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NHS COMPLAINTS PROCEDURE
NATIONAL EVALUATION

Report

York Health Economics Consortium
NFO System Three Social Research

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CONTENTS

	Page
Executive Summary	4
Chapter 1: Introduction	13
Chapter 2: NHS Complaints procedure	15
Chapter 3: Research Methods	18
Chapter 4: Views of those using the complaints procedure	25
Chapter 5: Views of those operating the complaints procedure	42
Chapter 6: Policy implications – Local resolution	55
Chapter 7: Policy implications – Independent review	69
Chapter 8: Conclusions	84
References	91
Appendix A: Characteristics of complaints managers, convenors, chairs and lay panel members	93
Appendix B: Focus groups in primary care	108
Appendix C: Regional complaints leads	121

EXECUTIVE SUMMARY

Objectives

1. The current NHS complaints procedure was introduced in April 1996 following the report of a review committee (Wilson, 1994) and the Government's response (*Acting on Complaints*, March 1995). The objective of this study was: *to provide an evaluation of how the new complaints procedures are operating across all parts of the NHS…and to meet the information needs of policy makers and managers concerned with the future development of the system* (Research Brief).

Methods

2. We have carried out a questionnaire survey of those with experience of operating the complaints procedure (complaints managers, convenors, chief executives, chairs and lay panel members, family health services (FHS) contractors, conciliators and clinical assessors) and those with experience of using the procedure (complainants, staff complained against, patient interest groups and health councils (or their equivalent in Scotland and Northern Ireland). More than 4,000 questionnaires were distributed.

3. We have also conducted more than 300 interviews with complainants, staff complained against, regional and national complaints leads and the Health Service Commissioners. We have facilitated focus group meetings with those working in primary care and workshops with key stakeholders. We have received a large number of written submissions from individuals and representative organisations.

Research Findings

4. The complaints procedure has two stages: *local resolution* involves the service provider attempting to resolve a complaint as quickly and as directly as possible. If a complaint cannot be resolved locally, a complainant may apply for *independent review*. The right to review is not automatic. A request for review is considered by a convenor (who is normally a non-executive of the organisation complained against) in consultation with an independent lay chair.

Views of those using the complaints procedure

5. Many complainants express a high level of dissatisfaction with the operation of the current procedure. This is true for complaints which do not proceed beyond local resolution as well as for those which give rise to a request for independent review:

- Among individuals whose complaint was dealt with locally, only one-third believed that their complaint had been handled well. No more than 20%-30% were satisfied with the time taken to deal with the complaint and a majority were dissatisfied with the outcome. A majority thought that the current procedure was either unfair or biased and a high proportion found the process to be stressful or distressing.

- Among individuals who had requested independent review, around a quarter believed that their complaint had been handled well. No more than one in ten were satisfied with the time taken to resolve their complaint and only 13% were satisfied with the outcome. Almost three-quarters believe that the complaints procedure is either unfair or biased. A significant majority found the process to be stressful or distressing.

6. The main causes of dissatisfaction among complainants are operational failures: unhelpful, aggressive or arrogant attitudes of staff, poor communication and a lack of information and support. The most important structural failure is the perceived lack of independence in the convening decision and in the review process generally.

7. Patient interest groups draw attention to the fact that some potential complainants are deterred by the fear that services will be withdrawn. This is more likely where the provider has a personal relationship with the patient and where a complaint may be thought to signal a breakdown of trust. Some complainants have been removed from a practice list on this basis, although the concern is not restricted to primary care services.

8. The views of NHS staff who have been the subject of complaint are in marked contrast to those of complainants. A majority of staff thought that the complaint against them had been handled well and they were generally satisfied with the outcome. Staff were well supported by professional and managerial colleagues and the majority thought that the process was both fair and unbiased. The only consistent source of dissatisfaction was that they were not always kept informed of the progress of a complaint against them. A number of respondents noted that they were initially unaware that a complaint had been made against them.

Views of those operating the complaints procedure

9. A majority of those with experience judge the current system to be superior to the systems in place pre-1996 on most criteria. Chief executives are supportive of the principles of local resolution and most believe that this aspect of the complaints procedure works well. Positive aspects include the encouragement to respond promptly to a complaint, the opportunity offered by complaints to improve the quality of services and the opportunity to meet complainants face-to-face.

