The pain of complaining

CAB ICAS evidence of the NHS complaints procedure

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May 2005

Contents

1. Summary and recommendations

1.1 Central to the Government's NHS reforms is a radical vision of a patient-focussed health service, designed around the needs of the patients rather than the service providers. Reform of the NHS complaints procedure has been a key part of this process.

1.2 The Department of Health has described its vision for the NHS complaints procedure in terms of four principles:

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

1.3 In order to deliver this vision, changes have been made to the complaints procedure and new structures put in place, which are intended to make the system more independent, more responsive and easier to access. These have included:

- from September 2003 the provision of a statutory service – the Independent Complaints Advocacy Service (ICAS) - to support people wishing to make a complaint and
- from July 2004 the transfer of responsibility for the Independent Review stage of the complaints process to the Healthcare Commission.

1.4 In addition a Patients Advice and Liaison Service (PALS) has been put in place in every Trust, to provide information and on the spot help where patients want to resolve a problem **without** making a formal complaint.

1.5 Citizens Advice is contracted to deliver ICAS in six of the nine Regional Government areas in England, building on its existing network of CAB outlets in local communities. People are able to access specialist ICAS support either via a referral from a CAB or by dialling an 0845 telephone number.

1.6 Further changes to the complaints procedure are anticipated, in order to respond to the outcomes of the Shipman Inquiry. In addition, in March 2005, the Health Service Ombudsman published a report highlighting continued weaknesses in the complaints system and making a number of recommendations for change.

1.7 The CAB service, with its active involvement in delivering ICAS as well as its wider advice role in health settings, is well placed to contribute to this area of policy development. The evidence from ICAS bureaux provides insight into how

the complaints procedure is working for patients. In the course of their work advisers see examples of both good and bad complaints practice, and patients who are both satisfied and dissatisfied with their experience of using the process.

1.8 The vast majority of people who use the health service do not expect or need to complain about the treatment they receive. However, when they do, it is often in the context of highly distressing circumstances which may have long term consequences for their health and well being, or resulted in the death of a loved one. In such circumstances it is crucial that people's experience of using the complaints system is positive rather than painful.

1.9 This report uses evidence from CAB ICAS work to examine the extent to which the four principles outlined above are being delivered in practice.

1.10 The overall picture is of significant variation in the extent to which Trusts have embraced these principles. A key finding which runs throughout the CAB ICAS evidence is that where the complaints procedure works well, it can be a powerful force for making things better, both at the level of the individual complainant and also for the wider NHS. Patients are satisfied, complaints are settled at an early stage, litigation becomes less likely, and changes are put in place which benefit the service as a whole and make a similar complaint less likely.

1.11 On the other hand, where the complainant faces barriers in terms of access, delays, a lack of transparency or defensive attitudes, then this experience simply makes matters worse. It increases the person's frustration and distress, and the likelihood that s/he will decide to pursue the claim through the legal system, at significantly greater cost to the public purse.

1.12 This report has detailed how patients can face:

- difficulties in finding out how to access the complaints system, because of a reluctance by Trusts to advertise the procedure and support services available through ICAS
- lengthy delays at every stage of the process, as both Trusts and the Healthcare Commission fail to deal with complaints within their targets
- a culture which is defensive rather than responsive, failing to provide complainants with explanations of what went wrong, or apologies when mistakes have been made.

1.13 The result is that lessons are not learned, much needed changes are not put in place and many people are far from experiencing a patient-centred complaints system.

1.14 The report makes a number of recommendations aimed at addressing the problems it has identified.

Raising standards

1.15 We recommend that the Department of Health should set a national framework for complaints handling in order to reduce the current wide variation in practice. The framework should include core standards to ensure that complainants experience a similar service regardless of where they live, or what organisation they are complaining about. The core standards must ensure that there is clarity of expectation on both sides regarding the content of the process, timescales for the various stages, and the nature of the outcome.

1.16 We recommend that ensuring compliance with these standards is a priority for the Healthcare Commission through its regulatory functions.

1.17 We recommend that the Healthcare Commission should develop best practice guidance in complaint handling. Patients and their representatives, including ICAS providers, must be actively involved in this process to ensure that it delivers a genuinely patient-focused service. In addition the engagement of professional bodies will be crucial if the existing culture of avoidance and defensiveness is to be overcome.

Improving access

1.18 We recommend that in relation to primary care, patients should be able to make their complaints direct to the Primary Care Trust (PCT), which should also play a central role in managing and monitoring the local resolution stage of the complaints process. Such a reform would help overcome patients' reluctance to make a complaint against their local health practitioner, for fear that this will have an impact on their ongoing care. It should also mean that resources and expertise in complaints handling can be pooled, thus raising standards of local resolution.

1.19 We recommend that there should be a single portal by which complaints or concerns can be directed to the appropriate quarter. We consider this should be a national service, delivered by a body which is transparently independent of all health service providers who may be the subject of a complaint. The portal should also provide information about the advice services available, including PALS and ICAS, and should help to ensure patients are clear about the respective roles of these services and the referral protocol.

Ensuring timeliness

1.20 We recommend that the current 20 day target for completing the local resolution stage should be reviewed to ensure that it encourages both a quality and a timely response by the Trust. We propose that, in order to ensure Trusts face no disincentive to arranging meetings where appropriate within the period, the target should be extended to 30 days. At the end of the period, patients should be sent a full 'signing off' letter, which clearly signals to the complainant that the local resolution process has reached its conclusion. To provide for exceptional cases where the 30 day timescale is insufficient, there should be a specific rider enabling Trusts to exceed the time limit, in which case

they must write to the complainant giving reasons and a clear deadline by which a full response will be given.

1.21 We recommend that consideration should be given to creating incentives for Trusts not to delay responding to requests from the Healthcare Commission for additional information and documents in order to pursue their investigation. Options could include the Healthcare Commission taking the delay into account in its considerations, compensation for complainants, or requirements to take remedial action.

1.22 Adequate resources to deliver a quality and timely service must be provided if the Healthcare Commission is to maintain its credibility as a monitoring organisation. There is also a need for the Healthcare Commission to develop strategies to ensure that it can meet its six months target.

Learning from complaints

1.23 We recommend that Trusts develop mechanisms to obtain feedback from patients who have experienced their complaints handling process. Patients' views on complaints handling should be included in patient satisfaction surveys. In addition, local authority Overview and Scrutiny Committees (OSCs) and Patient and Public Involvement (PPI) Forums, should monitor views from patients and advice providers, such as ICAS, regarding the quality of local complaints handling.

1.24 We recommend that a protocol should be set up so that all NHS Trusts and PCTs send copies of their complaints and PALS reports to the PPI Forums and to the local authority OSCs which are responsible for scrutinising their work.

1.25 We recommend that PPI Forums and OSCs should be kept informed of any outcomes from complaints which involve undertakings by Trusts to implement changes, so that they can check that these are put into effect. PPI Forums and OSCs should inform the Healthcare Commission when they have concerns that Trusts have not acted on undertakings that they have made.

1.26 We recommend that guidance and protocols are developed as a matter of urgency regarding reporting arrangements about trends in adverse incidents between ICAS, PPI Forums and OSCSs. This must be done in a way that does not compromise patient confidentiality. It is crucial that such developments are not delayed as a result of the reorganisation of functions from the proposed abolition of the Commission for Patient and Public Involvement in Health (CPPIH).

2. Introduction

2.1 The Government's publication in 2000 of the NHS Plan[1] heralded significant reforms to the NHS both in terms of levels of investment and service delivery. At its heart was an explicit and radical vision of a health service designed around the patient rather than the service providers.

2.2 In arguably one of the most controversial aspects of the reforms, Community Health Councils, which had provided support for complainants to a varying extent dependant on their capacity, were abolished and their various functions spread amongst a number of new bodies. These bodies (Patient Advice and Liaison Service (PALS), Independent Complaints Advocacy Service (ICAS), Patient and Public Involvement Forums (PPI Forums), local authority Overview and Scrutiny Committees (OSCs) and the Commission for Public and Patient Involvement in Health (CPPIH)) were intended to increase patient empowerment and involve patients and citizens in decision making at all levels.

2.3 Changes to the NHS complaints procedure were a key part of this reform, aimed at making the system more independent and responsive, and less adversarial. The most significant change was that in July 2004 the Healthcare Commission took over responsibility for the second stage (independent review) of the complaints procedure. This change was introduced following research[2] showing that 75 per cent of the public found the previous 'independent' review system to be unfair or biased, and neither independent nor timely.

2.4 Proposed reforms to the first stage (local resolution) were however put on hold pending the outcome of the Shipman Inquiry.

The current complaints procedure

2.5 The formal NHS complaints procedure consists of three stages:

2.5.1 Local resolution: Complaints should be made in the first instance to the NHS body providing the service. Local resolution aims to resolve complaints quickly and as close to the source of the complaint as possible, using the most appropriate means. The complaints manager should investigate the complaint, make arrangements for resolving the complaint (which may include inviting the client for a meeting and/or, with the client's agreement, arranging for conciliation, mediation or other help to resolve the complaint) and provide a written report detailing the substance of the complaint, the investigation and its conclusion. This report should be signed by the chief executive of the NHS body concerned and sent to the complainant within 20 working days.

