159 It is clear from information obtained about foreign complaints procedures that there is an increasing awareness of the rights of patients and an increase in the efforts to empower health service users to complain where they are dissatisfied. Though the work of this Review is to achieve similar goals, the experiences of the foreign countries looked at are not necessarily directly applicable. This is largely due to differences of an organisational nature between the NHS and the types of organisation providing health care in other countries.

VI. GENERAL PRINCIPLES

VI.1 INTRODUCTION

160 Having examined existing NHS procedures in Chapter II, considered the objectives of complainants and the NHS in Chapter III, how these objectives are met under current systems in Chapter IV, and what we can learn from elsewhere in Chapter V, we now begin to set out our own views on the improvements we believe can be made to the current position.

161 The principles of any system should embrace the objectives both of complainants and of the NHS. In this Chapter, we describe a set of general principles. **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.**

162 In developing these principles we owe a considerable debt to those laid down last year by the Government's Citizen's Charter Complaints Task Force as guidance for public services generally [257]. It could be argued that those listed here might also be applied to any complaints procedures. However, our concern is with the principles that relate most to complaints about NHS services.

VI.2 RESPONSIVENESS

163 In the first place, complaints procedures should be responsive and aim to satisfy complainants. This does not mean that all complainants will be satisfied with the outcome of their complaint, but the procedure should be directed to satisfying their objectives as well as those of the NHS [2,135,138,140,147,210,225].

VI.3 QUALITY ENHANCEMENT

164 As seen in both private and public sectors in Chapter V, complaints provide invaluable management information about the quality of services from the perspective of service users and their families and friends. They can help to identify problems and sometimes suggest solutions. The service improvements this can lead to may be to the benefit of all patients [2,67,142,151,154,220] and of those involved in providing services for the NHS.

VI.4 COST EFFECTIVENESS

165 Procedures must be cost effective to operate [144,225]. Although effective in theory, complaints systems which cannot be implemented because resources are not available benefit no one. Where cash limits apply, it is important that investment in complaint handling is not disproportionate to the resources available to improve services. Current information on costs of NHS complaints systems is poor. We have received some helpful information from the Department of Health [268] which showed how costly complaint handling for family health services can be and that costs increase substantially the more formally complaints are investigated and considered. It is difficult to measure the costs of missed opportunities for service improvement, but the value of complaints in this respect should not be underestimated.

VI.5 ACCESSIBILITY

166 To satisfy complainants and for management information from complaints to be available, it must be as easy as possible for complainants to make their views known [8,29,33,67,101,118,138,145,162,176,178,183,192,200,219,225,231,236,239]. This should include attempts to reduce potential barriers of class, race, language, and literacy, and to recognise the needs of vulnerable groups such as children, people with mental health problems, and people with learning difficulties [29,99,118,129,135,138,183,188, 191,234,237,239]. Procedures must be well-publicised and understandable to all [2,53,84,101,135,138,220,236,239].

VI.6 IMPARTIALITY

167 Once a complaint is made, both complainant and respondent should be able to expect the matter to be considered impartially [2,29,45,125,126,129,145,147,176,207, 210,225,227,231,236,247]. This means that procedures should ensure that different points of view are listened to and investigated without prejudice, and that support should be available to both parties involved. As the Institute for Health Services Management observes, "Complainants are more likely to accept outcomes if they feel they have been treated fairly" [225].

VI.7 SIMPLICITY

168 A simple complaints procedure is desirable [11,29,30,45,65,85,119,112,125,135,138, 142,144,184,192,194,199,208,225,231,236,241]. It is likely to be more accessible for complainants and easier to use by those operating it. The simplicity of procedures may be constrained by other organisational elements (eg the independent contractor status of GPs within the NHS) or by the complexity of the issues involved (eg in relation to clinical judgement).

VI.8 SPEED

169 Complaints procedures should ensure that complaints receive as fast a response as is possible [2,29,33,67,89,93,111,145,148,151,161,162,188,190,192,194,208,214,217, 225,231,237,240], without jeopardising other principles. This can help to prevent dissatisfaction growing or further complaints arising about delays.

VI.9 CONFIDENTIALITY

170 Complaints systems should encourage people to complain without fear that their current or future care will be compromised. This is of particular relevance to primary care, to priority care services (for people with learning disabilities, mental illness, long-term handicap and so on), and for some patients detained under the Mental Health Act, who may receive long term care from certain staff members or from one particular organisation.

171 The NHS treats patient information as confidential and all those who work within the NHS are bound by a duty of confidence. Confidential information moves only on a need-to-know basis. This must equally apply to exchanges of information taking place within, or as a result of, complaints procedures [11,29,136,170,178,225,243,249,250].

VI.10 ACCOUNTABILITY

172 It is important in relation to complaints that those bodies providing and purchasing services are accountable for what they do, and take responsibility at the most senior levels for the operation of complaints procedures [1,210]. Chairmen and non-executive members of trusts are therefore to be held ultimately responsible for the operation of their complaints systems [231,269].

173 Accountability can also be furthered by openness in publication of complaints statistics by trusts, and health authorities and health boards.

VII. FEATURES OF EFFECTIVE PROCEDURES

VII.1 INTRODUCTION

174 Principles alone are, of course, not enough to form procedures. This Chapter sets out how the principles we have described can be developed into particular features of effective complaints systems in the NHS – the things that will make a good complaints system work. Some of these flow naturally from the principles themselves: good publicity is needed for a procedure to be *accessible*; for a procedure to lead to *quality enhancement*, there must be effective data collection and monitoring systems with analysis of that data forming a feedback loop into the delivery of services. Other features relate more generally to effective procedures, so that well-trained staff are likely to promote the operation of all the principles identified.

175 We believe that whatever the detail of NHS complaints procedures, they should have the features described below, and we have therefore made specific recommendations in each Section wherever possible.

VII.2 MAXIMUM COMMONALITY ACROSS ALL NHS SERVICES

176 All unnecessary differences between NHS complaints procedures should be avoided to establish maximum commonality between them [2,3,14,29,81,102,118,127,121,129, 134,135,136,140,146,156,161,177,188,190,194,207,212,219,225,231,239,241,247]. This will facilitate *access* by patients, and – through greater uniformity – help understanding by staff and management of the procedures, so they can become more *responsive*.

177 The division in current procedures between complaints against family health service practitioners (who have contractual arrangements to provide services) and those against hospital staff (who are employees) is confusing to the public [134,140], and wrong in principle. A family health service complaints procedure which focused on the complaint rather than concentrating on trying to relate it to a contractual issue would be better for both patients and practitioners. It would allow the complainant's real cause(s) for concern to be addressed, without being directly linked to disciplinary proceedings against the practitioner [185].

178 We also think there is no need for a separate system for complaints about clinical judgement, whether of doctors or of other clinical staff (nurses, professions allied to medicine, etc) [161,231]. It is unhelpful to draw what is sometimes an artificial distinction between causes of particular concerns, sometimes within a single complaint. Complaints may, for example, be about facilities, behaviour or clinical practice, and often combinations of some, or all, of these. It can be confusing if these are handled under separate procedures. While we are convinced that it is essential for consideration of clinical complaints to include advice from someone who is appropriately professionally qualified, we believe that common principles and features must apply to the handling of all complaints [102].

179 **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.**

180 Greater commonality of procedures would also allow complaints consisting of grievances about a number of different service areas (for example against a GP and community physiotherapist) to be dealt with together more easily. We make recommendations in Chapter VIII about handling these types of complaints.

181 While we do not recommend a "single door" system as described in some of our evidence [13,101,117,161,162,166,167,172,194,237], the onus would not, as now, be on the complainant to find the correct organisational doorbell(s) to ring. **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** [2,113,225].

VII.3 SEPARATION OF DISCIPLINARY ELEMENTS

182 We believe strongly that it is important to draw a clear distinction between complaints and disciplinary procedures [2,3,123,124,126,128,137,140,170,189,207,214,216,225, 229,234,237]. Disciplinary issues are a matter between FHSAs/health boards and contractors, NHS employer and employee, or for regulatory bodies by way of professional accountability. **We recommend that complaints procedures should be concerned only with resolving complaints, and not with disciplining practitioners or staff.**

183 All employers and contractual authorities will continue to need appropriate procedures to examine disciplinary matters. While these procedures are outside our terms of reference, we note that, for example, family health service authorities and their equivalents will continue to need appropriate mechanisms for handling alleged breaches of terms of service and that there will still be a role for the NHS Tribunal. **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.**

184 As well as complaining to the relevant employer or contractual authority, people who feel dissatisfied with any NHS professional who has participated in their care additionally have the right to complain direct to the relevant professional organisation, such as the General Medical Council. NHS management must refer appropriate cases to the relevant professional organisation at as early a stage as possible. Our recommendations do not cut across this requirement. In some cases, this may mean that the appropriate response to a complaint is to inform the complainant that their concerns are being examined under disciplinary procedures and that no further action will be taken under the complaints procedure.

185 Within the NHS we believe it is a management function to initiate disciplinary procedures. There will be occasions where complaints highlight possible disciplinary issues and management will need to take a view on whether these should be pursued. We therefore accept that any complaints procedure has to make provision for disciplinary issues to be identified and passed to the relevant quarter for handling. This creates a dilemma in that full co-operation is needed from staff who, in the process, may feel a sense of double jeopardy. Respondents may feel that, while their actions are under the spotlight of the complaints procedure, they also face the possibility of future disciplinary proceedings. The NHS Support Federation has even argued that action under the complaints system should be kept "secret" from disciplinary procedures [29] to increase the likelihood of staff co-operation.

186 However, we know that it is only in a minority of complaints that disciplinary action will (rightly) follow. We believe that it would be wrong for such evidence to be ignored by employers or, where appropriate, professional bodies. Indeed, evidence from the General Medical Council suggests that such a flow of information would be welcome: "The referral of appropriate...cases...should be continued subject to the current criteria" [7]. Therefore **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** [135,160,241].

VII.4 PUBLICITY AND "BRANDING"

187 One clear criticism of the current situation is that poor information about the procedures leads to reduced *accessibility* [113,136,147,183,196,197,203,234,237,241]. Local initiatives have led to the production of good "How to complain" leaflets [135] and posters, and publicity for local Patient's Charters detailing how to complain as well as where and who to complain to. Better publicity is needed [2,3,11,29,33,45,47,67,68,72, 73,86,97,99,101,112,113,117,118,136,138,140,120,123,126,128,135,154,160,161, 162,166,178,192,194,203,208,219,234,236,239,241,247]. **We recommend that every purchaser and provider of NHS services should have simple, written information about how to complain readily available. 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.**

188 Access could be furthered through the use of a "branding" system for national and local complaints literature and publicity material, which would carry a recognised logo. A logo could provide a means of producing a standard identity for information and publicity material about complaints (the idea could be extended to the encouragement of patient views generally). This could also be used in any surgery, clinic, ward, or office. Approved display of the logo would identify information was available about making complaints about the NHS. **We recommend that "branding" should be considered as part of the implementation of any new NHS complaints procedures.**

VII.5 USE OF INFORMAL RESPONSES

189 Both NHS and patient representatives, and those handling complaints in other organisations, argue strongly that responsiveness is enhanced if complaints receive quick response from the organisation about which they are made [2,3,8,29,37,47,64,93,73,102, 123,125,135,152,138,140,142,147,161,170,178,181,184,190,198,219,225,231,234, 237,241]. This is supported by such academic studies as Lewis and Birkenshaw:

> Providing, of course, that the citizen obtains the redress which is required, then complaints or grievances are best settled at as immediate and local a level as possible [264].

This applies both to oral and to written complaints. It is helpful if front-line practitioners and staff are encouraged to resolve complaints, and also to help initiate service improvements.

190 We believe that the majority of complainants will be satisfied when an appropriate rapid informal response is made, and that staff will be encouraged to view complaints more positively. It will be easier to establish the cause(s) of dissatisfaction, and the response the complainant expects, if this information is gained when the complaint is fresh in the minds of all those concerned. This does not mean that complainants should be forced to make their complaint to the staff involved or in the situation which gave rise to their complaint, as this could inhibit some people from making their views known. **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** [28]. Such complaints should be recorded (see Section VII.12).

191 If complaints receive a rapid response, it is likely to be while the complainant is still in contact with the service and can therefore usually be made on a face-to-face basis. Where complaints cannot be resolved in this way, early personal contact (ie face to face or on the telephone) from a more senior member of staff can increase complainant satisfaction, particularly where this is unexpected, such as when the complaint has been made in writing. It will again be easier to establish the cause(s) of the dissatisfaction and the response the complainant expects. **We recommend that complaints procedures should encourage those handling complaints, including senior staff, to make early personal contact with complainants.**

VII.6 WELL-TRAINED STAFF

192 To be *responsive* to complaints and make procedures more *accessible*, practitioners and staff need training in communication and other interpersonal skills. The nature and extent of training will vary according to the degree of involvement in complaints handling, but **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** [2,6,8,25,29,40,46,47,51,64,96,101,102,113,116,135,137,145,147,152,154,165,174, 179,182,188,190,194,195,196,203,219,225,231,234,236,241,247].

193 Many complaints arise from a lack of communication or misunderstanding between patients and those responsible for their health care [156,190,237]. The incorporation of communication and interpersonal skills into the syllabus of study for health professionals of all disciplines would help alleviate many such misunderstandings. This type of training already forms part of the undergraduate education in some medical schools, such as the Royal Free Medical School and the University of Leeds. These learning activities are designed to help students understand the feelings of aggrieved or distressed people and also to understand the emotions which this arouses in doctors. Training in good communications skills and attitudes, including respect for patients and recognition of their rights, forms part of the General Medical Council's recommendations on undergraduate education, "Tomorrow's Doctors" [252].

194 Such training should also be incorporated in induction training programmes [2,118,234]. The use of good communications and inter-personal skills should be part and parcel of the way NHS service providers and purchasers do business. Integration with communications and customer relations training would be one way of encouraging a culture where complaints are viewed positively by NHS practitioners and staff. This would allow greater autonomy for staff to deal with complaints at source so would be of benefit in preventing incidents escalating unnecessarily.