10. Among those responsible for operating the procedure there is a broad consensus about the elements which need to be improved:

- There is a wide measure of agreement that independent review should be more independent and should be seen to be so. Irrespective of the impartiality of a convenor, it is accepted that complainants do not perceive the current procedure to be independent.
- There is a perception that current procedures, particularly those involving independent review, are time-consuming and costly to operate.
- Performance targets relating to the convening decision, the appointment of panel members and drafting a report of a panel are all perceived to be difficult to meet.

- There is agreement that procedures need to be improved to ensure that services improve following a complaint.

- Procedural improvements include the need for quicker access to clinical assessors and (in England and Wales) to lay chairs. Lay chairs in all countries would like to have better feedback on panel reports and on the outcome of complaints and more opportunities for networking and training. The desire for additional networking and training is common to almost all of the groups involved in operating the procedure.

Policy Implications

Local resolution

11. Because the process of local resolution is internal to the organisation, how well it works varies between organisations depending on the training and attitude of individual members of staff and on the culture of the organisation itself. Current mechanisms are inadequate to *ensure* that complaints are adequately addressed or that necessary action follows from a complaint.

12. Thus views on local resolution are equivocal. On the one hand there is support for the principles of local resolution and recognition of the potential value of complaints as a source of information for service improvement. There is also evidence that local resolution works well in many cases. On the other hand, many complainants express a high level of dissatisfaction and this is indicative that the current procedure also frequently fails. The key issue is lack of consistency.

13. Among complainants about family health services the level of dissatisfaction is higher on most measures than it is for other services. A majority of health council respondents believe that in primary care, local resolution performs poorly or very poorly. One reason for the particular focus on primary care may be the fact that, in comparison with other NHS organisations, most practices are relatively small and informally managed. In this situation the attitude of an individual practitioner in shaping the success of local resolution is more decisive than it is in a larger, more formal organisation.

14. In order to improve performance the culture of all NHS organisations must be such that satisfactory resolution of complaints is an important objective and information generated by the complaints process is valued. Resources must be appropriate to ensure that front-line staff are adequately trained and supported and that complaints can be investigated promptly and with authority. The organisation should be held accountable for its performance in handling complaints and for ensuring that serious mistakes are not repeated. Three factors in particular are likely to be central to improving performance:

- Those with responsibility for managing the performance of chief executives and chairs should be required to demonstrate that complaints-handling is an explicit part of the performance management framework.

- The board of every NHS organisation should be held accountable for the performance of the organisation in handling complaints. In particular, the board should ensure that: (a) all staff are adequately trained to deal with complaints and are supported in the event of a complaint being made against them. Training in handling complaints should be a compulsory part of induction and continuing education; (b) staff managing complaints are appropriately trained, have adequate administrative resource and access to senior managerial supervision and support; (c) the complaints procedure is integrated into the clinical governance/quality framework of the organisation.

- Consideration should be given to the development of a National Service Framework or its equivalent for the management of complaints. A service framework would provide clear guidance to NHS organisations on the standards which are expected and it would establish a framework for performance management.

15. In the particular context of primary care there is a need to ensure more openness and to offer complainants an opportunity to avoid the need to complain directly to the practice. We believe that the best way to achieve this is to encourage practices to work together within the structure of a primary care group (or primary care trust) to share information and to offer support in providing acceptable procedures for handling complaints.

- Complaints about family health services should be handled in the same way as complaints about all other services provided by the NHS. The board of a primary care trust or its equivalent should have the responsibility in relation to complaints about family health services contractors which currently lies with a health authority/board. Primary care trusts in Scotland already have this responsibility.

16. We have suggested a number of changes which, taken together, are likely to lead to improvements in the way in which complaints are handled locally. Many of these changes are already possible within the current procedure, and part of the emphasis in the future must be on ensuring that current mechanisms are properly enforced. A complete list of suggested changes is given at the end of this Summary.

Independent review

17. As a second stage in the complaints procedure, a system of review offers two important safeguards: it provides an additional opportunity to identify clinical or professional problems which may be overlooked when complaints are dealt with internally and, so long as the review process is linked to a system of monitoring, it offers an opportunity to ensure that necessary changes follow from complaints.

18. In order to offer these safeguards the review process must be *independent* and it must have the *authority* to ensure that recommendations are enforced. The current system does not meet either of these requirements.

19. Nor does it currently perform well. Of individuals who requested independent review, no more than one in ten were satisfied with the time taken and only 13% were

satisfied with the outcome of their complaint. Almost three-quarters believed that the procedure was unfair or biased. Even those involved in the operation of the complaints procedure agree that the review process should be more independent and less time consuming.