2.5.2 Independent Review: If the complainant is unhappy with this response s/he can ask the Healthcare Commission for an Independent Review of the complaint. The Commission will send a letter of acknowledgement to the complainant and, having ensured that it has information necessary to carry out an initial review

[1] *The NHS Plan; a plan for investment, a plan for reform*, The Stationery Office, July 2000 (Cm4818-1)
[2] *The NHS Complaints Procedure National Evaluation,* Department of Health, 2001

(such as consent forms, the original case file from the initial investigation, medical records) will determine whether its criteria are satisfied for them to look further at the complaint. The Case Manager may then contact the complainant or the complained against to clarify some details and may also take advice from an expert adviser. It then has a number of options available to it including:

- referring the matter back to the NHS body where the complaint was generated with recommendations as to what action might be taken to resolve the complaint
- referring the complaint to a health regulatory body, for example, the General Medical Council
- referring the complaint to the Health Service Ombudsman
- investigating the complaint further and, if appropriate and with the client's agreement, setting up a panel
- taking no further action, if it is felt that everything that could be done has been done.

Once the investigation is complete a report will be produced, recommending what action should be taken. A copy of the report should be sent to the client, the body complained about, the primary care trust and the health authority. An investigation should be completed in six months.

If the complaint is still not resolved, then the complainant can refer the complaint to the:

2.5.3 Health Service Ombudsman: The Ombudsman's office will use its discretion as to whether to investigate the complaint, taking into consideration whether the organisation complained against has done all that could reasonably be expected to put things right. The Office may seek to resolve the complaint by analysing the evidence and sending the complainant a detailed letter, by requesting the NHS organisation or practitioner concerned to take further action, or by carrying out a formal investigation. The latter is a very thorough process which may take at least nine months. The Ombudsman aims to provide complainants with a substantive reply or a decision to investigate within two months, and to complete formal investigations within a year in all but exceptional cases.

Supporting patients and complainants

2.6 To help people resolve problems when things go wrong two new and distinct bodies have been established:

2.6.1 A Patients Advice and Liaison Service (PALS) - based in every trust since April 2002 provides information and on the spot help where patients want to resolve a problem without making a formal complaint. Its role is to provide confidential advice, support and reassurance, and to resolve small problems locally. It should help the public become more involved in the NHS and provide feedback to the NHS, in order to improve its services. Crucially PALS is not part of the complaints procedure, although it should be resourced to ensure staff are fully aware of the complaints procedure and trained to recognise and address complaints by either providing information on the complaints procedure or

referring the complainant to ICAS.

2.6.2 The Independent Complaints Advocacy Service (ICAS) - a statutory service implemented in September 2003, to provide support for people wishing to complain about their treatment or care received under the NHS. The service, which was established under the Health & Social Care Act 2001, is intended to:

- 'empower(s) clients by providing information, support and guidance, helping them to articulate their concerns and navigate the complaints system. This may include assistance with constructing a complaints letter, drafting and/or attendance at meetings
- help clients find a solution as close as possible to the point of the service that has caused dissatisfaction (Trust level), maximising the chances of the complaint being resolved quickly and effectively'.[3]

ICAS does not deal with complainants seeking financial redress. Where this is what complainants are seeking ICAS advisers will explain the option of clinical negligence, for which clients would then need to seek legal advice. The NHS complaints procedure cannot be used in conjunction with legal action.

2.7 The interface between the complaints procedure and clinical negligence will be affected by changes being introduced in legal aid eligibility rules. The Government has recently announced that in future:

> 'most applicants will be expected to pursue any available complaints system before they are funded to take proceedings. This will give the potential defendant public body the opportunity to respond to the matters raised and provide an explanation or apology if appropriate before it is decided whether litigation is the appropriate remedy for the client. The LSC will consult further on when such an approach would not be appropriate and on guidance to further encourage the use of mediation in non-family disputes'.[4]

2.8 This will have significant capacity implications for the NHS complaints procedure and those involved in its delivery, including ICAS. It will also be important that there are adequate exceptions for those cases where it is clear that the applicant will not be able to achieve an appropriate remedy through the complaints system, so that time and resources are not spent unnecessarily. In addition, it will become even more important that the NHS complaints procedure itself is conducted speedily, in order to avoid applicants experiencing the distress of a long drawn out process, and to ensure that negligence cases are not constantly hampered by the fact that they relate to incidents which happened many years previously. It also underlines the need for complaints panels to be compliant with article 6 of ECHR (Salesi v Italy).

2.9 Further changes are expected to clinical negligence litigation, with the proposal for some elements of a no-fault compensation scheme managed through an

[3] *The First Year of ICAS: 1 September 2003–31 August 2004,* Department of Health, 2004
[4] Hansard, HoC Written Ministerial Statement, 2 March 2005.

inquisitorial process.[5]

ICAS and the CAB service

2.10 Citizens Advice Bureaux (CAB) have always been a first point of reference for people wishing to establish what their rights are in respect of health complaints, and the CAB service deals with over 80,000 health-related enquiries every year. Recent years have seen steady growth in bureaux working with local healthcare providers, creating a well-documented benefit to health through CAB advice given to patients in the NHS. Within health settings, bureaux are now providing advice in 752 GP surgeries and health centres, 62 general hospitals, 75 psychiatric hospitals and165 mental health clinics.

2.11 The CAB service is therefore well placed to provide support and advice for people wishing to use the NHS complaints procedure, and Citizens Advice is currently contracted to provide the ICAS service in six[6] of the nine regional Government areas in England. The service is accessible through any of the CAB outlets in the six regions. Alternatively there are six regional 0845 telephone numbers providing direct access to a specialist support officer who will provide initial advice, take details and arrange an appointment with one of the Specialist Caseworkers who are located in 32 CAB across the six regions.

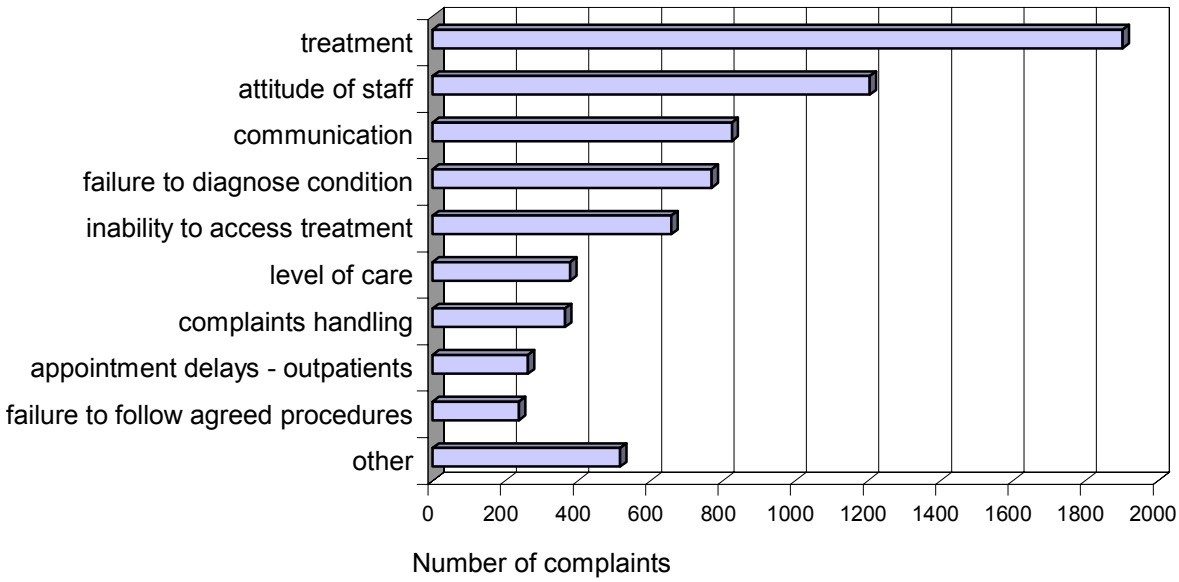
2.12 ICAS advisers assist and empower clients through the NHS complaints procedure. Between September 2003 and August 2004, ICAS CAB assisted with 8,711 complaints, over two thirds of which involved direct case worker intervention or assistance. Every client is asked for feedback on ICAS when their case is concluded, ensuring that a patient focus is built into service development. In the period September 2004 – February 2005, 88 per cent of respondents said that they were satisfied or very satisfied with the ICAS CAB.

2.13 The following tables profile some of the main characteristics of these complaints. In terms of the nature of the complaints (Table 1) the most common reasons given by clients for making a complaint were dissatisfaction with aspects of clinical treatment (22 per cent), attitudes of staff (14 per cent) and poor communication/information to patients (9 per cent).

[5] *Making Amends* , Department of Health, June 2003

[6] The CAB service delivers ICAS in London, North East, North West, South West, West Midlands and Yorkshire and Humberside regions.