VII.7 SUPPORT FOR COMPLAINANTS AND RESPONDENTS

195 To make sure they are treated fairly, support should be available to both complainants and respondents in a variety of forms [2,29,51,81,102,112,118,154,165,179,191,194,203, 234,236,241,247]. **We recommend that appropriate training is offered jointly to health council staff and others who may be asked to support complainants and respondents** [2,29,102,128,161,202,203,235].

196 Complainants may need help to access procedures, through advice or advocacy [2,99,111,112,135,154,166,167,186,203,230,234,236,237,241]. **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** [2,10,29,64,102, 158,161]. Some evidence submitted [158,167,175] suggested it may be advantageous for complainants to be given access to (independent) professional advice in the case of clinical complaints.

197 Respondents and their families may need counselling or other help, particularly where more serious allegations are made [51,138,222]. Advice, support and representation should be available both from management and from staff associations [170,219,247]. **We recommend that all NHS practitioners and staff should be made aware of the support available when a complaint is made against them** [142,137].

VII.8 INVESTIGATION

198 The investigation of NHS complaints can vary from making a simple enquiry about what happened from the staff concerned, to detailed examination of records and the taking of formal statements from witnesses [29,124,135,230,235].

199 To be *responsive*, an investigation needs to be as thorough as is necessary to meet the requirements of the complainant. This means that in some cases it may be more appropriate to concentrate resources on remedying the fault that gave rise to the complaint in the first place than on a detailed investigation. For *quality enhancement*, certain matters may need more detailed investigation than satisfying the complaint requires.

200 **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** [214,219].

VII.9 USE OF CONCILIATION

201 Conciliation is an important method of resolving disputes. It involves an independent third party listening to the views of the parties to a dispute and then using that information to help the parties to try to reach a resolution to which they can both agree. In the context of family health services, this usually includes trying to restore the patient/practitioner relationship.

202 The most common recognised use of conciliation in current NHS complaints procedures is within the informal procedure for family health services. This mediation is generally carried out by lay conciliators. Limited training has been available for this work, which frequently requires great tact and skill to achieve an acceptable outcome. (See Annex H para. 15)

203 Greater use of conciliation could be made for hospital complaints [161]. In appropriate cases [210], this can prevent complaints escalating unnecessarily. **We recommend that conciliation is more widely available throughout NHS complaints procedures, and that those attempting conciliation receive appropriate training** [2,11,37,77,86,115, 116,117,128,161,170,171,178,184,189,196,202,203,220,237,247,249].

VII.10 TIME LIMITS

204 Currently two types of time limits are used in complaints procedures. The first relates to time allowed for making a complaint and is usually expressed in the form of a period of time within which a complaint must be made. Such time limits usually run from the date of the action giving rise to the complaint or from the time the complainant became aware of having reason to complain. The second consists of time limits within which complainants will receive certain responses (usually an acknowledgement and final reply); or a deadline within which certain internal processes, such as an investigation, will be completed. Cheshire Family Health Services Authority [64] sum up the views of many who gave us evidence when they say that time limits for bringing complaints should be relaxed and those for responding to complaints should be tightened.

VII.10.1 Time limits for making complaints

205 We have carefully considered a variety of arguments about time limits within which complaints should be made. Evidence submitted to the Committee in this respect has focused on the desirability of extending the time limit from 13 to 26 weeks within which complaints about GPs must normally be made under the formal FHS procedure [2,81,86,97,101,102,122,123,128,136,139,140,175,188,245].

206 The case for having time limits is that responsive replies may not be able to be made unless the events complained of are sufficiently near to be properly investigated [115]. As time passes, memories of events fade and staff involved move on. It may also be unfair to leave potential complaint respondents with an indefinite period of uncertainty over whether a complaint might be made against them [4,70,113,219]. Professional disciplinary procedures have their own separate time limits, and, for most cases, the courts have a time limit of three years for personal injuries claims.

207 There are also strong arguments against having time limits. These arguments largely relate to *accessibility*: complaints should not be ruled out simply on the grounds of time [76,140,166,184,199,225,226,236,246]. However, there is also the issue of *accountability*: for the NHS to be perceived as accountable, it must respond to all complaints. There are cases where an individual, for example because of distress, may not be able to make their views known until well after the events concerned [135,175,179,227,225,235,236]. In addition, time limits are fertile ground for dispute, and can therefore create bureaucracy. Some complainants will wish to appeal against rulings if it is decided their complaints are outside the time limit.

208 Regardless of any time limits, the earlier a complaint is made, the fuller the response that may be able to be provided and the sooner any action to improve quality of service can be taken. Therefore **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.**

209 Whether there are time limits or not, it is clear that judgements will be needed about whether the investment of time and resources in considering a delayed complaint will produce a satisfactory outcome. So, if limits exist, there will be allowance for exceptional cases to be considered (the shorter the time limit the more likely it is such appeals will be made). Equally, if there are no time limits, some test of practicality will be required as to whether such consideration is likely to be helpful.

210 The majority of the Committee are persuaded that, provided the complainant is informed of the practical difficulties involved, there seems no reason in principle why time limits are necessary [76,225,226,230,231]. There are provider units which have decided to investigate complaints whenever the events complained of occurred. One of these is the Northern General Hospital, Sheffield and, in their experience, this causes few problems. If this were implemented as part of any new procedures, it would be wrong to encourage the reopening of complaints about matters that have occurred in the past and been rejected as late complaints. Since we have not come to a unanimous agreement, **we recommend that the Health Departments examine the desirability of time limits for making complaints in the light of the arguments we have outlined.**

VII.10.2 Deadlines for responding to complainants

211 One of the criticisms of current complaints systems noted in Chapter IV is that, whereas complainants are expected to adhere to time limits for making their complaints, there are no time limits for processing and responding to them. It is important that any new complaints procedures should be speedy, but it is equally important that they should be responsive and fair. The timescales of complaints handling must reflect these aims, but there can be no excuse for unnecessary delays. Speedier replies to complaints can be achieved through simple procedures, efficient handling, and – where necessary – increased resources.

212 There is consensus in the evidence that there should be uniform deadlines for processing and responding to complaints. No one has suggested that there should be no deadlines. The examples of local complaints procedures we have seen tend to specify time targets for acknowledgement of the complaint and investigation and final response.

213 A variety of deadlines are suggested or are in operation for acknowledging complaints: Ayr Hospital has a standard of acknowledgement within 24 hours [164]; Camberwell Health Authority and the Northern General Hospital, Sheffield within two working days [178]; St George's Healthcare NHS Trust has a three day standard [169]. On balance, **we recommend that written complaints are acknowledged within two working days.**

214 There is more agreement about the length of time needed for an investigation: St George's Healthcare NHS Trust, the Northern General, and Camberwell Health Authority, all have a four week standard. Arranging conciliation and/or obtaining reports and checking details does take time, but we feel that four weeks to complete conciliation or an investigation is too long. **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, we recommend that a further two weeks should normally be allowed for this.**

215 In general **we recommend that all stages of a complaints procedure should normally be completed within three months.**

VII.11 CONFIDENTIALITY

216 Patients may be concerned that the fact that they have made a complaint is included in their medical records. Some providers of health care make a note of complaints in patients' medical records. This may be seen as threatening: patients can feel that their future treatment and care could be compromised. While in certain circumstances it could be helpful to patients to have a record of their complaint in the notes, **we recommend that complaints should normally be filed separately from health records.** Patients will still have access to these through the provisions of the Medical Records Act.

VII.12 RECORDING

217 There is a variety of opinion about the levels of complaints recording. Some think everything should be recorded [2], with others concerned that recording can be costly in staff time and can be wasteful unless there are mechanisms in place for using the information collected. The lessons from the private sector are that recording complaints – including telephone calls – onto a database provides valuable management information (see VII.13 below).

218 The Select Committee on the Parliamentary Commissioner for Administration, which has oversight over the work of the Health Service Ombudsman, has recommended that a centrally agreed system for the categorisation of complaints and the reporting of outcomes be introduced in the NHS in England and Wales. This could build on the models developed by the Scottish Management Executive and by the Health Service Ombudsman in relation to secondary care. We have not considered classification systems in detail, this will require detailed technical consideration [203] and piloting, but **we recommend that a system for the recording and classification of complaints should be developed and implemented on a United Kingdom basis.**

VII.13 MONITORING

219 Complaints monitoring has obvious benefits both in terms of making sure the complaints system is working well and that information is available for *quality enhancement*.

220 In order to ensure that complaints procedures operate with *responsiveness* at a local level and *accountability* is promoted, senior managers and their boards must have monitoring systems to provide regular information about how complaints are being dealt with. The Patient's Charter requires purchasers to publish numbers of complaints received by principal providers and the time taken to deal with them on an annual basis.

221 **We recommend that non-executive directors should take a key role in monitoring performance on complaints** [231]. The Institute of Health Services Management has told us that in some trusts, the board regularly selects random samples of complaints for a thorough review [225]. We know that the Camden and Islington Community Health Services NHS Trust has a Customer Services Committee which is chaired by a non-executive director and includes a local health council chairperson and the head of a primary health care department. The Committee sets and monitors time targets for responding to complaints and receives details of all the Trust's complaints and any action taken as a result. We would support this approach but would also expect the board to be actively involved in systematic performance monitoring.

222 **We recommend that all providers and purchasers of NHS services review their complaints handling on at least a quarterly basis, and make an annual published report on these reviews to the relevant FHSA or health board, trust board, and main purchaser(s).** Such reviews may be sharpened by the inclusion of an independent person such as a health council Chief Officer or Chairperson [29,36,37,102,158,163,203].

223 **We recommend that organisations regularly establish what their users think about their handling of complaints.** The idea of "surgeries" to elicit clients' views about the service has been recommended to us by the East Suffolk Advocacy Network [168] and has been used elsewhere. We feel that such forums could provide a way to check satisfaction with complaints procedures. We also recognise that surveys can fulfil a valuable role here and note that businesses often survey clients immediately after they have received a service or had their complaints resolved. Such practices reflect one of the lessons from other organisations identified in Chapter V. Grampian Healthcare NHS Trust record all their complaints and carry out a quarterly audit of the previous three months' complaints. This is carried out by means of a telephone survey using a standard questionnaire designed to provide feedback on users' satisfaction with the trust's complaints procedures.

224 Monitoring must also encompass the use of information gleaned from complaints for *quality enhancement* [2,8,9,29,73,101,117,118,123,124,136,156,178,188,190,219,231, 234,235,236,241]. This information is particularly relevant for service providers, but also for purchasers [21,29,73,76,158,178,184,197]. It can enable problem areas to be identified, or confirm problems identified through other quality monitoring mechanisms. This can address issues of management of personal performance [168] through to issues affecting a whole provider unit [166]. **We recommend that information derived from complaints is incorporated into quality review mechanisms** [2,50,118,138,236].

225 Monitoring needs at a national level are different in nature. Current national statistics collected in England are all but useless to identify complainant concerns. In Scotland, in addition to information provided in the annual reports of health boards and trusts, a quarterly complaints bulletin is produced on a national basis. This gives an overview of the number of complaints dealt with, the issues raised, the outcome and the time taken to reply. Examples are given of ways in which practices or procedures have been changed in response to complaints. **We recommend that each of the Health Departments publish an annual complaints bulletin on the current quarterly Scottish model** [29,47,117,165].

VII.14 IMPARTIALITY

226 Complainants want *impartial* consideration of their complaint. Impartiality is achieved by care and accuracy on the part of the investigator. This applies whether the investigator [237] belongs to the organisation concerned or is outside it. Investigation by someone external to the organisation may appear more impartial, but we believe this is not essential. However, public confidence will be promoted if responses to complaints include information about who complainants should approach if they wish to take their complaints further.

227 We have received some evidence suggesting that all complaints should be referred to an independent Complaints Authority (the British Medical Association) or Complaints Commission (Association of Community Health Councils of England and Wales/Action for Victims of Medical Accidents) [1,2,13,20,134,135,161,168,187,214,227,230,236]. Calls are strongest for independent investigation, where there are doubts about whether those working in the organisation may have professional loyalties which override fair play [20]. It has been suggested that complaints against the medical profession face such a "closing of ranks" unless an independent element is incorporated.

228 We believe that complainants will be served best when the NHS body providing the service initially investigates and responds to a complaint [210], with the exception of certain serious cases, such as when a criminal investigation is required. We note that Action for Victims of Medical Accidents in its evidence to us [210] states that:

> There are good arguments in favour of any initial inquiry taking place as close to the place of the incident as possible and therefore being conducted by the hospital or practice managers etc.

Although these arguments are not specified, we would relate them to our principles of *cost effectiveness, speed, confidentiality*, and *accountability*.

229 Procedures for hospital complaints concerning the exercise of clinical judgement have been treated as an exclusively professional matter so far as the investigation and conclusions are concerned. Some of our evidence has suggested that lay involvement would add credibility and assist resolution of such complaints [29,102,175,225]. We believe it is essential that appropriate professional knowledge is brought to bear on complaints involving matters of clinical judgement (this may include the knowledge of nurses and other professions as well as that of doctors and dentists). We also believe that, where complainants are dissatisfied with explanations offered to them, the involvement of a lay person or office is likely to assist the resolution of the complaint.

230 **We recommend that all NHS complaints procedures should include at some stage the possibility of complaints being considered by impartial lay people** [6,78,210].

VIII. DESIGNING PROCEDURES

VIII.1 INTRODUCTION

231 Complaints do matter, as the National Association of Health Authorities and Trusts has said. In many parts of the NHS this is now recognised, but in others a major shift in attitude is needed for complaints to be valued, and used to enhance the quality of services. In the previous two chapters, we have recommended a set of general principles and a list of features which NHS complaints procedures should include in order to achieve that shift. Is this enough to ensure that more effective procedures can operate within the NHS?

232 We believe that the NHS must follow these principles and incorporate these features into its complaints procedures to make them more effective. We have already indicated where, in our opinion, some fundamental changes are required. If public services are to be responsive to those who use them, they must respond positively to complaints. This is in the spirit of the Patient's and Citizen's Charters, developing within the NHS and the public sector generally.