20. Suggested improvements include both procedural and structural changes (details are given at the end of this Summary). However, the fundamental requirements are to ensure that the review procedure is genuinely independent and that organisations are *actively* monitored in order to ensure that actions agreed following an independent review are implemented.

- Consideration should be given to the proposal that in future both the convening decision and the conduct of a review should be the responsibility of a regional or sub-regional lay panel appointed for the purpose. Panels may be accountable to a national complaints authority *or* to the regional offices of the NHS Executive (in England) and national or sub-national bodies in Scotland, Wales and Northern Ireland.

- The regional and national bodies responsible for NHS performance should ensure, through the performance management framework, that an acceptable action plan is produced in response to the report of an independent review and that the plan is implemented.

References

The Report of the Review Committee on NHS Complaints Procedures, chaired by Professor Alan Wilson: *Being Heard*, May 1994

The Government's Proposals in Response to "Being Heard": *Acting on Complaints*, March 1995

Summary of policy implications

Local Resolution
1. The board of every NHS organisation should be held accountable for the performance of the organisation in handling complaints. In particular, the board should ensure that: (a) all staff are adequately trained to deal with complaints and are supported in the event of a complaint being made against them. Training in handling complaints should be a compulsory part of induction and continuing education; (b) staff managing complaints are appropriately trained, have adequate administrative resource and access to senior managerial supervision and support; (c) the complaints procedure is integrated into the clinical governance/quality framework of the organisation (6.12). 2. The board of an NHS organisation should insist on receiving appropriate information at least quarterly on the causes of complaints and on the action which has been taken, or is proposed, to prevent recurrence. The board should take responsibility for ensuring that agreed actions are implemented (6.31). 3. The quarterly report to the board should provide an analysis of the causes of complaints, emerging trends and the action taken (or proposed) to prevent recurrence. This report should be presented to the board in person by the complaints manager or the chief executive (6.16). 4. The quarterly report to the board should be copied to the local health council (or equivalent), the proposed Patients' Forum in England and equivalent organisations which may be established in Scotland, Wales and Northern Ireland. The chief executive of the trust or health authority/board should invite these organisations to monitor the implementation of action plans agreed in response to complaints (6.31). 5. The regional offices of NHS Executive in England and the appropriate central NHS bodies in Wales, Scotland and Northern Ireland should be required to demonstrate that complaints-handling is an explicit part of the performance management of chairs and chief executives. These bodies should ensure that the information available to them is timely and relevant to this responsibility (6.31). 6. Consideration should be given to the development of a National Service Framework or its equivalent for the management of complaints. A service framework would provide clear guidance to NHS organisations on the standards which are expected and it would establish a framework for performance management (6.12).

Local Resolution – Continued

7. The same principles should apply to family health services as to other services. The board of a primary care group (PCG), (local health group (LHG) in Wales) or primary care trust (PCT) should have the responsibility in relation to complaints against contractors which currently lies with the health authority. In particular:

- The board should work with practices in order to assist members in ensuring that acceptable procedures are in place to deal with complaints
- The board should receive information quarterly from practices on the causes of complaints and on action taken or proposed.
- Where appropriate, the board should offer support to practices in dealing with complaints (6.21).

8. The board of a PCG/LHG/PCT should be responsible for providing access for complainants to a named individual whose responsibility it is to handle complaints about member practices (6.23).

9. Where primary care groups do not yet exist (as in Northern Ireland), alternative approaches will need to be considered to improve the handling of FHS complaints (6.25).

10. Less discretion should be available to individual organisations to decide the functions of, and resources available to, the complaints manager. More detailed guidance should be offered from the centre, based on an analysis of current best practice (6.36).

11. The complaints manager should play a central part in ensuring that front-line staff are adequately trained and supported in dealing with complainants. Training should be provided on a regular basis (6.37).

12. Wider use of conciliation should be encouraged. Organisations should review their policy on offering conciliation and should assess the availability of trained conciliators locally. Trusts and health authorities/boards, in conjunction with the relevant regional or central NHS bodies, should then address remuneration, recruitment and training needs (6.44).

13. There does not appear to be any compelling reason why targets for a full response to a complaint at local resolution should be shorter for FHS contractors. Performance targets should be the same in all sectors (6.46).