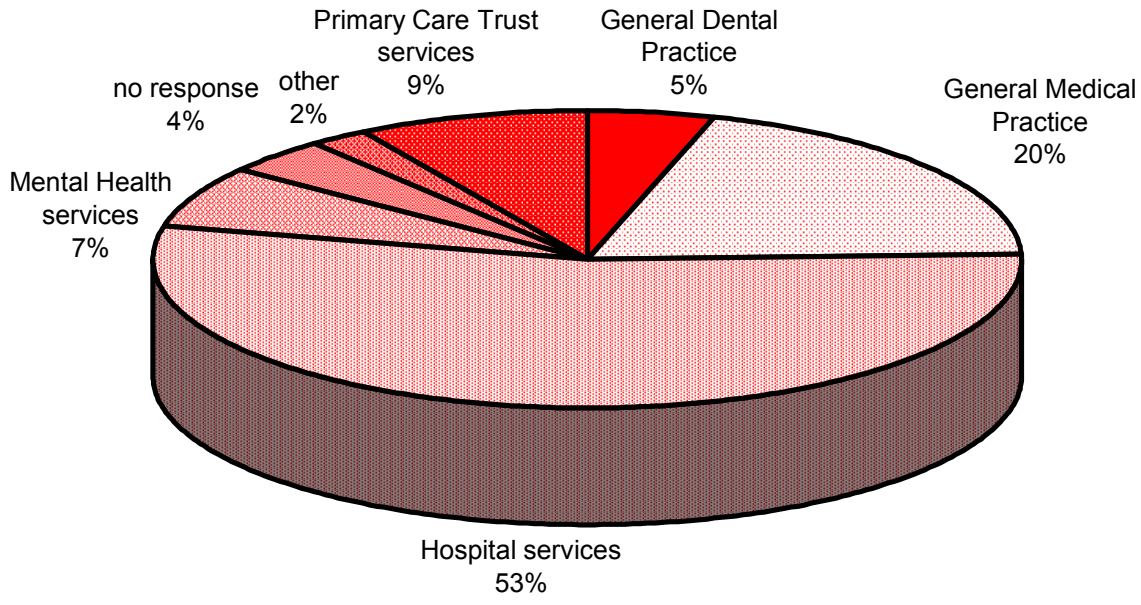
Table 1 - Top 10 nature of complaints (Sept 2003 - Aug 2003)



Base 8711

2.11 The majority of complaints related to hospital services (53 per cent), which accounted for more than twice as many complaints as any other service provider. However, general medical practices, mental health services and Primary Care Trusts (PCTs) also featured regularly.

Table 2 - Complaints against health services (Sept 03 – Aug 2004)



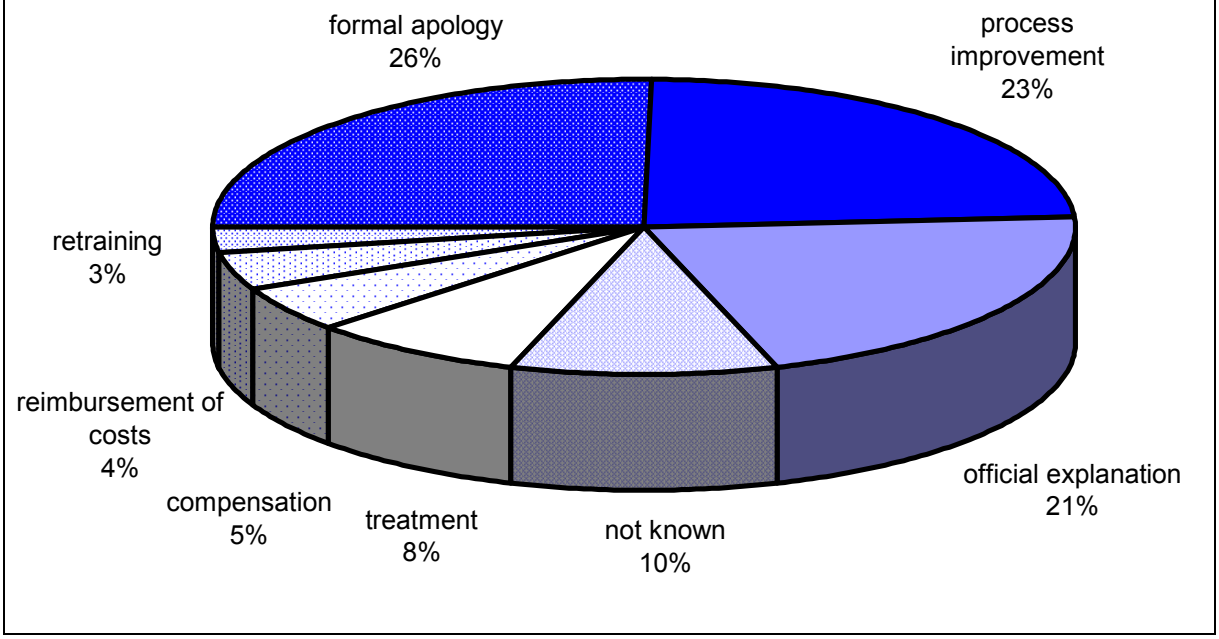
Base 8711

2.12 In terms of outcomes wanted, Table 3 shows that clients typically want one or more of the following:

- to find out what happened
- to make sure no one else goes through the same experience
- to receive an apology
- to make sure lessons are learned, with staff retrained or procedures changed where necessary.

2.13 Typically ICAS clients are not seeking financial compensation. However, perceived prevarication or avoidance (or an adversarial approach) can very quickly lead to further distress and a change of attitude - a fact which is all too often not understood by those within the process.

Table 3 - Solutions sought (Sept 03 – Aug 04)



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Recent developments

2.14 As noted above, the final shape of the complaints procedure is still emerging. The Department of Health put changes to the local resolution stage on hold, pending the outcomes of the Shipman Inquiry. The fifth report of this Inquiry[7], which considered complaints handling against GPs, was published in December 2004 and made a number of recommendations for change to the complaints procedure. These include:

[7] *Fifth report – Safeguarding patients: lessons from the past – proposals for the future*, Stationery Office, 2004 (CM6394)

- giving patients the option to lodge complaints directly with the PCT
- a far greater role for PCTs in monitoring and actively managing complaints about GPs, particularly in relation to clinical governance issues, with complaints about GPs being forwarded to the PCT within two days of receipt.
- a detailed procedure to enable PCTs to investigate complaints and/or refer them to another body, such as the police, the General Medical Council, or direct to the Healthcare Commission, at any point in the procedure
- ensuring there is a 'single portal' for use by people wishing to make a complaint, which can direct them on to the appropriate service.

2.15 In the light of these recommendations, revised regulations relating to the local resolution stage are expected later in the year.

2.16 The Healthcare Commission took over responsibility for the second stage of the complaints procedure in July 2004. In the early months this body found itself under considerable pressure because of the volume of complaints, which significantly exceeded expectations. Original estimates were for 5,000 referrals for Independent Review in the first year. However, the Commission now anticipates that the real figure will be nearer to 9,000. Whilst it has taken a number of actions to deal with this situation (recruiting additional staff and contracting out the handling of cases assessed as being of 'low' or 'medium' risk) there are obviously concerns that this will have a knock-on effect in terms of the timeliness and/or quality of its decision-making.

2.17 In March 2005 the Health Service Ombudsman published a report[8] highlighting continued weaknesses in the complaints system, which the interim changes have not resolved. These include inflexible processes, targets and timescales which are not centred on patients' needs, a lack of capacity and competence amongst staff handling complaints, and an absence of the right leadership, culture and governance. The report calls for the Department of Health to take a lead in setting, and ensuring compliance with, a national framework for complaints handling, which should include a set of core standards which apply across the whole of the NHS.

2.18 Clearly then, the coming months will be critical in determining the final shape of the NHS complaints procedure. The CAB service, with its active involvement in delivering ICAS as well as its wider advice role in health settings, is in a key position to contribute to this area of policy development. The ICAS bureaux are uniquely placed to provide insight into how the complaints procedure is working for patients. In the course of their work they see examples of both good and bad complaints practice, and patients who are satisfied and dissatisfied with their experience of using the process. It must be appreciated, however, that ICAS is called upon to assist with the more difficult cases and therefore there will be a natural bias towards those cases where the complaints process is particularly challenged.

[8] *Making things better? A report on reform of the NHS complaints procedure in England*, Health Service Ombudsman, March 2005 (HC 413)

2.19 This report is based primarily on evidence submitted by the 32 ICAS CAB in six regions in England[9], on the basis of their casework between September 2003 and February 2005.

2.20 The report also includes evidence from other CAB in England which have become involved in advising on NHS complaints, where this evidence throws light on the functioning of the complaints process and/or clients' experiences of using it.

[9] Although Citizens Advice encompasses England, Wales and Northern Ireland, this report relates only to England as there is a different complaints procedure in Wales and Northern Ireland.

3. Principles of best practice – evidence from the CAB ICAS experience

3.1 In setting out a new procedure for the NHS complaints system in April 2003[10] the Department of Health described its vision in terms of four principles:

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

3.2 Two years on, it is now possible to use the evidence from the ICAS work to assess how far these principles have been embraced by the NHS in order to deliver a patient-focussed service.

Open and easy to access?

3.3 The vast majority of people who use the health service do not expect nor need to complain about the treatment they receive. Perhaps as a consequence of this many people have little, if any, awareness of the NHS complaints process and how it works.

3.4 It is therefore crucial that information about the complaints procedure is given high visibility within hospitals and primary care services, and that people know where to go to get information and support if they need it.

3.5 However many CAB ICAS advisers report that the dissemination of information about the NHS complaints procedure, support through the complaints process and routes to redress, is thin at best. This is perhaps, in part, due to a perception that to advertise the possibility that mistakes will inevitably occur in such a large, complex and highly pressurised system, is to invite complaints.

> A CAB reported a client whose daughter was being treated in a mental health facility. The client was concerned that she was being mistreated as she was called out to find her with severe bruising. She had also been locked in a room and taunted by staff. The client felt extremely isolated, had no communication with any staff in the facility and had no idea how to make a complaint.

3.6 Some advisers report that there is reluctance amongst Trusts to inform patients that a formal complaints procedure exists. Most Trusts have many posters informing the public of their PALS service but they do not generally inform the

[10] *NHS complaints reform, making things right,* Department of Health, April 2003

public about the formal complaints procedure, nor do they display posters informing people of ICAS.

3.7 At its inception, the CAB service took steps to promote ICAS. Leaflets (translated into five languages) and posters were designed, the format and wording of which were approved in consultation with the Department of Health. These were distributed throughout the six regions where the CAB service is running ICAS and every Trust was given posters. The initial response, however, was very disappointing, with many Trusts refusing to use them, often on the grounds that they felt that using the headline 'Problems with the NHS?' would encourage people to complain.