233 Complaints should therefore be handled sensitively and with integrity whatever part of the complaints system is involved. The complainant's objectives and needs should be taken into account. Steps should be taken to help clarify these, and responses should be couched in terms that the complainant can understand covering all aspects of the complaint. Equally, practitioners and staff must feel that the procedure is fair [2,29,45,125,126,129,145,147,207,210,225,227,231,236,247] and be trained to operate it effectively [2,3,6,8,29,46,47,101,113,116,135,137,145,147,152,154,165,174,179, 182,188,190,194,195,196,203,219,225,231,234,236,241,247].

234 There needs to be a system in place which enables this to happen. In this Chapter, we therefore describe models of how we believe the principles and features we have described can be included in working procedures. The following models are not intended to be prescriptive. We feel it is important, particularly in view of the diversity of organisations within the NHS and from which it purchases services, that some flexibility is allowed in procedures. **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.**

235 In considering procedures for responses to complaints, we identified two distinct stages. In Section VIII.2, we make recommendations for a Stage 1 response from, or on behalf of, whichever part of – or provider of services to – the NHS is concerned. To achieve maximum commonality in procedures, we do not advocate separate procedures for complaints in primary and secondary care, or for complaints about clinical matters, and we indicate how the same system can be adapted to cover these and other areas.

236 In Section VIII.3, we make recommendations for a Stage 2 response which would be made by a body external to the organisation which made the initial response to the complaint.

VIII.2 STAGE 1 PROCEDURES

VIII.2.1 Introduction

237 Our view of the handling of complaints within Stage 1 by those providing services to patients reflects the principles and features described in Chapters VI and VII. We have stressed the importance of a rapid response aimed at satisfying complainants' wishes, and providing an opportunity for an investigation and/or conciliation. A number of providers have sent us copies of their own complaints procedures [6,9,34,90] which show aspects of our recommendations in operation, and we outline some of these in Section VIII.2.5.

238 **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 FHSA or health board for family health services or by the Chief Executive for trusts.**

239 In all cases, and especially for those at the front-line, training and support should be provided to enable practitioners and staff to respond effectively to complaints. All complaints should be recorded (and classified under a standard system to be introduced) and monitored to enable effective action on issues highlighted by complaints. The handling of complaints should also be carefully monitored [2,8,9,21,29,45,73,101,117, 118,124,136,156,158,178,184,188,190,197,219,234,235,236,241,249].

VIII.2.2 Access

240 A study by Mulcahy and Tritter for the NHS Management Executive [266] highlights the difficulties of gaining access to complaints systems. Some of the reasons for this have already been covered, such as exclusionary procedures, and systems too narrow in scope to cope with all complaints (see Chapter IV). Mulcahy and Tritter point out that front-line staff often decide whether a complaint enters the complaints procedure. They comment, "Particular concern has been expressed about 'de-selection' or unchecked rejection of complaints at this level" [266].

241 People must be able to find their way readily into the system if they wish to make a complaint [8,29,33,101,118,135,138,145,178,188,191,200a,219,225,231,234,236, 237,239]. We have already proposed that all practitioners and staff should be encouraged to receive complaints, and make an initial oral response. This provides a multiplicity of access points.

242 We recognise that some people may not want to approach those directly involved in their care. Much of our evidence supports the role of a designated complaints officer [11,118,126,161]. The Select Committee on the Parliamentary Commissioner for Administration has recommended that such posts are established to deal with complaints about family health services [270].

243 **We recommend that there must be well-publicised access for complainants to a named person such as a complaints officer** [2,231,239]. In primary care this person may be the senior partner or practice manager; in hospitals, the complaints officer. This person may either respond to the complaint themselves, or direct it for action by the relevant person in the practice, hospital, or health authority/board, including the Chief Executive where appropriate.

244 Providing advice and support for people wishing to make complaints is an important element in making complaints procedures accessible, which we discussed in Chapter VII. **We recommend that special attention should be paid to the needs of vulnerable groups for support and representation in making complaints.**

VIII.2.3 Three-fold approach

245 We now go on to describe the elements that make up our three-fold approach (see figure 4). We would stress that these elements need not be rigidly followed in sequence for each complaint. Normally only one or two of the three approaches will be used, but this is intended to be flexible with various entry points.

246 A judgement will be needed as to the appropriate handling that should be given to each complaint. So, while most complaints would be resolved through listening and an oral response (see VIII.2.3.1 below); some may be identified immediately as needing investigation and/or conciliation (see VIII.2.3.2); a few complaints might need to be referred immediately to the complaints executive for family health services or trust chief executive (see VIII.2.3.3). While some complaints might be resolved through a combination of the levels of the three-fold approach, only very few would follow all three. Practitioners and staff who receive complaints will need guidance on making these judgements, but if they are unsure the complaint should be referred to the named person or complaints officer within the practice or hospital.

VIII.2.3.1 Listening and first-line response

247 **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.** While oral responses would normally be given, a written response may sometimes be given as well as, or instead of, this. In either case, the response should aim to satisfy the complainant that his or her concerns have been listened to, and offer an apology and explanation as appropriate.

248 This part of the three-fold approach will normally be the responsibility of the person who the complaint is made to, whether the complaint is in writing or is made orally. Whoever receives the complaint should deal with it, wherever possible. As other organisations have testified (see Chapter V Lesson 6), the longer it takes to deal with a complaint and the more contacts required, the more difficult it is to achieve a satisfactory resolution. This first-line response can therefore be the most crucial element in an effective complaints procedure. There are important implications for training as a result.

249 We have received many comments that most complaints are about communication problems [190]. The Medical Protection Society has said:

> many complaints result from communication failures and could be resolved easily if not allowed to fester [11].

The Health Service Ombudsman has noted that about 70% of the complaints he investigates involve poor communications in some form or another [47].

250 We believe that good communications skills are vital for all NHS staff and practitioners. Therefore, **we recommend that NHS practitioners and staff in all disciplines and professions receive thorough training in communications skills and that this should be incorporated at an early stage into training for professional qualification, staff induction courses, and basic training at all levels** [51].

251 **We recommend that everyone who is likely to receive oral complaints should be trained in active listening skills** with the objective of getting a full picture of complainants' concerns. As well as ensuring that an accurate picture of the problem is obtained on which to base any further action, active listening will also give complainants the satisfaction of voicing their complaints and confidence that they are being listened to seriously (providing, in effect, an "oral acknowledgement"). Carried out well, this will enable the complainant to begin to feel more positive about the organisation.

252 The sensitivity we described earlier will need to be exercised here. Complainants should have the opportunity for privacy and for discussion with someone other than the practitioner of staff member directly involved, if that is what they want. Serious complaints, such as those where allegations include medical negligence, or a major failing in practice or hospital procedures such as a serious untoward incident, must be identified so that appropriate action can be taken quickly.

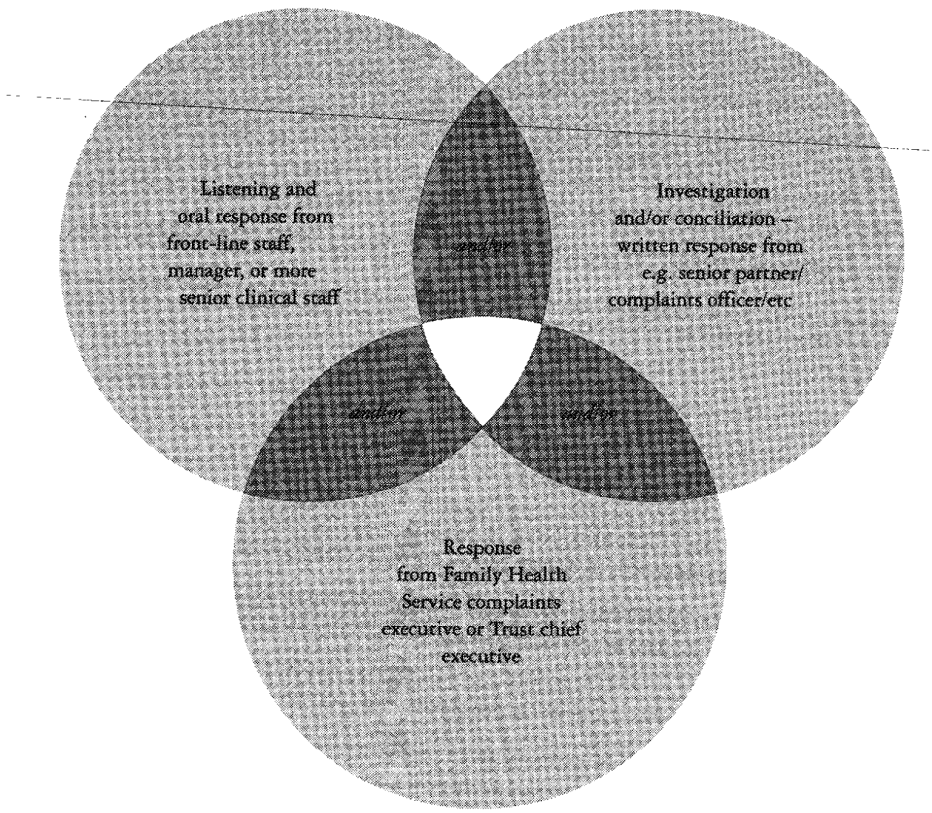


Figure 4: Proposed stage 1 procedures

253 In many cases, once the practitioner or member of staff has checked that they have correctly understood the substance of the complaint, it will be resolved instantly by an apology and/or explanation. In other cases, if the complainant remains dissatisfied, a meeting may be offered or alternative avenues explained, including the timescales involved.

254 **We recommend that oral and written complaints should receive the same consideration and sensitive treatment** [231]. This should involve making contact by telephone, meetings, or visits, bearing in mind that a few complaints may be made in writing in order to avoid more personal contact.

VIII.2.3.2 Investigation and conciliation

255 As the second element in the three-fold approach, senior partners, practice managers, general or clinical Heads within trusts, or health authority/board directors, should respond either orally or in writing normally within a maximum of three weeks to complaints directed to them either because it is appropriate or because the complainant had been dissatisfied with an earlier oral or written response. **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.**

256 Investigation (as defined in Section VII.8) will be used either separately from, or together with, conciliation where appropriate. In order to make the results responsive and fair, all investigations should include obtaining information from those complained against and any further information from complainants which might clarify their grievance or their expectations about the response to the complaint.

257 Conciliation (as defined in Section VII.9) can happen after, or alongside, a full investigation, but should not preclude an investigation or any further action taking place. We feel conciliation can be especially important in preserving patient-doctor relationships, or where it was felt the complainant needed access to further services (such as bereavement counselling).

258 **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.** Such a role might be combined with more general patient support functions, providing that the conciliator maintains impartiality and is not seen by practitioners or staff complained against as biased. Patient representative officers fulfil this broader role in some hospitals.

259 **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.** Once again, we emphasise the need for sensitivity and making sure that responses fully cover each aspect of the complaint, with explanations of the action being taken. Replies should be in language which the complainant can understand [146].

260 Taken together, these first two elements of the three-fold approach will in family health services normally form a distinct practice-based procedure [4], to be agreed with, and monitored by, the family health services authority or equivalent (see Section IX.3 below). We have received several models for practice-based procedures in the evidence provided to us [11,137].

VIII.2.3.3 Complaints Executive or Chief Executive action

261 **We recommend that in particularly serious cases or where the complainant remains dissatisfied, the complaint should be considered at the most senior level available.** If the improvements at earlier stages are made, such complaints should only be in a minority.

262 In trusts it is clear that this will mean the involvement of the Chief Executive concerned. However, there is no analogous figure for family health services. There is therefore a need for someone in primary care to take similar responsibilities for complaints. On balance, we feel this cannot simply rest with the senior partner of the practice concerned. Particularly for small or single-handed GP practices, but even for larger practices, it may not be possible to provide the necessary distance from the day-to-day care of patients.

263 Therefore, **we recommend that authorities and health boards responsible for family health services – in consultation with local practices and local representative committees – employ "Complaints Executives"** [2]. These Complaints Executives should be of sufficient standing (for instance, they may be an executive board member). They may not only respond to complaints which are not resolved within the practice, but may also be given responsibilities in relation to the audit of practice-based procedures [2] (see IX.3 below).

264 **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.** It may be appropriate for a trained non-executive member of the authority or board to attempt conciliation at this stage. **We recommend appropriate professional advice is always sought where complaints concern clinical judgement.** In primary care, this would normally be an advisor appointed following consultation with the relevant local representative committee; in the hospital or community setting, the trust medical or nursing director.

265 In all cases, a full written response should be sent to the complainant. When action was promised, the complainant should be informed that this had been or would be taken [135]. Where possible, the Complaints or Chief Executive would also speak personally to the complainant.

266 Given our emphasis on the devolution of complaints handling to enable rapid responsive replies to the majority of complaints, and the recommendations we have made to support this, we do not think it appropriate for Chief Executives to provide written replies to all complaints, as required by the Patient's Charter in England. We believe that our other recommendations should make sure that complaints are handled well and that the involvement of Chief Executives in all complaints would otherwise lead to unnecessary delays [231].

VIII.2.3.4 Progress within Stage 1 procedures

267 **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.** When a final response has been sent by the Complaints Executive or Chief Executive, and the complainant remains dissatisfied, the next step will normally be for the complaint to be considered under the Stage 2 procedures we now describe, although complainants will continue to be able to ask the Health Service Ombudsman to investigate at any stage.

VIII.2.4 Specific situations

268 The procedure we have described is intended to be capable of use by any provider or purchaser of NHS services but, because these organisations are so diverse in size and structure, we now go on to highlight particular issues within directly managed units, community services, non-NHS providers, and NHS purchasers. We also make a recommendation on complaints involving more than one organisation.

VIII.2.4.1 Directly managed units

269 There is likely to be a small number of directly managed units for some time – ie NHS providers which have not become NHS Trusts and are therefore directly managed by a health authority or health board. These units will be responsible for running our proposed Stage 1 procedures in the same way as other providers. However, **we recommend that the Unit General Manager of a directly managed unit should take chief executive action where this is required for complaints.**

VIII.2.4.2 Community services

270 Providers of community services can have some difficulties in making information available to their patients and receiving complaints from them because, unlike primary care and hospitals, clients usually receive the service in their own home instead of visiting the provider's premises. Community service providers usually have managerial structures in place which would enable them to handle complaints in similar ways to hospitals – sometimes they are part of a management unit that includes hospitals.