14. It is not reasonable that staff should be subject indefinitely to the threat of a complaint and, subject to the exercise of discretion in appropriate cases, the existing time limits on complaints should be retained (6.49).

15. Central NHS bodies in England and Wales should disseminate examples of good practice in dealing with vexatious complainants (6.52).

Independent Review

16. The criteria for granting an independent review should be publicised and should be applied consistently throughout the NHS (7.19).

17. Although a decision must be made in each country, consideration should be given to the proposal that in future both the convening decision and the conduct of a review should be the responsibility of a regional or sub-regional lay panel appointed for the purpose (7.27).

18. A further decision must be made in each country about the framework within which a lay panel would be accountable. Two options have been suggested:

- Panels are accountable to the regional offices of the NHS Executive (in England) or to the relevant national or sub-national bodies in Scotland, Wales and Northern Ireland
- Panels are accountable to regional or sub-regional offices of a new national complaints authority which is independent of the NHS locally and regionally (7.29).

19. If regions are to have greater responsibility for independent review, there must be a clear statement of the minimum standards which are expected and a commitment from the centre that regional directors will be assessed on their performance in managing the independent review procedure (7.32).

20. Further consideration should be given to the suggestion of the Health Committee that an independent review panel should have formal powers to summon witnesses and take evidence. In addition, the Health Service Commissioner should be consulted about the feasibility of a 'fast-track' procedure and, if appropriate, might be asked to suggest a protocol for referral (7.40).

21. The board of an NHS organisation should take *active* responsibility for all aspects of complaints-handling. The board should receive a copy of an independent review panel (IRP) report relating to the organisation (or to a member practice in the case of a PCG/LHG/PCT). The board should accept responsibility for ensuring that an action plan is produced and that agreed actions are implemented (7.43).

22. The regional and national bodies responsible for NHS performance should ensure, through the performance management framework, that an acceptable action plan is produced following recommendations of an IRP and that the plan is implemented. Regional and national bodies should receive copies of all relevant IRP reports *and* the action plan which is produced in response to a report (7.43).

Independent Review - Continued
23. IRP reports and action plans should be copied to the local health council (or equivalent), the proposed Patients' Forum in England and equivalent organisations which may be established in Scotland, Wales and Northern Ireland. One of the functions of the local health councils/Patients' Forum should be to monitor compliance with agreed action plans (7.43). 24. In England, a report of an independent review panel, together with the agreed action plan, should be copied to the Commission for Health Improvement (7.43). 25. There should be a review of the training offered to all those involved in the complaints procedure. There is a need for more central guidance in order to reduce the extent of variability between organisations in the amount and type of training which is offered. There may also be a need to make some training compulsory, particularly for convenors, chairs and other lay members (7.46). 26. In Scotland and Northern Ireland the list of clinical assessors was recently updated but in other parts of the UK it is acknowledged that the list is out-of-date and in need of revision. This should be addressed as a matter of urgency by the NHS Executive centrally. Consideration should also be given to whether current fee rates for assessors and advisers are adequate (7.50). 27. Consideration should be given to standardising expenses and subsistence payments for chairs and lay members and to replacing loss of earnings compensation with an annual retainer or a fixed fee per case (7.53).

CHAPTER 1: INTRODUCTION

The NHS Complaints Procedure

1.1 The current NHS complaints procedure was introduced in April 1996 following the report of a review committee chaired by Professor Alan Wilson (Wilson, 1994) and the Government's response (*Acting on Complaints*, March 1995). Prior to 1996 complaints about NHS services were handled under a number of separate procedures. Complaints involving clinical judgement were dealt with separately from those involving other aspects of service delivery. Because of differences in their contractual status, complaints about family health service contractors were handled separately from those about hospital staff. One of the most important recommendations of the Wilson report was that there should be a common system for handling complaints across the NHS.

1.2 The principles established by the Wilson committee were accepted by Government (*Acting on Complaints*, March 1995) and these principles formed the basis of the complaints procedure introduced in 1996. Although the broad structure of the procedure is the same across the UK there are operational differences in England, Wales, Scotland and Northern Ireland. Separate guidance is issued in each country.[1] The main differences are described in Chapter 2.

Terms of Reference

1.3 This study was commissioned by the Department of Health Research and Development Division, in collaboration with the NHS Executive in England, the Scottish Executive, the Northern Ireland Department of Health, Social Services and Public Safety and the National Assembly for Wales. The aims were:

…to provide an evaluation of how the new complaints procedures are operating across all parts of the NHS – hospital, community and family health services (FHS) – and to meet the information needs of policy makers and managers concerned with the future development of the system (Research Brief).