3.8 As a result would-be complainants may be unsure of where to go,[11] leading to frustration and anger.

> An ICAS CAB reported the case of a client with multiple health problems including epilepsy which affected her memory. She had been trying for a considerable time to make a complaint to the PCT regarding a decision on the suitability of treatment offered by the pain clinic, before being referred to ICAS. It was evident that she had found the complaints procedure confusing in that she had contacted the Health Service Ombudsman on three occasions, only to be advised that she needed to complete the first two stages of the process first. She had also requested an independent review only to be referred back to local resolution. She had not been satisfied with the outcome of local resolution but had not then made a further request for independent review. The time limit for doing so had now expired. When the CAB raised these concerns with the PCT on the client's behalf they acknowledged that she should have been referred to ICAS earlier.

3.9 There needs to be a general understanding that:

incidents happen;

provided questions are dealt with:

- quickly
- honestly
- openly
- equally

they diminish in stature and will often defuse altogether.

3.10 Citizens Advice is concerned that without proper information about the NHS complaints procedure, clients may instead turn to solicitors whose prolific advertising can give the impression that it is the only option. Indeed there is some evidence that this may be happening. As part of the advice process ICAS bureaux record how clients heard about ICAS. In one hospital Trust, which has

[11] this is reflected in a recent survey carried out by WHICH? that found six out of ten people did not know where to turn for help about making complaints about the NHS, WHICH? April 2005

developed a very strong PALS service and which has been reluctant to inform people of the formal complaints procedure, the bureau has found that most of their clients who are complaining about that Trust have been referred to ICAS by local solicitors. (This contrasts with figures from across the CAB ICAS, which show that only four per cent of clients had previously sought help from a solicitor.) These clients, dissatisfied with the attempt at resolution through PALS, still wanted to make a formal complaint but had not been informed of the NHS complaints procedure in a way that was accessible for them. They felt approaching a solicitor was the only way to get a resolution.

3.11 It is important that Trusts recognise that a failure to promote ICAS can be counter productive, as it may increase the likelihood that complainants resort to the legal option which is far more costly in terms of both time and money. In many cases resolution can be more easily, satisfactorily and cheaply attained through the complaints procedure.

3.12 However, attitudes vary and as Trusts gain confidence in ICAS the reluctance to advertise has started to disappear. Some Trusts, including County Durham and Darlington Acute Hospitals, are now actively ensuring that posters are prominently displayed around hospitals.

3.13 The establishment of PALS in every NHS trust has the potential to give greater visibility to the complaints procedure. Although not itself part of the complaints procedure, a key function of PALS is to signpost the complaints procedure by providing relevant information and directing patients to sources of support such as ICAS. But there is also a danger that the respective roles of PALS and ICAS can become blurred, leading to confusion for patients who, as a result, fail to get the independent support they need.

3.14 This is illustrated by the following extract from a letter received by a client from a senior partner of a medical centre, following the completion of the local resolution stage. Not only does the letter fail to signpost ICAS, but it could be wrongly interpreted as indicating that PALS can help a patient take their complaint to the Healthcare Commission stage of the procedure:

> "Further to our previous communication, please find enclosed a detailed response from Dr XXXX, which hopefully clarifies the situation. We would be very happy to discuss with you any outstanding issues from this. If you continue to be dissatisfied you may wish to contact the Healthcare Commission through the offices of PALS. For more information please ring PALS on…."

3.15 One of the key recommendations from the fifth Shipman report [12] was that there should be a single portal by which complaints or concerns can be directed or redirected to the appropriate quarter, incorporating a single national telephone number and internet service. This proposal is welcomed by the CAB service. However, the level of independence of the contact point will be crucial to the credibility of the system, as will the way people are guided through it. It will also

[12] op cit

be essential that this service provides information about the various advice services available to people considering whether to make a complaint.

3.16 In addition, if PALS are to be part of any 'single portal' system, they will need to operate within national standards. To date, PALS have evolved to meet the local needs of their Trust and the result is a varied service. For example, some PALS have set their own timescales as to when to pass complaints on to ICAS, and in some cases serious complaints have been delayed. Others have established that they will only assist a complainant if treatment is ongoing.

Fair and independent, emphasising early resolution?

3.17 There is clearly a genuine desire to embrace the principles behind the complaints process at the head of the NHS. This is, for example, reflected in the National Health Service Litigation Authority circular 02/02 which states:

> 'It is being issued ..... with a view to encouraging healthcare professionals, including managers, to be as honest and transparent with patients and their families as they would wish to be.
>
> **Apologies**
> It seems to us that it is both natural and desirable for those involved in treatment which produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives and to express sorrow or regret at the outcome. Such expressions of regret would not normally constitute an admission of liability, either in part or in full, and it is not our policy to prohibit them, nor to dispute any payment, under any scheme, solely on the grounds of such an expression of regret.
>
> **Explanations**
> Patients and their relatives increasingly ask for detailed explanations of what led to adverse outcomes. In this respect they are no different from their equivalents in any other field. Closely linked to this desire for information is the frequently expressed view that they will feel some consolation if lessons have been learned for the future.
>
> Care needs to be taken in the dissemination of explanations so as to avoid future litigation risks, but, for the avoidance of any doubt, NHSLA will not take a point against any NHS body or any clinician seeking NHS indemnity, on the basis of a factual explanation offered in good faith before litigation is in train. We consider the provision of such information to constitute good clinical practice, and provided that facts, as opposed to opinions, form the basis of the explanation, nothing is likely to be revealed which would not subsequently be disclosable in the event of litigation.'

3.18 However, evidence from ICAS indicates that individual Trusts vary significantly in the extent to which they adopt this approach in relation to complaints handling. Some see a good complaints system as an essential part of the change process, others see it as an imposed burden. Yet properly managed and resourced, the complaints system can be a massive catalyst for change and

improvement.

3.19 At one extreme complaints units can be well organised and effective, with complaints taken seriously, handled quickly, and lessons learned from a mistake.

> A bureau helped a client whose mother had to wait over 12 months to receive diagnosis and treatment for cancer. During this time she had to repeatedly chase up the Trust for appointments and results which were not otherwise forthcoming. The ICAS caseworker helped write the letter of complaint, and the response, received in just over the target 20 working days, contained an apology and an acknowledgement that the case demonstrated "a total lack of care and consideration which was totally unacceptable". The Trust also offered a meeting with the Service Improvement Facilitator, at which a presentation was given of the plan for improvement for consultants and their teams to change the systems which had caused the problem. The client was asked if she would like to be involved in the implementation of improvements and was invited to meet the Chief Executive, who apologised and agreed to send her a copy of the procedures planned to prevent this problem occurring again. As the complaint was dealt with promptly it was largely resolved before the client's mother sadly died. The speed of the process meant that before her death she had been able to take part in the complaint herself, including attending the meeting with the Service Improvement Facilitator, receiving the apologies and being informed about the planned improvements.
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> A bureau helped a client complain about the treatment of his mother in Accident and Emergency. His mother had a number of problems accessing any treatment, or care, and died later that night. At the local resolution meeting the family were assured that all the staff who had been on duty that day had been reprimanded and procedures relating to patients admission had been altered. The family were invited to go back to the unit and see the changes for themselves. As a result the client felt it had been worthwhile making the complaint and did not feel it necessary to take it any further.

3.20 However, at the other extreme advisers report that there are complaints units which are understaffed, undervalued and under-resourced. Some are run by only one or two staff, often at a junior grade. It would, therefore appear that, in those cases, they have virtually no influence on service-level decision making. Their role is essentially administrative.

3.21 As a result responses to complaints can often be poor, uninformed and misleading:

> A client was incorrectly informed by the Complaints Manager of a PCT that she could not make a complaint about the decision of the PCT Priorities Panel not to fund her treatment, after her appeal to the panel had failed. The client was completely dissatisfied with the PCT's response to the complaint and the bureau has helped the client refer her complaint to the

Healthcare Commission. She was particularly upset that the Complaints Manager gave inaccurate advice about the complaints procedure.

An ICAS caseworker wrote a letter of complaint to a GP, on behalf of a client, asking for an explanation of why some of her client's medication had been withdrawn and stopped without adequate information being given to the client. The caseworker included a signed authorisation form from the client giving authority to the ICAS caseworker to act on her behalf. The GP would not accept the authorisation form and would only deal with ICAS if they redrafted the consent form to incorporate details of the Access to Medical Report Act 1988. The case worker did comply with the request, although it was not relevant and appeared to be just an excuse to delay the complaints procedure.

3.22 Even between different hospital Trusts there are wide variations in the standing of the Complaints Manager and the attitude towards complaints. The current regulations[13] require each Trust to have a named person responsible for complaints. One hospital Trust has built up their PALS service to deal with *all* complaints on an informal basis, and has nominated their Head Nurse to deal with formal complaints. This has caused problems for clients who wish to make a formal complaint. Their complaints have not been handled properly as no formal complaints system exists. Letters addressed to the Complaints Manager have been directed by the post room to the PALS office and then lost. Formal notes, essential to the process, have not been taken when resolution meetings take place. In response to enquiries the hospital replied that they felt "as they had so few formal complaints, they did not need a separate Complaints Manager as PALS resolved everything". The ICAS team are working with the Trust to improve matters but they have still not appointed a separate Complaints Manager.