271 **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.** Community service providers will want to make sure their clients have access to information about making complaints, including the facility to complain to someone other than the member of staff visiting them. Such information could be provided on appointment cards, information packs, sent with correspondence.

VIII.2.4.3 Non-NHS providers

272 Where patients are referred for NHS care to non-NHS providers, whether in the independent or voluntary sectors, similar procedures must apply. The details may differ because of the organisational structures of those providers, but the complaints procedures operated with respect to NHS patients must enable them to have the same opportunities as if they were receiving care from NHS providers. **We recommend that purchasers specify complaints requirements in their contracts with non-NHS providers.**

VIII.2.4.4 Purchasers

273 Purchasers – both GP Fundholders and health authorities and health boards – will handle complaints about their activities in the same way as providers. GP fundholders will, of course, also act as providers and have the same procedures in that role as other practitioners. In health authorities and health boards, the Chief Executive will have the same role as the trust Chief Executive; for GP fundholders as purchasers, the responsible partner or practice manager must exercise these responsibilities.

274 We anticipate that purchasers will receive complaints which have a political dimension, eg about issues related to allocation of resources and placing of contracts and the impact this has on individual cases. In some cases these complaints will concern matters, such as waiting times, which have both operational and policy aspects. It is important that purchasers and providers liaise to make sure these complaints receive a full response, and that there is no buck-passing. We feel that these issues require special handling to ensure that they receive proper consideration and are not dismissed solely on the basis that the complainant's views challenge policy decisions. **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** [143]. Purchasers should consider involving a non-executive member in this process as part of monitoring their own actions.

275 Since complaints about purchasing decisions and policy matters are likely to revolve around differences of opinion, we do not consider that the matter can be reconsidered within NHS procedures if the complaint cannot be resolved in Stage 1. Therefore, **we recommend that, if complaints about purchasing decisions and policy matters cannot be resolved locally, complainants should ask the Health Service Ombudsman to investigate.** Though he is not in a position to reach a new judgement on decisions which have been made, the Ombudsman can investigate and comment on decision making processes and whether they have been properly followed.

VIII.2.4.5 Policy issues

276 Complaints may arise where a complainant feels a policy or decision has been arrived at incorrectly or simply disagrees with the outcome. These complaints require special consideration in that they should not be dismissed solely on the basis that the respondent disagrees with the complainant's views. **We recommend that complaints about policy decisions are handled on the same basis as those about purchasing which we describe above.**

VIII.2.4.6 Complaints involving more than one organisation

277 **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.** This may mean the recipient passing the complaint to the complaints officer responsible for the most substantial part of the complaint, or the co-ordination of a combined response from various bodies. In such cases, the patient's permission should be sought before the complaint is passed on, and the complainant should be kept informed at all times. The important thing is to avoid the complainant feeling that they are being passed from pillar to post.

VIII.2.4.7 Community Care

278 As more patients receive NHS care in the community, complaints in this area may increase. These complaints will require close co-operation between NHS and social services staff as they may involve elements from both services. We know that social services and NHS providers in many parts of the country have developed excellent integrated working practices and we would like to see these arrangements developed to encompass complaints handling. Whilst social services are clearly outside our remit, **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.**

VIII.2.5 EXAMPLES OF WORKING PROCEDURES

VIII.2.5.1 Introduction

279 The evidence submitted to us illustrates that there is much good practice in the NHS in relation to complaints which already meets with our recommendations. We can therefore use a variety of examples to demonstrate the feasibility of these recommendations in a variety of different environments.

VIII.2.5.2 Family health services

280 Lambeth, Southwark, & Lewisham Family Health's complaints procedure embodies principles of equity (impartiality), accessibility, accountability, and humanity. The Authority operates a procedure where Contract Managers (employed to manage the contractual arrangements with the various contractors for whom the FHSA is responsible) investigate and attempt to resolve appropriate complaints prior to the formal stage. They also employ an in-house conciliator. In addition, following the outcome of a formal complaint, feedback is given to the contract managers about matters which need to be followed up or discussed with individual contractors.

281 We have often met with the comment that it is difficult, if not impossible, for single-handed or small GP practices to implement practice-based complaints procedures. This is said to be because their size means that complainants can complain only to the person they wish to complain about, or the practice is unable to consider complaints objectively. We do not accept this premise and there are examples which avoid these objections. In a practice in Grassington, North Yorkshire [255], complainants are encouraged to complain to the Practice Manager, but, if they do not wish to do this, they can complain to one of four members of the practice's Patient Participation Group. The names, addresses and telephone numbers of these individuals are publicised in the Patient Information leaflet and in the surgery waiting room as well as on a special leaflet about the complaints procedure.

VIII.2.5.3 Hospital services

282 Altnagelvin Hospital in Londonderry has a Patient's Advocate, whose role embraces that of complaints officer, who acts to resolve many complaints on a relatively informal basis. There is extensive personal contact with complainants to ensure that their particular concerns are identified, and that any breakdown in communications is overcome.

283 The Glan Hafren Trust in Newport, Gwent, has a complaints procedure that meets many of our recommendations. On receipt of a complaint, the investigating officer is expected to arrange a meeting or telephone the complainant for a detailed discussion "to ensure that they accurately identify all the issues the complainant wishes to be fully investigated". After this initial contact, a written acknowledgement is sent setting out the agreed areas of complaint. Complainants dissatisfied with the initial investigation, are advised that they can take the matter to the Chief Executive. All complainants are made aware of, and encouraged to seek, the assistance of the Community Health Council [9].

284 The Hastings and Rother NHS Trust, which provides hospital, community and mental health services, has set up a Complaints Panel which meets quarterly to review trends and the handling of individual complaints. The Trust has also appointed a consumer relations manager who, among other things, co-ordinates complaints handling, helps managers handle complaints and participates in staff training on consumer relations and complaints handling [99].

VIII.2.5.4 Community services

285 First Community Health in Stafford have developed a complaints procedure – "Are You Satisfied?" – intended to be as simple and direct as possible. It is displayed in all the Trust's clinics and in health centres, alongside the local patient's charter. Patients are given a leaflet about the system on their first contact with the Trust. The display poster describes four ways of making a complaint and promises that the Trust will deal with any complaints promptly; will explain what action has been taken; and will advise complainants about support and further action they can take [90].

VIII.2.5.5 Mental health care providers

286 The State Hospital, Carstairs, provides all patients with an information pack on admission to the hospital. This includes the hospital's charter which explains how to complain about any aspect of care. Patients are encouraged to raise issues with their named nurse or their doctor in the first instance but, if their complaint remains unresolved, can write on a confidential basis to the General Manager. If patients are still not satisfied, they can raise their complaints with the Mental Welfare Commission for Scotland.

287 Salford Mental Health Services have adopted a policy of dealing directly with complainants on a personal basis. They feel that this has a variety of benefits: it lets the complainant know that someone in the organisation cares about their complaint; the personal contact gives the complainant the opportunity to talk about their problems, giving more background information than might be available from a letter; allows greater discussion and explanation of what is being done to prevent the situation arising again than would be possible in a letter of response; finally, it allows the organisation to apologise for the circumstances which gave rise to the complaint in a much more personal way. In the experience of Salford Mental Health this method of complaints handling is not only quicker than dealing with complaints by correspondence, but it leads to greater satisfaction on the part of the complainant, and provides the organisation with more information which can be fed back into quality improvements, preventing similar situations from arising again [253].

VIII.2.5.6 Purchasers

288 Some purchasers specify how complaints should be handled in their contracts with providers. For example, evidence provided to the Committee by Bradford Community Health included performance standards laid down by Bradford Health Authority for complaints handling within the trusts contracted to provide services to its residents. These standards are outlined in an agreement which forms part of the contract between the authority and the trust [254].

VIII.2.5.7 Support for complainants

289 Advocacy is a form of support which has been mainly used with priority care groups such as elderly people, people with mental health problems or people with learning disabilities. The Patients' Council operating in Stanley Royd Hospital, Wakefield is an example of self advocacy. Here service users, some of whom may feel that their care could suffer as a consequence of complaining, can air general complaints through the Patients' Council while retaining their personal anonymity. This was established through the Richmond Fellowship Advocacy Project and is primarily resourced by Wakefield Healthcare, the local purchaser, with contributions from Wakefield and Pontefract Community Health, the controlling NHS trust, and the local government authority.

290 The National Association of Health Authorities and Trusts is currently managing a project funded by the NHS Management Executive which has established Patient Representatives in Brighton Health Care NHS Trust and Frenchay Healthcare NHS Trust. Here there is extensive personal contact with complainants to ensure that their particular concerns are identified, and that any breakdown in communications is overcome. Similar posts currently exist within the NHS – we have already referred to the Altnagelvin Hospital in Londonderry. The Northern General Hospital NHS Trust, Sheffield has a patient representative officer, who acts in the same way to satisfy many complaints on a relatively informal basis.

VIII.2.5.8 Concluding remarks

291 We compliment those involved in the examples above which have been drawn to our attention. They represent, of course, only some of the current good practice within the NHS. They largely include the principles and features we identified earlier, as well as our recommendations on procedures themselves. They also demonstrate the need to allow flexibility for local innovation.

VIII.3 STAGE 2 PROCEDURES

VIII.3.1 Introduction

292 We have argued strongly that the main focus in NHS complaints handling should be on effective procedures within the organisations where complaints arise. We have made recommendations for these in the previous Section. In this Section, we describe what further arrangements we think should be in place for complaints which are not effectively resolved under such "internal" procedures.

293 If operating well, Stage 1 procedures should be able to address the vast majority of NHS complaints and satisfy complainants' objectives. With effective internal procedures operating, even though the number of complaints may increase with improved publicity and easier access, we would not expect a corresponding increase in those complainants requiring a response from outside the organisation concerned (Chapter V, Lesson 6).

294 While there are important differences in the nature of the cases considered, the approximate numbers of complaints currently considered in detail beyond the current equivalent to Stage 1 procedures in England are as follows:

FHSA Service Committees	2 000
Independent professional reviews	300

This excludes complaints which are made to Government Ministers or the NHS Management Executive. In addition, the Health Service Ombudsman receives some 1 200 complaints a year, of which he investigates 150-200. The Mental Health Act Commission receives a similar number of complaints as the Ombudsman.

295 **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** (see figure 5). The purpose of providing what we will call a Stage 2 procedure is to offer a more formal degree of impartiality than can be achieved if an unresolved complaint is reconsidered by a part or agent of the organisation complained against. These procedures should continue to embody the general principles we described in Chapter VI and the relevant features from Chapter VII.

296 There may again be occasions in which, because of the issues raised, complaints are referred directly from Stage 1 procedures for criminal investigation, disciplinary action, or to a public inquiry established by the Secretary of State concerned.

297 We start this section by describing what we think Stage 2 might normally involve: screening (VIII.3.2), and – if the complaint is accepted – consideration by a panel (VIII.3.3). We then go on to consider the options for the ownership of these processes (VIII.3.4).

VIII.3.2 Screening

298 In order to ensure that Stage 1 procedures are not bypassed, **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).**

Discussions with the complainant are likely to be necessary to achieve this.

299 We consider that there is sufficient flexibility in the arrangements outlined in our Stage 1 procedures, for complaints to start with Stage 2 only in very exceptional circumstances. In many cases, screening will mean that the complaint is referred back to the service provider for a (further) response within Stage 1. This practice has a parallel in the statutory requirements governing the independent Office of the Health Service Ombudsman which states that complaints must first be considered under current internal NHS procedures.

300 **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** [167,174]. Whatever decision is reached, the complainant should be given a full explanation and the opportunity to produce further information for the decision to be reviewed. Following an acknowledgement within two days, this explanation should be made to the complainant within 14 days. Complainants would be informed of their right to ask the Health Service Ombudsman to investigate if they were dissatisfied with a screening decision.

VIII.3.3 Panels

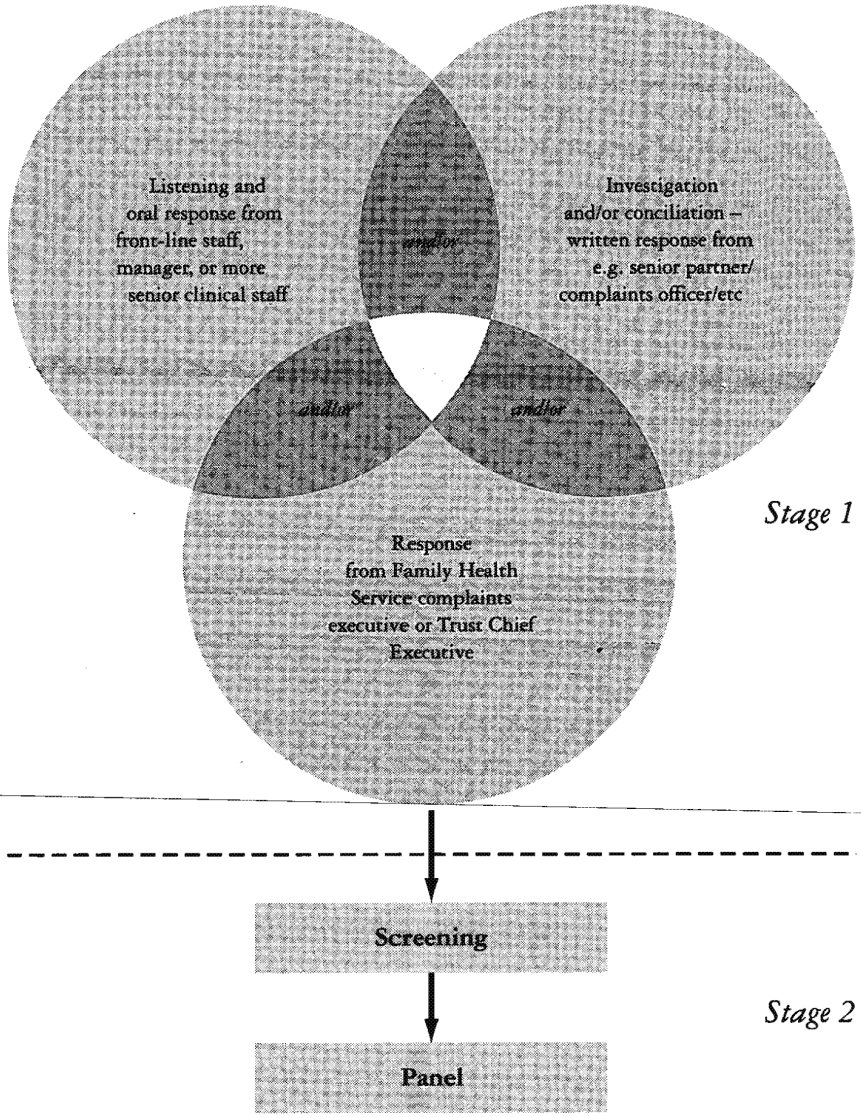
301 The panels we propose would be able to consider complaints concerning primary or secondary care, and non-clinical or clinical issues [135]. Complaints covering more than one type of service, or more than one service provider might be considered together as a whole. **We recommend that panels should normally have three members. If the complaint raises issues of professional judgement or requires particular specialist knowledge, two additional members might be appointed.**

302 **We recommend that panels should always have a lay majority (including a lay Chairman** [210]), **and vary their members according to the nature of the complaint** [135,167,210,225]. **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.** (Under existing statute, detained patients might choose to ask the Mental Health Act Commission to investigate as an alternative, or addition, to the proposed Stage 2 procedures.) **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.**

303 Chairmen and panel members will need training to enable them to fulfil their role. **We recommend that the body appointing panels should be responsible for ensuring that Chairmen and panel members receive adequate training.**

304 It would be for the panel to decide how they would consider each case. They could consider all relevant documentation, and see both complainant and respondent. The process should be investigatory, not adversarial.