1.4 In addressing these aims we have sought the views of those working in the NHS and of others with experience of the complaints procedure about how the procedure currently operates, what features of the current system work well and what needs to be improved.

Structure of the Report

1.5 Chapter 2 provides a summary of the current complaints procedure and highlights the ways in which the procedure differs between the four countries of the UK. Chapter 3 outlines the methodology used in the research. The main research findings are

[1] The most recent guidance in each country is: NHS Executive, March 1996 (England); Scottish Office, May 1999 (Scotland); Department of Health, Social Services and Public Safety, April 2000 (Northern Ireland); Welsh Office, April 1996.

summarised in Chapters 4 and 5. Chapter 4 reflects the views of service users (complainants, staff complained against, health councils and patient interest groups) on the current procedure. Chapter 5 summarises the views of those operating the system (chief executives, complaints managers, convenors, lay chairs, family health services (FHS) contractors and regional/national complaints leads). Where results differ between countries, findings are reported separately. Chapters 6 and 7 discuss the main findings and policy implications in relation to local resolution and independent review respectively. The final chapter (Chapter 8) summarises the main findings of the research and brings together the policy implications discussed in earlier chapters.

1.6 Appendix A provides details of the characteristics, workload and training of complaints managers, convenors, lay chairs and panel members. Results are presented by country where possible. Appendix B and Appendix C provide summaries of FHS focus groups and interviews with regional complaints leads.

CHAPTER 2: NHS COMPLAINTS PROCEDURE

2.1 This chapter provides a summary of the current NHS complaints procedure. The main aim is to highlight the ways in which the implementation of the principles established in *Acting on Complaints* (March, 1995) differ between England, Wales, Scotland and Northern Ireland.

2.2 The current procedure has two stages. *Local resolution* involves the service provider attempting to resolve a complaint as directly and as quickly as possible, with the primary aim of satisfying the complainant. Local resolution may involve an immediate informal response from front-line staff or it may require an internal investigation, use of conciliation or direct action by a chief executive.

- In Northern Ireland local health and social services boards have responsibility for health and personal social services provision, and the complaints procedure covers both health care *and* social services. In other countries in the UK the procedure covers health care only.
- In Scotland the Health Act 1999 made it possible to delegate responsibility to primary care trusts (PCT) for handling complaints about family health services. In the other countries this responsibility lies with the host health authority (England and Wales) or health and social services board (Northern Ireland).

2.3 If a complaint cannot be resolved locally, a complainant may apply for *independent review*. The right to have a complaint reviewed is not automatic and a request for review is considered by a convenor in consultation with an independent lay chair.

- In England and Wales the convenor is a non-executive director of the trust or health authority complained against.[2] Requests concerning family health service (FHS) contractors are considered by a convenor who is a non-executive director of the local health authority. An independent lay chair is nominated in all cases by the local regional office of the NHS Executive or the National Assembly for Wales.
- In Northern Ireland *all* requests for independent review are considered by a convenor appointed by the local health and social services board. The convenor is a non-executive director of the board. An independent lay chair is nominated by the local health and social services board.
- In Scotland the convenor is a non-executive trustee of the trust or health board complained against. Requests concerning FHS contractors are considered by a convenor who is a non-executive trustee of the relevant PCT (or island health board in some circumstances). An independent lay chair is nominated in all cases by the relevant health board.

2.4 A convenor must take appropriate professional advice where a complaint relates to the exercise of clinical judgement or, in Northern Ireland, to the professional judgement of a social worker.

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[2] If there is more than one convenor in an organisation the lead person with this role will be a non-executive director. Similar principles apply in Scotland and Northern Ireland.