3.23 This experience also shows how people value support which is independent from the NHS Trust they are complaining about. Many of this bureau's clients said that the PALS people were very approachable and helpful, but that they had tried to dissuade them from going through the formal complaints procedure by suggesting that it takes years and that they could resolve the issue quicker. Some of those referred to ICAS from solicitors commented that they were angry when they found out that, by going through PALS, the complaints "never went outside the hospital". They had therefore approached a solicitor to try and ensure that lessons were learned.

Delays

3.24 Comments by PALS about delays in the formal complaints process are, however, justified. Under the complaints regulations Trusts should provide a written response to the complainant, summarising the conclusions of its investigation, within 20 working days of the complaint being made. In practice however, the picture is very different, with delays of weeks, if not months, in completing investigations and issuing letters by no means unusual.

[13] S. I. 2004 No.1768 - The National Health Service (Complaints) Regulations 2004

A CAB reported a client who had had concerns about his health treatment and had written to the Trust to ask for an investigation under the NHS complaints procedure. Six months later he had had no reply.

3.25 Inadequate processes can result in delays, which in turn can seriously limit the capacity of the complaints procedure to operate effectively, as key staff move on or retire:

A bureau was helping a client who was complaining because a gynaecological procedure was shown to a junior doctor without the patient's consent being sought. The client was also unhappy about the attitude of the consultant. The first letter to the Trust was lost, and then they refused to arrange a meeting at local resolution level. Now the junior doctor has moved on and the Trust will not attempt to contact him. The client has been left with a feeling of injustice as the Trust has not taken the complaint seriously and they have not investigated properly.

A bureau was helping a client who made a complaint to a Trust in 2003 about the lack of anaesthesia given during an operation. The client suffered trauma as a result. There was one resolution meeting in 2003 but it was agreed that a second meeting would be arranged and this was confirmed in a letter in November 2003 apologising for the delay. Despite ICAS's active involvement in trying to resolve the problem, the meeting was still not facilitated. The matter was therefore referred to the Healthcare Commission in late 2004. The client was very dissatisfied that the complaint has not been dealt with, and had not been able to move on from her traumatic experience. The bureau was unsure if the Healthcare Commission would act, as the staff have changed at the Trust. Therefore the Trust is likely to assert that the claim is no longer valid.

3.26 The common criticism that targets, unless carefully devised, can distort priorities instead of solving problems, is all too evident in the complaints area. Achieving the time target has significance for the star rating system. Bureaux report that it is not uncommon for Trusts to put all their resources into reaching the 20 day target in terms of a written report, but to place no priority on arranging meetings:

A client wrote a letter of complaint about an inaccurate diagnosis in A&E in January 2002. She received a written response quite quickly but it did not address her questions and so a local resolution meeting was requested in March 2002. The bureau regularly contacted the hospital Trust by telephone and letter over the next twelve months. In June 2003 a letter apologising for the delay was received. Again, despite further pressure from the bureau, the next letter arrived in March 2004, explaining that the Complaints Manager "was on leave". Another letter was received in April 2004 explaining that the case had been passed to a senior manager. Then in May 2004 a letter was received explaining that the complaint had been passed to someone else. The case never had a local resolution meeting and was referred to the Healthcare Commission in October 2004.

> A CAB reported the case of a woman who made a complaint regarding the treatment of her mother. The first complaint letter was sent in 2003. Communication with the Trust involved has been subject to delays, in part due to the regular issue of holding letters on the day a deadline has been reached. The Complaints Manager was regularly making contact with the client over the phone and never delivering what was promised. The bureau has now asked that the Trust comply with the procedure and that the Complaints Manager no longer contact the client directly.

3.27 In some cases, the length of the process can result in complainants simply giving up:

> A CAB reported a woman who made a complaint about problems with delayed diagnosis of her husband's cancer. The misplacing of her husband's X-rays led to delays in the diagnosis of cancer, which had by then spread too far to be treated. The local resolution stage took 12 months and did not reach a satisfactory conclusion for the client. Although the client considered applying for an Independent Review she felt the time was better spent with her husband. She wrote to the ICAS to say that because of "all the worry that caused me, I didn't have the strength to continue with it, so basically I just gave up. I'm never going to get them to admit to any failures am I, and (my husband's) life is too short for me to spend so much effort on them. Thank you for your help and support over the last few months, it was very much appreciated."

3.28 The 20 day target is intended to ensure that complaints are addressed speedily. However, it is important that speed does not compromise the quality of the investigation. The regulations clearly specify that:

> 'The complaints manager may, in any case where he thinks it would be appropriate to do so and with the agreement of the complainant, make arrangements for conciliation, mediation or other assistance for the purposes of resolving the complaint' [14]

3.29 Yet it may well prove difficult if not impossible to carry out these additional measures adequately within the 20 day time limit. ICAS advisers report that frequently the consequence is that no face to face meetings are held, the complainant remains dissatisfied and so decides to refer the complaints on to the already overstretched Healthcare Commission. This body examines the papers, notes that no face to face meeting has been held and may therefore refer the case back for further resolution. The result is a procedure which unnecessarily prolongs and complicates the process for the patient, and is inefficient for the public bodies concerned. Nor is it line with best practice in complaints handling.

[14] op cit

3.30 Some Trusts, in a pragmatic effort to meet claimants' needs and to get around the time limit problem, are sending a decision letter within the 20 day limit but are including in the letter the offer of a meeting if the complainant wishes. Not only does this send confusing messages to the complainant about the significance of the 20 day letter, but it has also resulted in further problems should the client subsequently decide to take their complaint to the second stage. At one stage the Healthcare Commission, perhaps in an attempt to deal with its burgeoning workload, was adopting a strict interpretation of the requirement in the regulations that referrals to it should be made within two months of the written decision letter. On this basis they were rejecting some such cases as being out of time, where subsequent meetings had belatedly taken place. The complainant's only resource then was to go to the Ombudsman. Following representations by Citizens Advice this practice has now ceased. However, it serves to demonstrate how inappropriate time limits can distort the process and result in a situation where there are no winners.

3.31 Many complainants undoubtedly value the opportunity of a face to face meeting. One ICAS bureau examined this issue in more detail, in relation to one Trust. They found that only one per cent of their clients expressed satisfaction with the outcome following receipt of the written letter only. However, where this was followed by a face to face meeting 83 per cent of clients considered that their complaint was at least partially resolved. Clients often said that they preferred to discuss their complaints face to face, as this resulted in less misunderstanding and confusion. The bureau also considered that there was often a difference in tone between initial written responses from the Trust and subsequent dialogue which was more conciliatory.

3.32 We therefore recommend that the 20 day target is reviewed and consideration given to allowing a longer period – perhaps 30 days – for final completion of the local resolution stage, including holding a meeting if necessary.

Capacity

3.33 Issues of capacity are at the heart of the problems which patients experience with the complaints procedure, and delays in the Healthcare Commission are no exception. The Commission finally took over responsibility for handling the second stage of the complaints procedure in July 2004. This reform was introduced in recognition of the need to introduce greater independence to the handling of complaints, and as such, was warmly welcomed by the CAB Service. However its rushed implementation has resulted in a lack of preparedness, with major problems in building up capacity, lack of clarity about transitional arrangements and inadequate time for the public, NHS staff and independent advisers to understand how the new regulations were to operate. In addition it inherited a backlog of cases from the previous arrangements. In her recent report the Health Service Ombudsman has chronicled the problems which beset its implementation.[15]

[15] op cit

> A CAB reported a client who had requested a review by the Healthcare Commission at the beginning of September 2004. Despite requesting an acknowledgment none was received. Three months later she wrote to the Commission to find out what progress had been made, only to be told that it would be another three months before she would receive any decision on her complaint. The client was very upset that the process had been so prolonged.
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> A CAB reported a number of cases where clients referring complaints to the Healthcare Commission had faced excessive delays. When the bureau contacted the Commission in January 2005 regarding complaints submitted in August 2004, they were told that it would be another month before a case worker would be even allocated.

3.34 The Healthcare Commission has a target to complete its investigation within six months. However, at a meeting with the Commission in February 2005 we were told that they had some 4,000 cases outstanding, with 1,350 awaiting an initial assessment and cases arriving at a rate of 150 to 200 a week. In some cases problems were caused by delays of 40 to 50 days in obtaining copies of the original case/complaint notes from Trusts. This is despite the fact that in legal cases, Trusts are required to respond within a three-day time limit. The ICAS CAB had some 350 cases with the Commission at February 2005, some of them dating back to its inception and beyond. Advisers report that clients regularly contact them to complain about the slow progress their complaints are making.

3.35 In order to address the backlog, the Healthcare Commission has adopted a strategy of categorising complaints according to their perceived risk level on the basis of an initial assessment, and then outsourcing those considered 'low' and 'medium' risk to an external provider. This approach obviously raises some concerns and it will be essential that its outputs are closely monitored, particularly in terms of patient satisfaction. For example complaints may be inappropriately categorised as on occasion the full risks may not be apparent until the case is fully investigated:

> One of the last independent reviews held at Trust level in one region under the pre-July 2004 system, investigated a complaint over treatment of a CAB client's elderly mother. One of the issues was the attitude of a member of staff, which would now be categorised as a 'low-risk' matter. However, through the investigation it transpired that this staff member (the staff nurse in charge of a geriatric night ward) was not even registered as a nurse. The matter has now been referred to the Health Service Ombudsman.