305 The purpose of the panel's consideration would be to identify what had happened as accurately as possible and offer the most satisfactory explanation to the complainant. **We recommend that the panels should make a report with any appropriate recommendations to be sent to the complainant** [135,231], **and copied to person(s) against whom the complaint had been made** [231] **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.**



Complainants who are dissatisfied after Stage 1 and Stage 2 may approach the Health Service Ombudsman.

Figure 5: Proposed complaints procedures

306 This would complete the action under Stage 2. If still dissatisfied, the complainant could still ask the Health Service Ombudsman to investigate within the terms of his jurisdiction. This currently excludes complaints about clinical judgement and the family health service independent contractors ie general medical practitioners, general dental practitioners, pharmacists, and opticians (see our recommendations below at VIII.4).

VIII.3.4 Options for the organisation of Stage 2

307 We have considered a number of options for the organisation of the Stage 2 procedure. Ownership must be sufficiently distinct from local management to testify to its impartiality, but need not necessarily lie outside the NHS. We have therefore considered the following options:

A the Chief Executives of health authorities and boards, or trusts;

B health authorities and boards, or consortia of them;

C NHS Management Executive Regional Offices in England/the Management Executive of the NHS in Scotland/the Welsh Office/the Central Services Agency in Northern Ireland;

D a new Complaints Commission.

VIII.3.5 Analysis of Stage 2 options

308 We now analyse the options we have identified for ownership of the Stage 2 procedures.

VIII.3.5.1 Option A – Chief Executives

309 In Option A the Chief Executive from the FHSA or health board holding the practitioner's contractual arrangements for family health services, or from the trust for hospitals or community services, would be responsible for setting up and servicing the panel.

310 These options have a number of positive points in their favour: they keep the response close to the point of service; Chief Executives can take direct action for quality enhancement; they are cost effective, as staff are available to service the panels; they give ready access for complainants; and, they are simple to use and accountability is reinforced since the same chief executive has responsibility for Stage 1 and Stage 2 of the procedure. The greater degree of impartiality required at Stage 2 can be achieved through consultation over panel members or by their being chosen from an approved list (perhaps established by the relevant Secretary of State).

311 We have also identified a number of arguments against the Chief Executive option. Since there might be fewer than ten panels held each year by an individual health authority, board, or trust, this might be insufficient to allow expertise to develop; there could be inconsistencies in appointing panel members, and in panel conduct; the arrangements might not be seen to be impartial, since the complaint respondent would be responsible for appointing and conducting the panel; there might also be concerns by family practitioners over the dual health authority and board role in relation to complaints and disciplinary procedures; complaints involving more than one provider would require agreement on the constitution of the panel; confidentiality of details of the complaint may be broken if there was consultation over the membership of the panel.

VIII.3.5.2 Option B – Purchasers or purchasing consortia

312 In option B the panels would be appointed and serviced by individual purchasing authorities or boards or consortia of them [2,190] and panel members are district health authority or family health service authority non-executive members or others appointed for this purpose (such as associate members). Arguments identified in favour of Option B are: individual purchasers can require action on quality enhancement; complaints involving family health, hospital, or community services can be readily considered as a whole; it is cost effective – NHS staff could be available to service panels; purchaser non-executive and associate members (ie the panellists) are independent of service providers; expertise could be gathered on a Regional basis (under the consortia model) for running panels. It is also important that purchasers are accountable for the quality of services purchased by them.

313 On the negative side, the consortium or individual purchaser responsible for each complaint would need to be identified; trusts might have concerns over purchaser involvement in operational issues; the public may not perceive purchasers as impartial [135]; family practitioners might again be concerned about the possible overlap with health authority or board responsibilities in relation to discipline.

VIII.3.5.3 Option C – Regional Offices of the Management Executive, etc

314 In Option C, the panels would be appointed and serviced by the Regional Offices of the NHS Management Executive with the servicing perhaps being delegated to an individual purchaser or agency (similar to the existing Welsh Common Services Authority, or Central Services Agency in Northern Ireland). Panellists might again be drawn from health authority or board non-executive members or others specially appointed for this purpose.

315 We saw this option as having three particular arguments in its favour: distance, and therefore independence, from service providers; purchaser non-executive and associate members (ie the panellists) are independent of service providers; expertise would be gathered on a Regional basis for running panels.

316 We felt there were also some powerful arguments against this option: lack of direct levers over service quality issues; possible additions to central bureaucracy; the need to identify the Regional Office responsible for each complaint; as we understand them, it does not fit in well with other proposed Regional Office functions; and, the new regional offices will be part of the Department of Health, which, since it is part of central government rather than the NHS, does not come under the jurisdiction of the Health Service Ombudsman.

VIII.3.5.4 Option D – Complaints Commission

317 In Option D panels would be established by a national Complaints Commission from a national list of independent members. The panels would be serviced by regional offices of the Commission based, perhaps, in the Regional Offices of the NHS Management Executive. This option would ensure a central locus of expertise on membership and the totally independent establishment of panels [1,80,115].

318 However, this option would also mean separation from quality enhancement; it would require a new quango to be established with powers over service providers, eg to obtain records, interview staff, etc; a bureaucracy would be needed to establish/maintain lists of potential panel members; there would be lack of local access for complainants and no obvious local structure for identification of members or servicing panels.

VIII.3.6 Recommendation for Stage 2 organisation

319 We have discussed in some detail each of the options for the organisation of the higher level procedures. Each is supported in some measure by some members of the Committee. Some members favoured Option A, but others felt that the Chief Executives concerned might not have, or be seen to have, sufficient impartiality. Some members felt Option B gave appropriate recognition to the developing role of purchasers in the reformed NHS, but others were concerned that purchasers may also not be perceived as sufficiently impartial, although they may be so in future. Option C offered more independence from the service provider through the involvement of the Management Executive and the prospect of developing a central mass of expertise in operating the procedures. However, largely because of the emerging role and nature of the Management Executive's Regional Offices, others felt unable to recommend this option. Several members regarded Option D as their "Rolls Royce" option, but others were concerned about the resources required.

320 We would emphasise that the operation of the Stage 2 procedure is more important than its organisational home, although it must offer independence from the original complaint respondent and accessibility for the complainant. Screening must be rigorous to ensure that the Stage 1 procedures have been followed and that there is a reasonable prospect of achieving something further in Stage 2. Equally, panels must be seen to be impartial and they must have access to the necessary expertise and advice to conduct their business. We are convinced that the procedure can be made to work whatever option is chosen for their organisation. **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.**

VIII.4 THE HEALTH SERVICE OMBUDSMAN

321 We have received the report of the Select Committee on the Parliamentary Commissioner for Administration [270] following its recent inquiry into the jurisdiction, powers, and work, of the Health Service Ombudsman. We have taken account of, and fully endorse, the Committee's recommendations as they relate to NHS complaints procedures.

322 **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** [2,33,113,118,132,140,212,220, 225,235,241].

IX. IMPLEMENTATION

IX.1 INTRODUCTION

323 The procedures we have described in Chapter VIII will need to be implemented and monitored.

324 Implementation will require the following elements which we describe in sections IX.2 – 5:

- legislation, regulation, and guidance to remove existing complaints procedures, and establish key elements of new procedures (described in our recommendations in Chapters VII and VIII);
- audit and monitoring by purchasers;
- development of training;
- resources.

325 We also propose the establishment of implementation groups within the four NHS Management Executives (IX.6) and a review mechanism (IX.7).

IX.2 CENTRAL LEGISLATION, REGULATION, AND GUIDANCE

326 If our recommendations are accepted by Government, we have been advised that primary legislation and regulation will be required certainly within England, Scotland and Wales, particularly in relation to family health services. We have not considered the detailed requirements, but trust that this will be done in a way which does not inhibit local innovation as described earlier. We hope that a suitable opportunity would be found as soon as possible within the Government's legislative programme for the necessary measures.

327 More detailed central guidance will be required, but we hope this will not be over-prescriptive. Good practice – like the examples we have identified – should be promoted in this way. Advice on good complaints handling might also be sought from such bodies as the Health Service Ombudsman (as recommended by the Select Committee on the Parliamentary Commissioner for Administration [269]) and the Audit Commission, without compromising their independence.

328 **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 [4], and co-operation with other aspects of NHS complaints procedures.**

IX.3 AUDIT

329 We believe it is essential that the operation of new procedures is enforced – and provision made for management audit – through the contractual arrangements between health authorities, family health service authorities, and health boards as the purchasers of services and their providers, whether practitioners, trusts, or other organisations.

330 Audit is necessary to ensure effective procedures are in operation while maintaining some degree of flexibility, both in response to the characteristics of individual providers (who will vary in size, management structures, etc) and to allow the development of local innovation as experience is gained in operating new procedures.

331 We see a key role for NHS purchasers, who are ideally placed to carry out or secure such audit as part of their general responsibilities in relation to the quality of services they obtain on behalf of their residents. As in other areas of quality specification, it is likely that the main purchaser will be responsible for establishing standards, and monitoring these generally. Purchasing authorities have a key role in assuring service quality. **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.**

332 While the vast majority of complaints concern operational issues that are the immediate responsibility of service providers, purchasers have a dual role in relation to two of the NHS objectives on complaints we identified in Chapter III.

333 In relation to maximising complainant satisfaction, purchasing authorities will need to make sure that their service providers have effective complaints procedures, which have been approved by the main purchaser concerned (the branding we described in Section VII.4 might be used as a form of "kitemarking"). This will mean that the purchasing authority concerned knows both that the procedures meet centrally imposed requirements, and is satisfied that complaints are being handled properly. This will particularly apply to contracts with non-NHS providers, who will not otherwise be bound by statute and guidance on complaints. One way in which poor complaints handling may be identified will be the numbers of complaints which are not resolved within Stage 1 procedures, but there will also be a need to ensure that complaints are not being suppressed at that stage, for example through poor accessibility.

334 In relation to quality enhancement, purchasing authorities will need to make sure that service providers have adequate monitoring systems to learn from complaints. Reports should be provided to enable purchasers to make their own judgements about the adequacy of quality improvements.

335 **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.**

IX.4 TRAINING

336 The NHS reforms, particularly the introduction of NHS trusts, have led to more management initiatives being taken at a local level, including adoption of communications strategies. As a recent Audit Commission report has shown [256], it is important that these strategies should give a high priority to good communications with patients. Good communications practice can also alleviate possible causes for complaint.

337 As we have argued, a more responsive approach to complaints will only take place with appropriate training programmes. Training packages might be commissioned by the Implementation Groups (see IX.6 below), who would seek input to course syllabuses for professional and other training; organise courses/conferences; and could approve training organisations and/or courses. Links might be established with particular educational authorities or training bodies.

IX.5 RESOURCES

338 The proposals we make will require resources to implement and administer. Resources are currently consumed by existing procedures which largely fail to meet the needs of both the NHS and its users. Opportunities are also being missed to improve services, which might make them more cost effective.

339 Available resources should be redirected into better complaints handling and training. Clearly the level of resources required for complaints handling is related to the numbers of complaints received. We make no apology – and believe the Government should take the same position – for welcoming in advance the increases in the numbers of recorded complaints we anticipate if accessibility and recording are improved. However, our proposals also involve a greater proportion of complainants being satisfied by the first response they receive, rather than requiring consideration by more formal mechanisms, so the resources required will not increase proportionately. Overall some increase in resources for complaints handling is likely to be required, although this should be offset against savings from quality enhancement.

IX.6 IMPLEMENTATION GROUPS

340 In order to place responsibilities within the central management of the NHS, **we recommend that implementation should be managed through four Implementation Groups within the Management Executives of the four UK countries**, who will be able to take steps over a period of time to prepare for and implement the varying changes required in those countries, and act as locuses of expertise. The Implementation Groups should manage the introduction of the new complaints system, and we believe they should have a lifespan defined in advance of not more than two years.

IX.7 REVIEW MECHANISM

341 While we recognise the role of the Health Departments in achieving implementation, we are concerned that there should be some independent oversight of this. **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.** This review might be linked to the annual publication of a complaints bulletin recommended earlier (see para. 225). In England the review might be chaired by a non-executive member of the NHS Policy Board.

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).

ANNEX A – LIST OF MEMBERS

Professor Alan Wilson (Chairman)
Vice-Chancellor, University of Leeds

Professor Judith Allsop
Professor of Health Policy, South Bank University; member, Citizen's Charter Complaints Task Force

Dr Ewen Bramwell MBE
Retired General Practitioner; Medical Advisor to Surrey FHSA and South West Thames RHA

Mr Chris Dabbs
Chief Officer, Salford Community Health Council

Mr Steve Forster
Operations Manager of Aluminium Division, London and Scandanavian Metallurgical Co. Ltd; member, Rotherham FHSA

Mrs Vivienne Harpwood
Director, Medico-legal Studies Unit, University College of Wales, Cardiff

Mrs Deirdre Hutton
Chair, Scottish Consumer Council

Mr John James
Chief Executive, Kensington and Chelsea and Westminster FHSA

Mr Pat Killen
Managing Director, Tyrone Crystal; Chairman of the Northern Ireland Citizen's Charter Advisory Panel

Dr Bruce MacGillivray
Lately Consultant in Clinical Neurophysiology and Neurology, Royal Free Hospital

Rabbi Julia Neuberger
Chair, Camden and Islington Community Health Services NHS Trust; Vice President, Patients Association

Mrs Irene Scott
Nurse Executive Director, Christie Hospital

Observers

Mr Richard Oswald, Deputy Health Service Commissioner

Ms Isabelle Low, Scottish Home and Health Department

Ms Kate Cassidy, Welsh Office

Mr Allan Gault, Department of Health and Social Services, Northern Ireland

Secretariat

Mr Neil Paterson (Secretary)

Ms Claire Potter

Mr Mark Trout

Ms Elizabeth Connell

ANNEX B – LIST OF EVIDENCE

1. STATUTORY OFFICERS

Mrs Jill McIvor, Ombudsman, Northern Ireland [98]
Mr William K. Reid, Health Service Ombudsman [47]

2. NATIONAL ORGANISATIONS

Action for Victims of Medical Accidents (AVMA) [210]
Action Group for the Relief of Pain and Distress [233]
Association of Community Health Councils of England and Wales (ACHCEW) [1,16,161]
Association for Improvements in the Maternity Services (AIMS) [227]
Audit Commission [99]
College of Health [243]
Consumer Association [3]
Council on Tribunals [214]
Law Society of Scotland [181]
Medical Defence Union Ltd [137]
Medical Practitioners Union [247]
Medical Protection Society [11,170]
MENCAP [239]
Mental Welfare Commission for Scotland [79]
Mental Health Commission for Northern Ireland [87]
National Association of Health Authorities and Trusts (NAHAT) [2,5,185]
National Association for Mental Health (MIND) [236]
National Consumer Council [14,241]
National Development Team for People with Learning Difficulties [191]
NHS Support Federation [29]
NHS Trust Federation [231]
Patients Association [237]
Prevention of Professional Abuse Network (POPAN) [230]
Scottish Association of Health Councils [162]
Scottish Consumer Council [190]

3. PROFESSIONAL BODIES

Association of Health Centre and Practice Administrators [120]
Association of Optometrists [180]
Association of Senior Managers, Northern Ireland [148]
British College of Optometrists [173]
British Dental Association [165]
British Medical Association [117]
Chartered Society of Physiotherapy [207]
Council for Professions Supplementary to Medicine [200]
Dental Protection Ltd [152]
English National Board for Nursing, Midwifery and Health Visiting [25]
General Medical Council [7,160,252]
General Medical Services Committee [4]

General Optical Council [19]
Health Visitors Association [145]
Institute of Health Services Management [225]
Joint Consultants Committee [91]
Royal College of Anaesthetists [78]
Royal College of General Practitioners [39,46]
Royal College of Midwives Trust [85]
Royal College of Nursing [142]
Royal College of Obstetricians and Gynaecologists [133]
Royal College of Physicians [115]
Royal College of Surgeons of England [193]
Royal Pharmaceutical Society of Great Britain [174]
Scottish CAMOs Group [127]
Scottish Pharmaceutical General Council [155]
United Kingdom Central Council for Nursing, Midwifery and Health Visiting [67]

4. HEALTH AUTHORITIES

Regional Health Authorities

North East Thames Regional Health Authority [140]
Northern Regional Health Authority [18,135]
South West Thames Regional Health Authority [159]
Family Health Services Appeal Unit, Yorkshire Regional Health Authority [182]

District Health Authorities

Bath District Health Authority [118]
Bromley Health Authority [202]
Camberwell Health Authority [178]
Ealing, Hammersmith and Hounslow Health Authority [209]
Leicestershire Health [77]
Northampton Health Authority [89]
Redbridge & Waltham Forest Health Authority [197]
St Helen's and Knowsley Health Authority [68]

Family Health Service Authorities

Barnsley FHSA [96]
Berkshire FHSA [43]
Birmingham Family Health Services [144]
Brent and Harrow FHSA [215]
Cheshire FHSA [64]
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9. **OTHERS**

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24. Mrs C. Buck, Nottinghamshire
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26. Mrs J. Brown, Cambridgeshire
27. Mr J. Santcross, Middlesex
28. Mrs S. Deighton, Surrey
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30. Mrs Y.E. Buckoke, Bristol
31. Mr F.C. Lambert, Middlesex
32. Ms J. Burnett, Southampton
33. Mrs A. Wilks, Kent
34. Llandough Hospital NHS Trust
35. Mrs M.A. Cassidy, Cleveland
36. Mrs P. Moberly, London
37. Mr Tom Richardson, Oxford
38. Mr J. Farr, Buckinghamshire
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226. Mr Martin Ibbitt, Cambridge
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228. Dr Lawrence Singer, Essex
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ANNEX E – NHS COMPLAINTS PROCEDURES

I. INTRODUCTION

1 Separate complaints procedures have developed for primary care and hospital services and there is no integration between the procedures themselves. The reasons are largely matters of history. The two elements of the NHS developed separately and there is also a different legal basis for managing the two services. Staff working in the hospital services are mostly directly employed by the NHS. Although subject to monitoring and review by the FHSA or Health Board, GPs, dentists, opticians and pharmacists (who provide the bulk of primary care services) are independent contractors who provide certain services to the NHS and have considerable autonomy in how they go about providing those services.

2 In England and Wales the management arrangements relating to family health and hospital and community services are also distinct. Family Health Service Authorities and District Health Authorities (respectively) are responsible for purchasing the services in question. In Scotland and Northern Ireland the management arrangements are the responsibility of health boards which act both as contractor for primary care and purchaser of secondary care. Health boards are therefore responsible both for monitoring the handling of complaints and for investigating possible breaches of terms of service by GPs, GDPs, opticians and pharmacists. If other changes are not made, this situation will be mirrored in England if DHAs and FHSAs are permitted to merge.

II. PRIMARY CARE PROCEDURES

II.1 Introduction

3 Primary care services largely consist of those provided by general practitioners (GPs), dentists, opticians, and pharmacists, and staff employed by them. Complaints must be made to the local family health services authority (FHSA) or health board where they can be handled under either formal or informal procedures. Complaints must normally be made within 13 weeks (6 weeks in Northern Ireland) of the event complained of (but see para. 17 below for dentists).

II.2 Informal procedures

4 In England and Wales, FHSAs have been directed to establish informal procedures, under which a lay conciliator appointed by the FHSA can attempt to settle the differences between the complainant and the practitioner and/or restore the patient-practitioner relationship. The lay conciliator should have access to professional advice. The Patient's Charter sets a target of one month for complaints to be cleared in this way. In Scotland, a Board officer may seek to achieve a reconciliation through correspondence and this informal procedure is often used. In Northern Ireland, recognised informal procedures only exist for complaints against GPs. The GP Advisor to the Health and Social Services Board investigates the complaint and tries to resolve any differences between the complainant and the GP with the objective of restoring the patient/practitioner relationship.

5 Under the Patient's Charter, GPs have been encouraged to establish practice-based procedures. Under these procedures complaints may be made to a named contact within the practice, without prejudice to further investigation or referral under more formal procedures.

6 If the complainant remains dissatisfied, the formal procedure can be used, but only where the contractor may be in breach of his or her terms of service – the contractual arrangements governing NHS work. So, for example, complaints about failures to visit can be considered under the formal procedure but those about attitude cannot, unless it can be argued that they led to a breach of the contractor's terms of service eg a GP was rude and therefore did not obtain from the patient the full details of his or her illness.

11.3 Formal procedures

7 The formal procedure involves an investigation by a service committee which may either be handled entirely through correspondence or involve a hearing. The complaints are handled by the relevant FHSA or health board, except in Northern Ireland where they are handled on the behalf of the Health and Social Services Boards by the Central Services Agency.

8 In England, Northern Ireland, Scotland, and Wales in 1992, 2 350 complaints were formally investigated in this way, of which 1 688 related to general medical services, 533 to general dental services, 111 to pharmaceutical services, and 18 to ophthalmic services.

9 Service committees normally have five to seven members (the quorum is five): two or three lay members, two or three members drawn from the same profession as the contractor who is the subject of the complaint, and a lay chair. Hearings take place in private. The parties are not allowed to be legally represented, though they can be accompanied by a friend or advisor. If a service committee finds a practitioner is in breach of his terms of service, they can recommend penalties which could include a withholding of remuneration. In England, Scotland, and Wales in 1992, breach was found in 715 (30%) of the 2 324 cases investigated, with a decision to withhold renumeration in 281 (40% of cases where a breach was found).

10 Service committee recommendations are referred to the FHSA for decision in England and Wales, for endorsement by the relevant health board in Scotland and Northern Ireland and Scotland, before they can be put into effect. In Scotland where the health board considers a withholding from renumeration would be appropriate, the final decision rests with the Secretary of State. Service Committee's findings of fact must be accepted as conclusive but their recommendations may be accepted or others substituted. The standard of proof is the civil standard, and may be flexible depending on the seriousness of the case.

11 Complaints can only be made about locums or deputising service doctors if the patient's doctor made proper deputising arrangements and the deputising doctor is on the FHSA's medical list. If these conditions are not satisfied the complaint has to be made about the GP who employed the deputy.

12 In England and Wales, the Regulations set a time limit of 13 weeks after the event which is the subject of the complaint within which complaints against GPs must be made. In Northern Ireland, this time limit is six weeks.

II.4 Appeals

13 Appeals may be made against the decision of an FHSA or health board to the relevant Secretary of State if it has been handled under the formal procedure. In England, Northern Ireland, Scotland, and Wales in 1992, appeals were made against FHSA decisions in 630 cases (26% of FHSA decisions, nearly twice as many as in 1991), 473 by complainants and 162 by practitioners. Only 32 of these appeals were allowed to complainants and 14 to practitioners.

14 The appellate function for England was delegated in April 1992 to Yorkshire RHA who carry it out via the Family Health Services Appeal Unit. The Unit either considers the appeal on paper or holds an oral inquiry, and may also receive advice in England from the Medical or Dental Advisory Committee – a statutory professional body which will advise on penalties when a withholding over £500 is recommended. Although there appears to be a widespread misconception that withholdings from GPs or dentists over certain amounts lead to an automatic referral [7], health authorities and boards, and the Director of the Appeal Unit, do not refer cases automatically.

15 In Scotland and Northern Ireland, the appellate function is handled by the Scottish Home and Health Department and the Department of Health and Social Services respectively. In Wales, the administration has recently been devolved to the Welsh Health Common Services Authority, though control of its activities in this respect and the decision making rests with the Welsh Office.

16 A formal decision is given on the appeal which is final, unless the complainant can construct a case for judicial review by the courts. No formal time limits are applied to the appeals process.

II.5 Dental services

17 Complaints about NHS dental treatment are subject to the procedures described above but differ in the following respects:

* complaints must usually be lodged within six months after completion of the treatment which is the subject of the complaint, or thirteen weeks after the matter which is the subject of the complaint comes to the complainant's notice, whichever is the earlier (in Northern Ireland these limits are six months and six weeks respectively);

* in England and Wales the Dental Practice Board (in Northern Ireland the Central Services Agency), which monitors dental practice, may use the complaints procedures where they feel a dentist is deliberately over prescribing or utilising "unusual" treatment plans;

* the Scottish Dental Practice Board (SDBP) can draw to the attention of Health Boards instances where there is cause for concern about the services provided by a dentist – the SDPB cannot themselves act as a complainer in terms of the Regulations;

* FHSAs in England and Wales may set up a special "dental conciliation committee" to deal with complaints about the fit or efficiency of dentures (there is no similar provision in the Scottish regulations);

* where a complaint is upheld, the relevant service committee may recommend that a dentist be required to submit estimates for prior approval of the Dental Practice Board (in Northern Ireland, the Dental Committee of the Central Services Agency) before commencing specified course(s) of treatment for a specified period.

II.6 Optical services

18 NHS procedures cover complaints made about services provided as part of general ophthalmic services. Formal complaints are dealt with under the same procedures as those for other primary care services (see above), although the numbers of complaints considered by Service Committees are very few in number (12 in England in 1992).

19 In 1992 the optical professional bodies established the Optical Consumer Complaints Service, an independent complaints service [19]. This – and the decreasing role played by the NHS in optical services – has lead to Optical Service Committees being all but abandoned in many parts of England.

II.7 The NHS Tribunal

20 The NHS Tribunal investigates representations that a practitioner's continued inclusion in a Health Board/FHSA's medical, dental, ophthalmic or pharmaceutical list would be prejudicial to the efficiency of the service in question. Any person or body may make representations to the Tribunal at any time, but this action is normally taken by FHSAs. Following an investigation, usually by means of an oral hearing, the Tribunal may direct that a person's name be removed from an FHSA's relevant list and also from all equivalent lists if that is appropriate. Witnesses may be called to these hearings and the parties may be legally represented. Orders for costs can also be made. The Tribunal Chairman is appointed by the Lord Chancellor and there is a standing lay member.

21 A respondent may appeal to the Secretary of State against a decision of the NHS Tribunal and, if this happens, an oral hearing must be held. The Secretary of State appoints someone to hold the inquiry and report to her and that person is assisted by a practitioner from the relevant profession. Witnesses may be called and the parties may be legally represented. The Secretary of State's decisions on these appeals is final and conclusive.

22 Practitioners may subsequently apply to the Tribunal or the Secretary of State that he or she should no longer be disqualified for inclusion in an FHSA's list.