3.36 The workload pressure may also create incentives to compromise on the quality of the investigation, with the result that patients' confidence in the process is undermined. For example, it will be important that there is consistency as to when Case Managers should seek independent advice, given that the regulations do not require them to do so wherever there is a medical aspect to the complaint:

> One CAB had had three clients who had received unfavourable decisions

from the Healthcare Commission by April 2005. The first was received in October 2004 and in it the Case Manager clearly stated that she had taken independent clinical advice. She also explained for each aspect of the complaint the independent expert's opinion and why they felt no further action could be taken. In contrast, the two responses received more recently in March and April 2005 made no reference to any independent clinical advice being taken despite the fact that both cases related to medical issues and decisions. The responses did little more than restate the Trusts' position, and as such could leave clients feeling that, after waits of six and eight months respectively, the Commission had simply accepted the Trusts' position without further investigation.

3.37 Where a case is subsequently referred to the Ombudsman's office, a full investigation can add a further year to the process. Doctors may have moved on or retired and hospitals, in response to Ombudsman recommendations, will often accept the comments as relevant to the situation when the claim occurred but assert that the situation no longer exists.

3.38 In order to cope with the consequences of this situation, the CAB ICAS service has negotiated with the Health Service Ombudsman to prioritise cases where a patient is terminally ill, about to have their treatment stopped, or where the complaint is impacting on clinical health.

Responsive?

3.39 Providing an appropriate and proportionate response which demonstrates transparency and accountability is at the heart of a patient-centred complaints procedure. At its best it can transform a patient's feelings about what has usually been a traumatic experience, it can restore their confidence in the system and prevent the patient feeling the need to take the complaint any further:

A CAB reported the case of a client who experienced a life threatening situation as a result of the failure of a GP to accurately diagnose her condition. The GP practice responded to her complaint within a week, having discussed the incident with the doctor concerned who undertook to "use the event as an important learning opportunity to prevent similar problems arising in the future and apologises unreservedly." There was also a commitment to undertake a critical event audit within the practice and to let the patient know the outcome.

Inadequate procedures

3.40 However in practice ICAS workers continue to deal with cases where either the complaints handling procedure or the health professionals involved appear to treat the complaint defensively or dismissively, and the complainant without respect. In some cases there appears to be an intention to avoid any written reference to the issue for fear of being held accountable:

An ICAS clientmade a complaint regarding the fact that she experienced

increased bladder problems following natural birth. The client had asked if her existing problems were likely to worsen if she had a natural birth and been assured by two doctors that they would not. After the natural birth, the problems worsened and she has now been told that this was due to the natural birth. The Trust would not respond in writing to the client's complaint even though a full written response was requested. The client felt pressurised to attend a meeting with no pre-arranged agenda. Only after ICAS intervention was a written response received six months after the complaint was submitted.

A bureau reported the case of a client who had had an operation cancelled twice. The anaesthetist then considered that the client was too ill to have the operation. The client felt the Trust was avoiding the issues and he was frustrated that he could not get answers to his questions. The complaints managers assigned to the case kept changing and the only responses received from the Trust were to inform him of the new staff dealing with the case. The Trust made no attempt to answer the client's questions and the CAB eventually took the case to the Healthcare Commission. Subsequently the client began to experience depression which he felt was caused by his experience of the whole system. Unless he got a prompt answer from the Healthcare Commission (who at the time of writing had had the case about three months) then he intended to seek legal advice and pursue a case for clinical negligence.

A client came to ICAS for help in complaining about a consultant who she felt had never acknowledged the level of pain she experienced after an operation, and had been rude and abusive towards her. When the initial response letter was received the client felt that it included a number of inaccuracies. A meeting was arranged but when the notes of the meeting were received it appeared not to have been proof read and the client noticed a number of factual errors. The client wrote to the Trust, asking for corrections to be made. When the revised notes were received, only minor matters such as the spelling and punctuation had been corrected but the errors identified by the client had not been amended. The client rang the complaints officer and was told that these corrections were "only her view" but that they could be added as an addendum to the notes. The refusal to amend the notes as she had requested made the client feel that only the Trust staff were entitled to a view on what had happened at the meeting. She did not pursue her complaint through ICAS and is taking legal advice.

3.41 Patients with mental health problems in particular can find that their complaints are not taken seriously simply because they are mentally unwell:

An ICAS CAB reported a client with chronic stress and anxiety, food intolerance, chronic fatigue, dizziness and poor concentration. He visited his GP because he feared his symptoms were caused by iron deficiency. However, neither his psychiatrist nor his GP would refer him for any tests or treatment for these symptoms. When he attended a complaints meeting he felt that staff did not take his complaint seriously because he had a mental illness.

> The CAB reported another case where a client was unhappy with the community care assessment plan drawn up by the mental health trust. The report suggested that she had poor compliance with her medication, was reluctant to use services offered and could be verbally intimidating. However, it did not acknowledge her reasons for her behaviour. When she made a complaint she felt it was not taken seriously because she had mental health problems.

3.42 Failure to keep proper records of incidents and meetings can lengthen the process unnecessarily, adding to patients' distress and to staff workload:

> A PCT arranged a local resolution meeting with ICAS and their client, who was unhappy at the introduction of new restrictions on podiatry services. The client was still not happy with the Trust's explanations given at the meeting and asked for an Independent Review of his treatment. As the Trust had taken no notes at the meeting, the Convenor was unable to establish whether local resolution had been exhausted. They therefore had to ask the client to attend another meeting so notes could be taken (Although this case took place under the old procedure, the issue is still valid as the Healthcare Commission would also need to see minutes/notes of the meetings).

> The father of a bureau's client broke his hip and sustained severe bruising to his left shoulder whilst staying in a centre run by the PCT. Staff were unable to explain how or when his hip was broken or how he suffered the bruising. As a result of the broken hip the client's father suffered a substantial loss in quality of life before his death. ICAS helped the client through the complaints procedure, and at the Independent Review the panel upheld all parts of the complaint. Amongst the recommendations was that an apology should be made to the client and his family and policies put in place to prevent a repeat. They also recommended that the PCT enforce its complaints policy more robustly, citing a lack of documentary evidence from the Investigating Officer.

Defensive attitudes

3.43 Without a culture change in the organisation as a whole, moving away from viewing complaints as criticism, then fundamental change to deliver a genuinely responsive service is unlikely. The following examples illustrate how trusts can take a defensive stance and seek to hide behind confidentiality.

> A CAB reported the case of a client who had experienced serious problems during childbirth which resulted in the loss of her baby. Initially she made an informal complaint to the Trust which held a meeting with her and obtained an independent medical report on the events. The client had not found the meeting satisfactory and so sought help through ICAS to make a formal complaint. She requested a copy of the medical report prior to the meeting in order to help her prepare. The Trust refused, claiming the circumstances of another patient in labour at the same time were included

in the report and therefore it would breach confidentiality. The client was very anxious about attending the meeting without having seen this report. Following the CAB's intervention, the Trust agreed to release the report with the reference to the other patient removed. The client was therefore able to prepare properly and felt that this second meeting went much better.

A bureau was assisting a client with a complaint about the local Ambulance Trust. The Trust's attitude was very defensive and, at the local resolution meeting, references were made to the statements which the crew had made to the Trust about the incident. When the client asked to see them, the Trust initially refused, and subsequently insisted on obtaining the ambulance crew's permission on grounds of staff confidentiality. Eventually the bureau received the statements after promising to destroy them after reading them. The client was left with the feeling that the Trust was being deliberately obstructive because they had something to hide. The Trust also required him to sign a form confirming that he would not resort to legal action "because the information they were to provide was confidential". This has escalated the situation so that the client has now gone to a solicitor to pursue a claim for clinical negligence.

On a more positive note in this case, ICAS have now managed to persuade the Trust to change radically the way it will investigate future complaints. In future, when statements are taken from staff, they will be told that as a gesture of openness the complainant will be entitled to see the statement. ICAS have not been able, however, to stop the Trust continuing to require applicants to sign forms confirming that they will not resort to legal action.

3.44 In areas where the client suspects that authorities are being less than open, it is more likely that they will pursue matters through the courts where rules of disclosure will demand that information is provided.

3.45 It is crucial that the culture, understandable as it may be, changes from one of defensiveness to one where the need to apportion blame is suppressed and more emphasis is placed upon improvement and learning. The proposals for a National Redress Scheme go some way towards developing such a culture and it is to be hoped that this will have a positive influence on the complaints procedure itself. These proposals include a quick independent assessment into a complainant's treatment to decide if clinical negligence has occurred and a prompt offer of compensation for cases up to a set limit (possibly £30,000). The aim is to reduce the spiralling legal costs the NHS face.

3.46 The challenge which such a shift in NHS complaints culture presents should not be underestimated. Often the problem appears to relate to individual practitioners who are unwilling or unable to change what may be longstanding attitudes. This can leave managers with complaints handling responsibilities in a very difficult position:

In response to four serious complaints about one surgeon and the delay in getting a response to the complaints, a senior Trust manager wrote a full

> letter to the CAB acknowledging that the surgeon concerned, "tends to be frank with patients, especially if he has little to offer them. And he does not believe in inconveniencing them with repeated clinic attendances that serve no purpose. He admits he does not handle what he perceives as challenge and aggression well, tending to rise to it rather than dissemble… This does not sit easily with current public expectations for reasoned dialogue with the health professional. It is unfortunate that some of our better surgeons are less able communicators. We do have several complaints that stem from interpersonal conflicts between patients and doctors. He recognises these character traits and has come to see the distress they can sometimes cause. He is working on them with some success and will continue to do so. However, we must be realistic about how much change can be accomplished before retirement."

3.47 Following receipt of this letter a meeting was held between the Trust Managers, and ICAS to discuss how things could be moved on. However, six months later the Trust had still not been able to get the surgeon to attend a meeting. The cases were therefore to be referred to the Healthcare Commission.