23 A separate NHS Tribunal exists in Scotland. The Chairman is appointed by the Lord President of the Court of Session. The other two members (a lay person and a practitioner member) are appointed by the Secretary of State for Scotland. It has rarely met – about once every six or seven years. A separate Tribunal also exists in Northern Ireland. The Chairman is appointed by the Lord Chief Justice and must be legally qualified. The other two members are appointed by the Department of Health and Social Services and the Secretary of State for Northern Ireland respectively. It has not met since 1984.

III. HOSPITAL PROCEDURES

III.1 Non-clinical matters

24 Each hospital or group of hospitals must have a designated complaints officer to whom complaints can be made. The identity and location of the designated officer should be made known to patients, visitors, staff, and local health councils.

25 In Northern Ireland, complaints which are not dealt with verbally at source and are registered in writing are handled by a nominated officer within each provider unit such as a trust.

26 The designated officer should investigate the complaint, ensuring that the complainant and any staff involved have the opportunity to provide information or make comments. They are advised to seek legal advice if they consider a complaint carries a threat of litigation. On completion of the investigation the complaints officer writes to all the parties informing them of the reasons for any failures and what is being done to ensure they do not recur. In Northern Ireland, complaints must be acknowledged within three days and an investigation completed and reply sent within a month.

27 In England in 1991/92, 44 680 complaints were made in hospital under this procedure, of which 19 410 (43%) were recorded as being wholly or partly clinical. This represents five per thousand in-patient and day cases (with a Regional variation of under four per thousand in Northern and Oxford, and over seven per thousand in three of the Thames Regions and the postgraduate SHAs). In Scotland, information on hospital complaints has only been collected since last April. The Management Executive in the Scottish Home and Health Department estimate that 6 000 hospital complaints are received annually.

28 There are separate procedures for dealing with complaints about matters of clinical judgement, serious untoward incidents, disciplinary proceedings, physical abuse of patients, and possible criminal offences.

III.2 Hospital clinical complaints procedure

29 The clinical complaints procedure is an agreement between the Departments and the medical and dental professions reached in 1981. It applies to complaints concerning the exercise of clinical judgement by hospital doctors and dentists.

30 In the first stage, a complaint concerning clinical judgement is looked into by the consultant in charge of the patient who is encouraged to see the complainant and discuss their anxieties to resolve the complaint. If the complainant is dissatisfied, in the second stage the Regional Director of Public Health (RDPH) is informed of the complaint and discusses it with the consultant concerned. At this stage the consultant may have further discussions with the complainant and the RDPH may also see him or her.

31 If the complainant is still dissatisfied, and the RDPH considers it appropriate, the complaint may proceed to a third stage of Independent Professional Review (IPR). At this stage two independent consultants working in the same specialty in different parts of the country are nominated as "second opinions" by the Joint Consultants Committee to look at all the notes, discuss the case with the clinicians concerned and discuss the issues with the complainant in the context of a further medical consultation. Following this, the "second opinions" make a report to the RDPH who decides what comments should be passed on to the complainant and the hospital. If appropriate, the "second opinions" have discussions with the medical staff concerned to help avoid a recurrence. In England in 1992/93, there were over 200 IPRs, although this hides a Regional variation between 36 in South East Thames and one and two in East Anglian and Oxford respectively.

32 Wales, Scotland, and Northern Ireland operate similar procedures. The Welsh Office appoints Medical Officer (Complaints) (there are currently two) to perform this work. Although based in the Welsh Office, they are perceived by the public to act independently. In Scotland, the Chief Administrative Medical Officer (CAMO) of the Health Board currently performs the role of the Regional Director of Public Health and in Northern Ireland this is performed by the Boards' Chief Medical (or Dental) Officer. In Scotland in 1991 there were 11 IPRs.

IV. PROCEDURES FOR COMMUNITY SERVICES AND COMMUNITY CARE

33 NHS community services have no specified complaints procedures but are exhorted by the relevant Government departments to follow similar processes to the hospital complaints procedure. In England in 1991/92, 6 400 complaints were made, of which 1 420 (22%) were recorded as wholly or partly clinical. In Scotland, information on community services complaints has only been collected since last April. The Management Executive in the Scottish Home and Health Department estimate that 500 community services complaints are received annually.

34 Directions issued under the NHS and Community Care Act 1990 require local authorities to operate complaints procedures in relation to their social service functions. Authorities should first try to resolve complaints informally but, if this fails and a formal complaint is lodged, they must give a full written response within specified time limits. If the complainant remains dissatisfied, they can ask that their case be referred to an independent review panel, including at least one independent member. The local authority will decide how to act in the light of the panel's recommendations.

35 The Children Act 1989 requires local authorities, voluntary organisations, and registered children's homes to establish procedures to consider representations, including complaints made by or on behalf of children. An independent element must be included in the procedures. The Children (NI) Order 1994 will make similar provisions for Health and Social Services Boards in Northern Ireland.

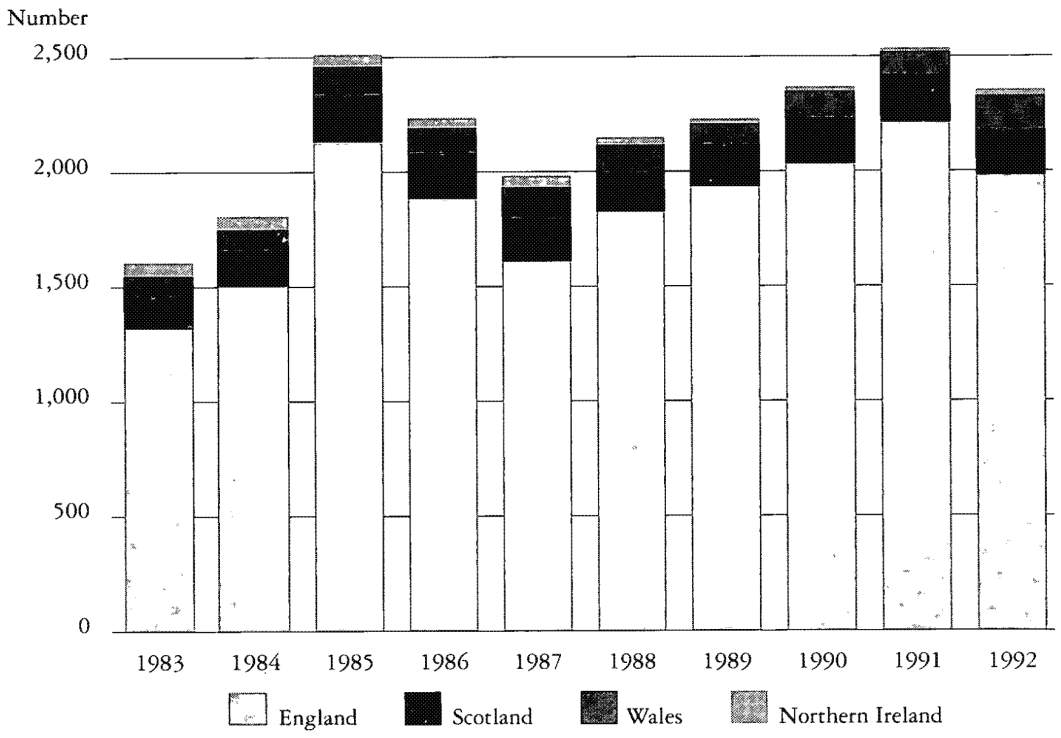
ANNEX F – STATISTICS

FAMILY HEALTH SERVICE COMPLAINTS 1983 to 1992

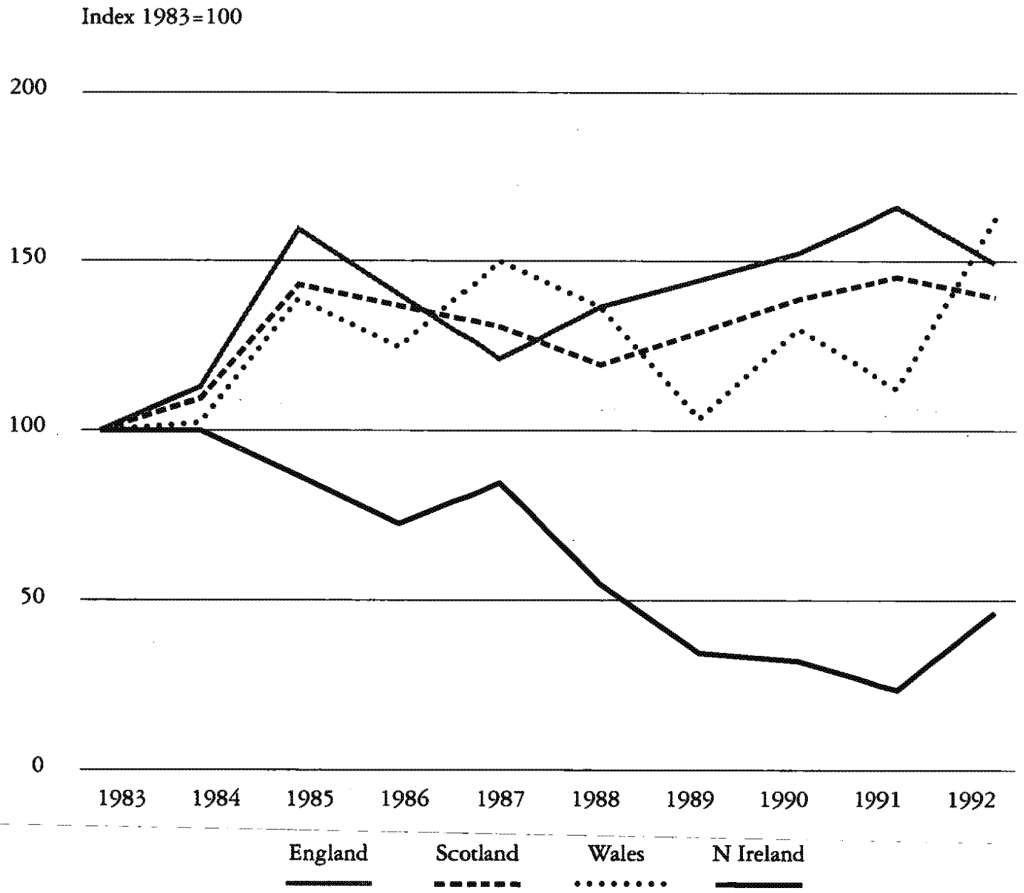
	England	Scotland	Wales	N Ireland	UK
1983	1313	142	91	55	1601
1984	1496	158	94	55	1803
1985	2123	207	129	48	2507
1986	1875	200	115	40	2230
1987	1603	188	139	47	1977
1988	1818	172	124	30	2144
1989	1927	184	94	19	2224
1990	2025	200	120	18	2363
1991	2205	209	102	13	2529
1992	1974	199	151	26	2350

Figures given are for formal investigations by Service Committees.

FAMILY HEALTH SERVICE COMPLAINTS 1983 to 1992



FAMILY HEALTH SERVICE COMPLAINTS 1983 to 1992



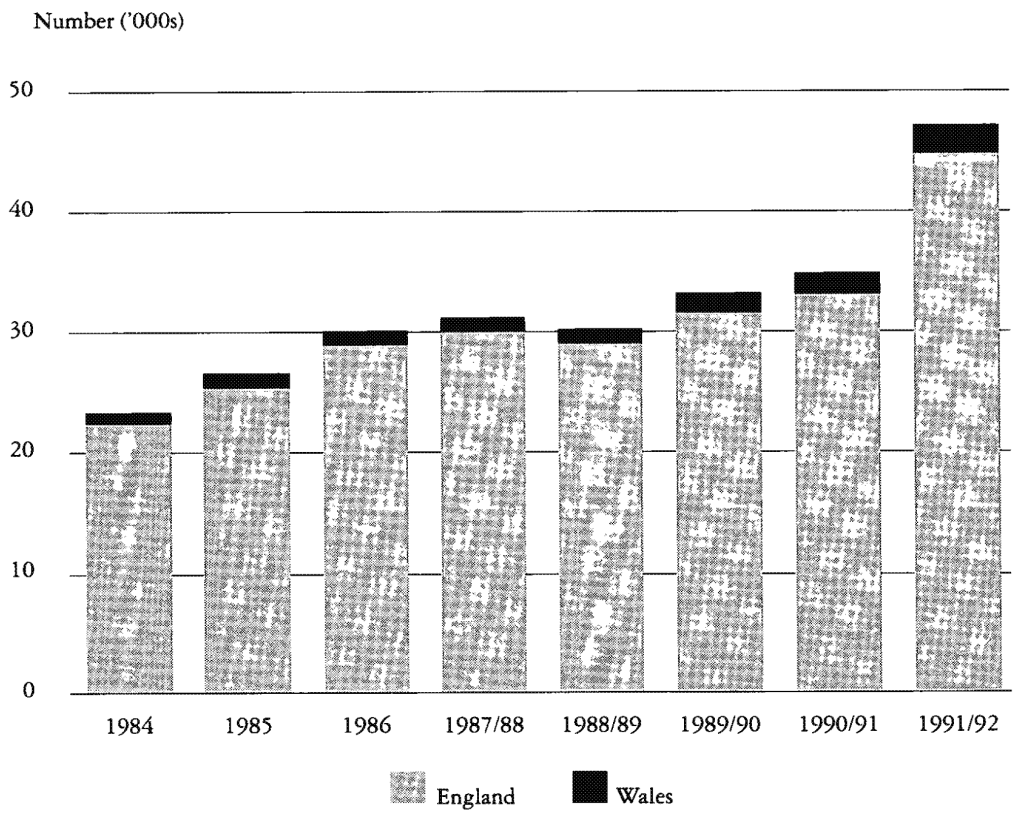
HOSPITAL COMPLAINTS 1982 to 1992[1]

	England	Wales[2]
1982	16,218	—
1983	19,255	—
1984	22,354	981
1985	25,336	1,264
1986	28,872	1,216
1987/88	29,956	1,213[3]
1988/89	28,935	1,267
1989/90	31,467	1,683
1990/91	32,996	1,800
1991/92	44,680	2,377