3.48 Some professionals still appear to consider it legitimate to refuse to engage with the complaints procedure at all:

> A CAB reported the cases of a woman who made a complaint about problems following a hernia operation. Letters of complaint were written and a request for a meeting with the consultant concerned. The consultant contacted ICAS directly and intimated that he was not prepared to respond to the client's letters or have a meeting to discuss the complaint.

3.49 Many patients are now better informed and increasingly have access to information previously denied to them. As a consequence they are better equipped to ask more searching questions when something appears to have gone wrong. This can be seen as threatening by health professionals who can no longer rely on unquestioning respect. However, this does not take away from the importance of ensuring that all information is communicated in an accessible way that the 'non expert' patient can understand:

> A CAB assisted a client who had had to have her arm amputated. She was aware that it was due to a flesh eating disease, which she felt she must have acquired at the hospital. The letter she sent with ICAS help making the initial complaint was clear, "I have asked for this letter to be written because I want you to know of my condition and the prevalence of this disease. I also want [the Trust] to improve its standards so that no one else has to go through what I have gone through."
>
> The Trust's letter of reply was three pages long. It was almost entirely made up of obscure medical terminology and test results, the significance and meaning of which were not explained, and it appeared to be intended to obfuscate. There was no attempt to answer the client's questions, nor any mention of the flesh eating disease. The client was very frustrated and was convinced the hospital was being evasive and that "all doctors stick

together". The complaint is still ongoing.

Patients' fear of the consequences of complaining

3.50 Perhaps the most telling evidence of the failure of the complaints procedure to achieve the responsiveness envisaged by the Department of Health is the fact that many people are still wary of complaining in case this damages their relationship with their health care workers or even results in them being struck off GP or dentists' lists. This can be a particularly significant problem in rural areas where alternatives may be limited or non-existent.

> A CAB reported a client who made a complaint against a doctor at a hospital clinic where he was receiving ongoing treatment. Since making the complaint he has experienced rudeness from staff, and treatment and referrals refused.
>
> A CAB reported a client who was prescribed a drug as a precautionary measure against osteoporosis. The GP told her there were no serious side effects. However following a holiday abroad she developed a serious skin condition which resulted in a five week hospital stay. She has been told that this is a side effect of taking the drug and is now unable to go out in daylight and must keep curtains drawn at all times. She is devastated by the consequences of taking the drug but does not want to make a complaint in case the GP responds by removing her from his list.

3.51 Despite the recent strengthening of the regulations in this area through the new GP contract, which now requires that patients be given a warning in advance of removal and which clearly specifies the limited circumstances in which a removal can be made, there continues to be evidence that this threat is very real:

> A CAB reported a client who complained to her GP surgery about their appointment system. Following this, the whole family was removed from the list, with the GP alleging breakdown of doctor/patient relationship. The patient believes the reason was because of her complaint. She is now making a complaint about her removal from the list.
>
> A CAB reported a client with mental health problems and dyslexia who was concerned at the difficulty he had had in accessing mental health services. After a lengthy discussion the bureau helped the client write letters of complaint to his local NHS trust and to his GP. As a result of the complaint he was removed from his GP's list without explanation.

3.52 The threat of inappropriate removal from lists is one of the reasons why it is important that PCTs are actively involved in monitoring complaints against, and complaints handling by, primary care providers.

3.53 A responsive system must also recognise that many patients will be reluctant to make a complaint directly to the practitioner concerned, particularly as they have ongoing responsibility for the person's medical care. We therefore welcome the

recommendation of the fifth Shipman Report that patients should be able to lodge complaints direct with the PCT if they prefer, and that PCTs should have an enhanced role in monitoring and handling complaints. It will be essential however that such a development is properly resourced, to ensure PCTs have the expertise and knowledge to provide genuine leadership in best practice.

3.54 The more active involvement of the PCT could help to improve patients' experience of the complaints process. Some clients have raised a complaint with the practice manager, then been referred to PALS, thence to the PCT Complaints Manager and then, finally, referred to ICAS. This process can take several weeks and causes huge frustration for complainants.

3.55 CAB ICAS caseworkers have for sometime been aware of the need for such a PCT role and indeed some have started routinely to copy complaints to PCTs. However the response has not been positive and many query why they have been sent details as "we do not get involved". PCTs, even under the new General Medical Service (GMS) contract, are not required to be informed by Independent Practitioners such as GPs about the nature of the complaint, but simply that it has been dealt with.

> A client had serious complaints against an NHS dentist who, amongst other issues, had misplaced the client's dental records which were confused with those of his brother. The client wrote a letter of complaint in November 2003 to the dentist. The dentist did not respond and the client then wrote to the PCT for assistance. The PCT did not attempt to contact the dentist to reinforce local resolution but instead, replied with a standard letter offering conciliation or Independent Review. The client requested an Independent Review, as the correct procedure had not been explained to him. In response to the convenor's request for a list of grievances, the client explained that local resolution, which was what he had wanted, had not taken place. The convenor then suggested the client should write to the dentist! Finally after nearly a year, ICAS became involved and was able to obtain a response from the dentist.
>
> A bureau had been trying to assist a client who started a complaint verbally 14 months previously. The complaint was about a sole practitioner GP who refused to deal with the complaint and had subsequently retired. ICAS had asked the PCT to become involved and they initially gave incorrect information to the client over time limits, saying the complaint was out of time. ICAS pointed out the complaint was ongoing and not a new complaint. The Trust then arranged a meeting with the new GP to discuss the issues on an informal basis.

3.56 This case and the next highlights the importance of PCTs being actively involved in complaints handling, as clients can be left helpless under the NHS complaints procedure if dealing with sole practitioners or doctors who are unwilling to co-operate.

> A client complained about her GP. Despite NHS guidance issued in the wake of the Shipman case to the contrary, the GP handled his own

complaint. There was no involvement of the PCT and the complaint was handled directly by the GP in a very defensive and negative way.

3.57 It is important to recognise that the complaints procedure presents both patients and clinicians with situations where face-to-face discussions can be emotional and difficult. ICAS evidence indicates that there is still a long way to go before staff throughout the NHS are able to handle complaints with the professionalism required to deliver a genuinely patient-centred and responsive system.

Learning and development?

3.58 The evidence in this report has already illustrated the variation which continues to exist in the way different Trusts handle complaints and in the attitudes of the practitioners involved. Similar variation is apparent in the extent to which Trusts learn from their complaints and introduce changes in order to prevent the same thing happening again. Yet knowing that the complaint has led to changes in practice is often of key importance to the patient making the complaint, as the following case illustrates:

> A client was convinced that the defensive letters from the Trust were a cover-up and the complaints procedure was pointless. Then a letter of apology was received from the Trust acknowledging that the care his father had received was not of a high enough standard and the family were asked to relate their experiences to staff as training in improving communications across the hospital. This completely changed the client's view of the NHS complaints procedure.

3.59 When the complaints procedure works well, it can result in changes to the benefit of many patients, and the NHS itself, which may far outweigh the inconvenience or cost of dealing with the complaint itself. The following case shows how a client was satisfied that her complaint had been worthwhile and that all the patients on the ward were benefiting from the visible improvements arising from issues she raised in her complaint.

> A patient was admitted to a hospital for rehabilitation following complex neurological surgery at the Regional Centre. The patient's partner lived one hour away from the hospital and was restricted in the number of times she could visit due to work and family commitments. She therefore had to rely on an assumption that, as the Unit was housed in new hospital premises, the level of care provision would be to latest standards. However, instead she found that the Rehabilitation Unit was poorly equipped and insufficiently resourced to bring about effective rehabilitation. Through ICAS she submitted a formal NHS complaint citing these shortfalls. Following the written response from the Trust a meeting was arranged at which all the issues were raised. The meeting resulted in an action plan to improve the facilities being drawn up and, six months after the meeting, the client and ICAS caseworker were invited to return to the Rehabilitation Unit to review the changes. The client was very pleased to see improvements that included stimuli on walls in the Unit, date and day orientation as well as reorganisation of the day room with more pictures,

books and activities.

3.60 In contrast, in other cases ICAS workers report an apparent reluctance to implement agreed changes and an absence of external pressure to bring these about:

> A bureau helped a client with a complaint about failure to diagnose cancer. As a result of this complaint it was recognised that a new care pathway for non-specific cancer needed to be introduced. During the following year ICAS chased regularly for confirmation that the care pathway had been implemented but, despite continual discussions and promises, it was not started. The client has unfortunately now died. Other issues from the complaint have been addressed, such as a nurse specialist for such cases and multi-disciplinary team meetings to discuss types of treatment available prior to consultation to speed up the process. But the care pathway for non-specific cancers was what the client wanted - so others did not suffer.

The price of failure

3.61 The following case reported by an ICAS CAB illustrates the tragic consequences which can occur in the absence of procedures for Trusts to learn from mistakes.

> A client's young husband had been found dead in his car with a hose leading from the exhaust pipe. The client was devastated as he had attempted suicide the previous day and having been found, was treated at a hyperbaric unit and the local Accident and Emergency (A&E) department, seen by a psychiatrist and then discharged at 3am without the family being notified. This treatment involved two trusts: the Acute Hospital Trust and the Mental Health Trust. At the local resolution stage of the complaints procedure a meeting was held with senior clinicians and managers from both Trusts. Everyone at the meeting was very apologetic and appeared sincere in their desire to learn the lessons from the tragic death. There was a post-incident review held and a number of recommendations made including:
>
> - that junior doctors should be trained in risk assessment on induction including criteria for admitting patients at risk of suicide in the absence of any mental illness
> - improved liaison arrangements between Senior House Officers on call assessing patients in A&E, the Psychiatry department and the GP.