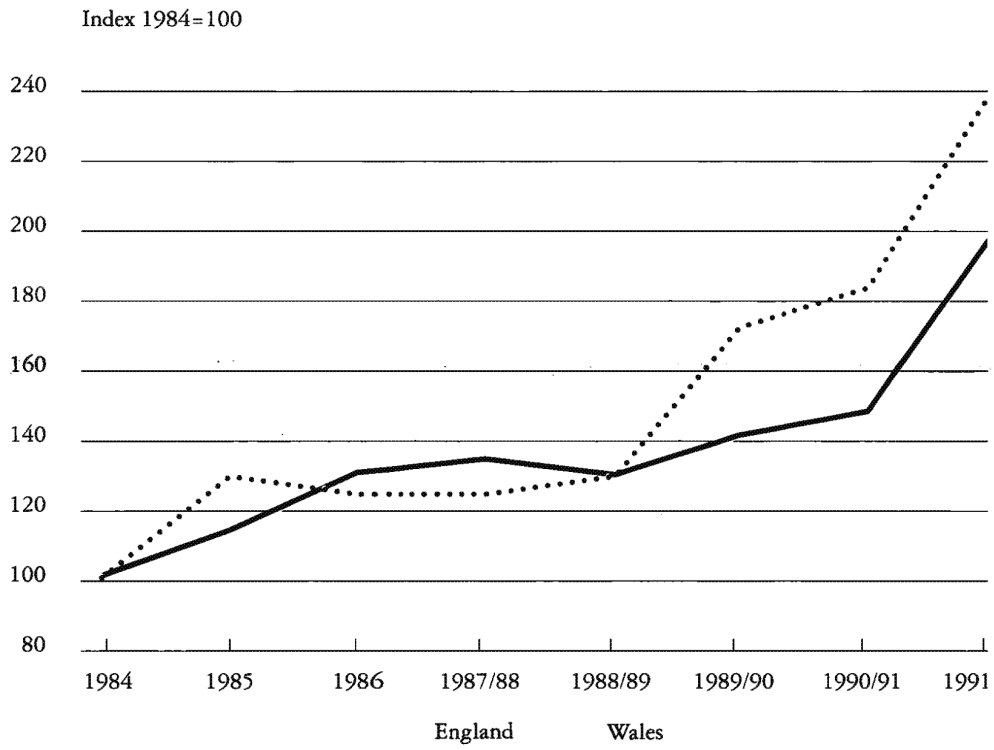
Figures given are for formal complaints (total clinical and non-clinical).

1 Figures not collected for Northern Ireland and Scotland prior to 1992.
2 Figures for Wales not available before 1984.
3 Figure for calendar year of 1987.

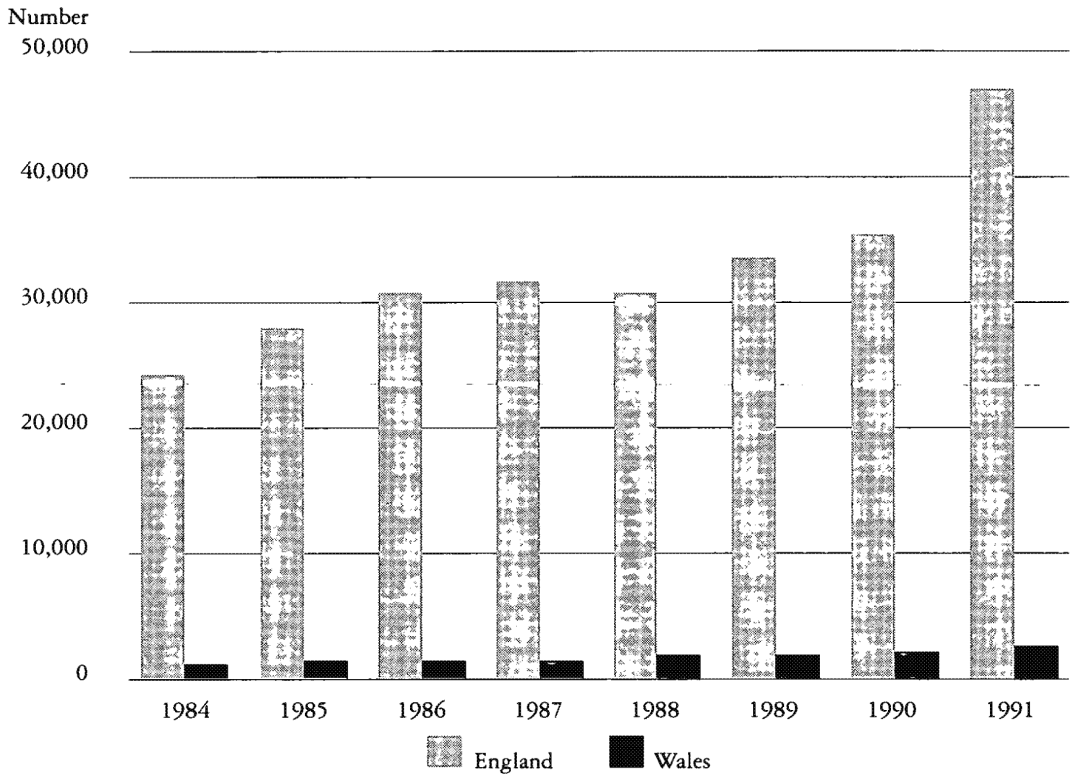
HOSPITAL COMPLAINTS 1984 to 1992



HOSPITAL COMPLAINTS 1984 to 1992



COMPLAINTS: Family Health Service and hospitals 1984 to 1991



From 1987 hospital complaints for year beginning 1 April

ANNEX G – GLOSSARY

community services	services provided in a community setting such as community nursing carried out by health visitors, community psychiatric nurses
complaint	an oral or written expression of dissatisfaction
conciliation	an attempt by a third party to resolve a dispute by bringing the two sides together
district health authority	the authority in England and Wales responsible for purchasing hospital and community services on behalf of its resident population
family health services	NHS services provided by independent contractors (GPs, dentists, pharmacists, and opticians)
family health service authority (FHSA)	the authority in England and Wales responsible for family health services
grievance	the cause of dissatisfaction leading to a complaint
health authority	a district health authority in England and Wales
health board	the board in Scotland and Northern Ireland responsible for obtaining family health, hospital, and community, services
health council	a Community Health Council in England and Wales, Local Health Council in Scotland, and Health and Social Services Council in Northern Ireland, which represents the public interest in NHS services
Health Departments	the Department of Health in England; Scottish Home and Health Department; Welsh Office, Health and Social Work Department; and Department of Health and Social Services in Northern Ireland
investigation	the obtaining and consideration of oral and/or written evidence
NHS Management Executive	the head office(s) of the NHS within the Health Departments in England, Scotland, Wales, and Northern Ireland
practitioners	general practitioners and other independent contractors such as dentists, pharmacists, and opticians
provider	any organisation which provides services to NHS patients
purchaser	district health authorities and GP fundholders who obtain health care services for the people in a given area or who are registered with a particular practice
respondent	the person or organisation which responds to a complaint
staff	all directly employed NHS staff

ANNEX H – SUPPORT AND TRAINING

I. INTRODUCTION

1 This annex describes the arrangements for providing support to complainants and respondents. We go on to describe the training that is available for those who process and respond to complaints. We also give details of current initiatives and good practice in both areas.

II. SUPPORT FOR COMPLAINANTS

II.1 Information

2 The most important form of support for dissatisfied people is the information made available about how to make a complaint. There is a centrally produced leaflet about the FHS procedures in England. Information on hospital procedures is most often incorporated in admission booklets. The freephone Health Information Services established in 1992 provide information about how to complain. Information is also often provided by health councils (see below).

II.2 Health councils (Community Health Councils, Local Health Councils, and Health and Social Services Councils)

3 Health councils – in England and Wales, Community Health Councils; in Scotland, Local Health Councils – were established in 1974. In Northern Ireland, Health and Social Services Councils were established in 1991 and carry out a similar role to other health councils, although their responsibilities also include personal social services. Health councils were introduced to represent the interests in the health service of the public. With certain exceptions (for geographical or other reasons) there is one health council in each health authority or health board area.

4 Health councils can assist members of the public to complain about services provided by the NHS in several ways. Health councils can:

- provide information on the relevant complaint procedures;
- advise the public on complaints, including advice for service users of the possible consequences of their complaint and what is appropriate to complainant's wishes and aims;
- help users in the making of complaints including help in the drafting of the correspondence of the complaint; ensuring response times are met on the behalf of the complainant; acting as the complainant's "friend", representative and advocate, during Service Committee Hearings, informal conciliation sessions, etc.

5 Health councils are not under a statutory obligation to provide this assistance, although guidance from the Health Departments has recognised their role in supporting complainants.

6 Complaints make large demands on the limited resources of health councils, with much Chief Officers' time being devoted to assisting the public in making complaints about NHS services. Only a few health councils (such as Barnsley, Bradford, Leeds, and Nottingham) have designated complaints advisers whose sole remit is to assist the public with complaints.

11.3 Advocacy

7 Advocacy can also be provided to counter the imbalance, either real or perceived, between the users and providers of NHS services. This is particularly true in the case of long-term users and/or those belonging to priority care groups; such as people with learning difficulties or with mental health problems. Various types of advocacy have been identified as follows.

11.3.1 Enabling/representative advocacy

8 In representative advocacy an external, independent advocate acts on behalf of an NHS user in making a complaint, or enabling the complainant to do so. This includes roles played by health councils (see above), CABx, voluntary organisations, and charities.

9 There are four pilot studies under way in Scotland in Dumfries and Galloway, Fife, Lothian, and Grampian, testing a variety of approaches in supporting patients. These include different client groups such as the physically disabled, people with learning difficulties, patients in an acute hospital and people in a rural setting.

11.3.2 Citizen advocacy

10 Citizen advocacy involves partnerships between unpaid citizens and individuals, the advocate then supporting and representing the views of their partner. This is particularly effective for those in priority care groups and is mainly used in relation to oral complaints.

11.3.3 Self-advocacy

11 This can be based on user only groups, such as patients' councils, usually based in a particular client group. It can provide a forum for voicing concerns to the service providers. This form of self-advocacy is thought to be particularly effective in long term care priority care situations, where clients may feel that their treatment would suffer as a result of their lodging a complaint. Here the client can register their complaint through the self-advocacy group while maintaining personal anonymity. This form of advocacy is often facilitated through charities.

11.3.4 Patient's representatives

12 Patient representative officers were first established in the USA in the 1960s. In a project by the National Association of Health Auhtorities and Trusts (NAHAT) funded by the NHS Management Executive, pilot sites have been established at Brighton Health Care NHS Trust and Frenchay Healthcare NHS Trust. Here the Patient's Representatives have two main tasks:

a. to respond directly to patients and relatives who feel their concerns are not being resolved in a satisfactory manner. This deals with patients' issues quickly and prevents problems escalating;

b. to work with other staff to improve services so that they become more patient-focused and so that problems experienced by patients are less likely to occur again.

There are many similar posts already in existence around the UK and the NAHAT project aims to provide a forum for discussion of views and experiences for those in similar posts throughout the NHS.

III. SUPPORT FOR COMPLAINT RESPONDENTS

13 When a complaint is made against an individual that person is likely to be concerned. Depending on the nature of the complaint – and the respondent – these concerns may range from irritation to serious worries about the effect on their reputation or even their employment.

14 At present, staff may be informed that the services of a staff organisation or professional defence union are available to them.

IV. TRAINING

IV.1 FHSA training

IV.1.1 Lay conciliator training

15 A training scheme has been devised for lay conciliators as collaboration between the National Association of Family Mediation and Conciliation Services and the College of Ripon and York St.John, funded by the Department of Health through NAHAT. The course is made up of four modules: the first two are theoretical, dealing with the structures and procedures of the FHSA complaints systems; the third module is a two day training course in conciliation using skills based role playing. The fourth module deals with feedback from complaints and quality issues.

16 In the past individual authorities have given locally based training to their staff and conciliators. This new initiative is an attempt to set up a standardised national programme of training. The people who are expected to attend the course are FHSA complaints officers, professional advisers and of course FHSA lay conciliators. Pilot courses have been run in Bradford and Birmingham, and further courses are to commence this autumn.

IV.1.2 Service Committee staff training

17 This consists of a local based two-day skills training course for service committee members in England. It was developed as a collaboration between the London FHSA Complaints Consortium and The Industrial Society funded through NAHAT. The course has been piloted and dates for subsequent courses have been offered. The course caters for 12 to 14 participants comprising of service committee chairmen, professional and lay members. The Welsh Office have decided to subscribe to the training scheme and courses should also be available in Wales. In Scotland, Health Boards are responsible for arranging training for their Service Committee members.

IV.1.3 Training for trainers

18 This course has been designed on the basis that the most cost effective way forward for training service committee members will be for FHSAs to train their own staff. Run by The Industrial Society, this course will train the future trainers of service committee members.

IV.1.4 FHSA complaints staff training

19 This is a course run by the South Bank University for FHSA staff handling complaints and forms part of the course for Postgraduate Certificate in General Practice Management.

IV.2 Hospital complaints training

20 There are local initiatives run by individual trusts giving some training in complaints handling. For example, the induction course attended by all new staff at Wakefield and Pontefract Community Health NHS Trust which includes a lecture on complaints by the Chief Officer of the Community Health Council for one of the two towns.

ANNEX I – UK PUBLIC AND PRIVATE SECTOR COMPARISONS

Organisations interviewed by Peter Gibson Associates:

Avis Europe
Braintree District Council, Planning and Development
Brent Register Office of Births, Marriages and Deaths
Bristol Severnside Benefits Agency
British Gas
British Airways
British Telecom
Broadland Environmental Service Department
CLARENCE (Customer Lighting and Roads Enquiry Centre), Lothian District Council
Clwyd County Council – Library and Information Services
Dorset County Council – Social Service Department
First Direct
HM Customs and Excise – Edinburgh VAT Office
Ipswich Borough Council – Sports Division
Leicester City Council – Sports (Direct Services Organisation)
National Breakdown
National Consumer Council
Nissan
OFTEL
Ordnance Survey
Polaroid (UK)
Safeway
Sainsbury
Shell UK
TARP Europe
Wessex Water Customer Service Committee
West Lothian District Council

Businesses interviewed by the Committee Secretariat:

Marks & Spencer
Regional Railways Customer Relations

NOTES

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