3.62 The Trust also reassured the client that any such patients would be discharged into the care of family or friends and not left to walk out of the hospital alone. The client was satisfied that another family would not suffer the same way.

3.63 One year later another young man was found hanging in the grounds of the Acute hospital after discharge from A&E after being treated for carbon monoxide poisoning in the early hours of the morning. In this case the family was notified that he was to be discharged but when his family arrived he had already been declared 'medically fit to be discharged' and had left the hospital building. A

complaint was made and the same ICAS caseworker attended another resolution meeting with the same senior doctors and senior managers from both Trusts who were (again) very apologetic and made very sincere expressions of wanting to learn the lessons from the tragic death.

3.64 The recommendations from the post-incident review were virtually identical to those made a year earlier, calling for greater guidance for trainee doctors, improved liaison arrangements and due consideration to the time of discharge. Again the family was reassured that potential suicide cases would not be allowed to walk alone from A&E.

3.65 These cases had a profound effect on the ICAS caseworker involved as she had been so convinced by the sincerity of the outcome of the first case that she was devastated to realise the system had not been changed at all. They highlight the need for an independent mechanism to check that, where there have been undertakings that changes will be made, these are in fact implemented.

3.66 At the time of the above case, CAB were specifically prevented under the ICAS contract from informing either the PPI Forum or the local authority Health Overview Scrutiny Committee (OSC) about their concerns as such reports could only be made when they related to a 'trend', defined as five similar cases per quarter. This was a matter of significant concern to ICAS CAB and to the PPI Forums, as arguably, such a restriction would have prevented even cases like Shipman being reported. Following consultation with the Department of Health this provision has now been changed and a more detailed report including an outcomes report is regularly made to the PPI Forums for monitoring purposes. This change is very welcome.

3.67 In fact, the bureau involved with the above cases decided that the incidents were too serious to ignore and that it had an overriding duty to inform the PPI Forum, but has never received any feedback as to how or what the PPI Forum are monitoring.

3.68 With the proposed changes to the management of PPI Forums still under consideration following the proposed abolition of the Commission for Patient and Public Involvement in Health (CPPIH), there is a risk that much needed clarification of the nature and extent of their future powers will be delayed. They share with the OSCs the role of monitoring of local health care. However, both seem unsure of how they should undertake their duties and how they should ensure that the change process is properly scrutinised.

3.69 This is not helped by the absence of formal protocols for communicating information about trends which raise concerns, to and between these different bodies to enable them to undertake their monitoring and scrutiny functions, but without compromising patient confidentiality.

3.70 Without such clarification, there is a risk that the full potential for learning from complaints will be lost.

4. Conclusions and recommendations

4.1 The picture which emerges from this report is of significant variation in the extent to which Trusts have embraced the Government's vision for a complaints system which is easy to access, fair, responsive and which results in lessons being learned.

4.2 Where this is happening, the benefits for all sides are clear. Patients are satisfied, complaints are settled at an early stage and litigation becomes less likely, and changes are put in place which benefit the service as a whole and make a similar complaint less likely.

4.3 However the experience from ICAS CAB is that these good practices are still the exception rather than the rule. This report has detailed how patients can face difficulties in finding out how to access the complaints system, lengthy delays at every stage of the process, and a culture which is defensive rather than responsive. The result is far from being a patient-centred system. This is reflected in ICAS CAB statistics which show that only 53 per cent of respondents whose cases were concluded between September 2004 and February 2005 were satisfied with the NHS complaints system.

4.4 The concept of a formal NHS complaints procedure is not new, although the current system is still in its infancy. Continued professional contact between the various services should lead to improved understanding and trust but the public will now expect to see change evolve quickly. Overcoming the cultural problems which undoubtedly exist will be the single most effective way of achieving the necessary change.

4.5 The CAB service welcomes the recommendations from the fifth report of the Shipman Inquiry[16] and the recent Health Ombudsman report [17], some of which were outlined above (page 11). We believe that together they provide a sound basis for taking forward further reform of the complaints process. On the basis of the evidence set out in this report, we consider that the following recommendations must be priorities:

Raising standards

4.6 We recommend that the Department of Health should set a national framework for complaints handling, as proposed by the Health Service Ombudsman in her recent report. This should include core standards to ensure that complainants experience a similar approach regardless of where they live, or what organisation (including Foundation Trusts) they are complaining about. In relation to support and advice for patients, for example, there should be a national referral protocol between PALS and ICAS services. The core standards must ensure that there is clarity of expectations on both sides regarding the content of the process, timescales for the various stages, and the nature of the outcome.

4.7 We recommend that ensuring compliance with these standards is a priority for the Healthcare Commission through its regulatory functions.

[16] op cit
[17] op cit

4.8 We recommend that the Healthcare Commission should develop best practice guidance in complaint handling. It will be essential that an inclusive process is used for drawing up this guidance. Patients and their representatives, including ICAS providers, must be actively involved in the process to ensure that it delivers a genuinely patient-focused service. The engagement of the professional bodies in this process will also be crucial. Their leadership will be vital in order to overcome the problem outlined in this report that many clinicians and practitioners still see complaints as an irritant and are reluctant to participate in resolution meetings.

Improving access

4.9 We recommend that, as proposed by both the Ombudsman and the fifth Shipman report, patients should be able to make their complaints direct to the PCT which should play a central role in managing and monitoring the local resolution stage of the complaints process. It will be essential that PCTs are provided with adequate resources and training in order to undertake this new function. Such a reform would help overcome patients' reluctance to make a complaint against their local health practitioner, for fear that this will have an impact on their ongoing care. It should also mean that resources and expertise in complaints handling can be pooled, thus raising standards of local resolution.

4.10 We recommend, as proposed by the fifth Shipman report, that there should be a 'single portal' by which complaints or concerns can be directed to the appropriate quarter. We consider this should be a national service, delivered by a body which is transparently independent of all health service providers who may be the subject of a complaint. The portal should also provide information about the advice services available, including PALS and ICAS, and should help to ensure patients are clear about the respective roles of these services and the referral protocol.

Ensuring timeliness

4.11 We recommend that the current 20 day target for completing the local resolution stage should be reviewed to ensure that it encourages both a quality and a timely response by the Trust. We propose that, in order to ensure Trusts face no disincentive to arranging meetings where appropriate within the period, the target should be extended to 30 days. At the end of the period, patients should be sent a full 'signing off' letter, which clearly signals to the complainant that the local resolution process has reached its conclusion. To provide for exceptional cases where the 30 day timescale is insufficient, there should be a specific rider enabling Trusts to exceed the time limit, in which case they must write to the complainant giving reasons and a clear deadline by which a full response will be given.

4.12 We recommend that consideration should be given to creating incentives for Trusts not to delay responding to requests from the Healthcare Commission for additional information and documents in order to pursue their investigation. Options could include the Healthcare Commission taking the delay into account in its considerations, compensation for complainants, or requirements to take remedial action.

4.13 The independence of the Healthcare Commission and its well earned respect throughout the NHS faces one of its biggest challenges in being able to deal with the volume of complaints without excessive delay. At the time of writing, ICAS bureaux are helping clients who have waited over six months since lodging a complaint and have only received a number of letters acknowledging the complaint and apologising for the delay. **Adequate resources to deliver a quality and timely service must be provided if the Healthcare Commission is to maintain its credibility as a monitoring organisation. There is also a need for the Healthcare Commission to develop strategies to ensure that it can meet its six month target.**

Learning from complaints

4.14 We recommend that Trusts develop mechanisms to obtain feedback from patients who have experienced their complaints handling process. Patients' views on complaints handling should be included in exercises to assess patient satisfaction. In addition, local authority Health Overview and Scrutiny Committees (OSCs) and PPI Forums should monitor views from patients and advice providers such as ICAS, regarding the quality of local complaints handling.

4.15 We recommend that a protocol should be set up so that all NHS Trusts and PCTs send copies of their complaints and PALS reports, to the PPI Forums and OSCs which are responsible for scrutinising their work.

4.16 We recommend that PPI Forums and OSCs should be kept informed of any outcomes from complaints which involve undertakings by Trusts to implement changes, so that they can check that these are put into effect. PPI Forums and OSCs should inform the Healthcare Commission when they have any concerns that Trusts have not acted on undertakings that they have made.

4.17 We recommend that guidance and protocols are developed as a matter of urgency regarding reporting arrangements about trends in adverse incidents between ICAS, PPI Forums and OSCs. This must be done in a way that does not compromise patient confidentiality. It is crucial that such developments are not delayed as a result of the reorganisation of functions which will flow from the proposed abolition of the Commission for Patient and Public Involvement in Health.

Appendix: Citizens Advice Bureaux which submitted evidence on NHS complaints handling between January 2004 and February 2005.

Ashford
Barnsley & District ICAS
Bootle ICAS
Brandon
Brighton & Hove
Bromley ICAS
Camden ICAS
Combined Hospitals ICAS
Coventry ICAS
Dudley ICAS
Eastbourne
East End ICAS
Gloucester ICAS
Hackney ICAS
Harrogate ICAS
Heswall ICAS
Hyndburn & District ICAS
Littlehampton
North Tyneside ICAS
North Cornwall
Poole ICAS
Rotherham ICAS
Salford (Eccles)
Salford Mental Health Services ICAS
South Gloucestershire
South Lakeland ICAS
Stoke-on-Trent ICAS
Tamworth
Vale Royal ICAS
West Lancashire ICAS
West Wiltshire ICAS
Westminster ICAS
Worcester ICAS
York ICAS