- In the case of trust complaints in England and Wales the convenor will normally seek advice from the medical or nursing director of the trust or other appropriate professional head. If independent advice is required a clinical adviser will be nominated from a list maintained by the local regional office of the NHS Executive or the National Assembly for Wales. In the case of FHS complaints clinical advice is provided by a practitioner from the same profession as the practitioner complained about. The regional office maintains a list of practitioners nominated by the relevant local professional representative committees.
- In Northern Ireland professional advice will be sought initially from the medical director or the director of social services of the relevant health and social services board. An independent adviser will be appointed by the board for all complaints involving FHS contractors and for other complaints as required. As in England and Wales, clinical advice for FHS complaints is provided by a practitioner from the same profession as the practitioner complained about. The health and social services board maintains a list of practitioners nominated by the relevant local professional representative committees.
- In the case of trust complaints in Scotland the convenor will normally seek advice from the medical or nursing director of the trust or other appropriate professional head. If independent advice is required a clinical adviser will be nominated by the local health board. In the case of FHS complaints, clinical advice to the convenor is provided by an independent practitioner from the same profession as the practitioner who is being complained about. A list of practitioners nominated by local professional representative committees is held by the health board.

2.5 If a review is granted a panel will be appointed to consider the complaint. An independent review panel (IRP) has three members: a lay chair, the convenor and a third lay member. If the case involves the exercise of clinical judgement at least two clinical assessors will be appointed to advise the panel. The panel is appointed by the trust or health authority complained against or, in the case of complaints about FHS contractors, by the local health authority/board.[3]

2.6 In England and Wales lay members are nominated from local lists maintained by the regional offices of the NHS Executive or the National Assembly for Wales. Responsibility for nominating and maintaining a list of independent lay members lies with the local health board in Scotland and the health and social services board in Northern Ireland. Clinical assessors are nominated in the same way as independent lay members. In England and Wales clinical assessors are drawn from a central UK list. The Scottish Executive produced a separate up-dated list of clinical assessors for Scotland in 1999. The Northern Ireland list was up-dated in 2000.

2.7 Having exhausted the NHS procedure, if a complainant is still not satisfied with the response to their complaint, they may refer the case to the Health Service Commissioner (Commissioner for Complaints in Northern Ireland). The Commissioner is independent of the NHS and his jurisdiction was extended in 1996 to

[3] In Scotland responsibility for appointing a panel to review a complaint against an FHS contractor lies with a primary care trust or island health board.

include matters involving clinical judgement and complaints about FHS contractors, so that he can now investigate any aspect of care provided by the NHS.

CHAPTER 3: RESEARCH METHODS

Introduction

3.1 Part of our brief was to provide

..a practical and realistic analysis based as far as possible on the actual experiences of those using and operating the procedure (ie complainants and staff respectively)..

3.2 In order to address this brief we have carried out a questionnaire survey of those operating the complaints procedure (chief executives, complaints managers, convenors, chairs and lay panel members, conciliators and clinical assessors) and those with experience of how it operates (complainants, staff complained against, health councils and patient interest groups). More than 4,000 questionnaires were distributed.

3.3 We have also conducted more than 300 interviews with complainants, staff complained against and regional and national complaints leads. We have facilitated a number of focus group meetings with those associated with primary care and workshops with key stakeholders, and we have received a large number of written submissions from individuals and representative organisations.

3.4 This is a UK study and all of the elements of the research were undertaken in each of the four countries. Where sampling was necessary, separate samples were drawn for each country in order to ensure that the sample is representative of the population locally.

Convenors, Complaints Managers and Chief Executives

3.5 A postal questionnaire was sent to the complaints manager, convenor and chief executive of all of the trusts and health authorities/boards in the UK.

3.6 Each health authority/board and trust must have a designated complaints manager whose prime role is to oversee the complaints procedure. Similarly, each health authority/board and trust must appoint at least one person to act as a convenor[4]. The convenor is normally a non-executive director of the organisation. Some organisations have more than one convenor or complaints manager. The questionnaire was directed to the *lead* individual. Response rates are shown in Table 3.1

[4] In Northern Ireland trusts do not appoint a convenor.

Table 3.1: Convenor, complaints manager, chief executive (Questionnaire survey)

	Sample size	Response	Response rate
Trust • Convenor • Complaints mgr • Chief executive	 404 404 404	 257 274 219	 64% 68% 54%
Health authority/board • Convenor • Complaints mgr • Chief executive	 123 123 123	 85 85 60	 69% 69% 49%
Total	1581	980	62%

Lay Chairs and Panel Members

3.7 An independent review panel comprises three members: a lay chair, the convenor and a third lay member. In England the regional offices of the NHS Executive are responsible for maintaining lists of lay chairs and lay members. In Scotland and Northern Ireland responsibility lies with the local health boards, in Wales with the National Assembly for Wales.

3.8 We asked each of the responsible bodies in the UK to provide us with lists of chairs and lay members who had served in that role in the past 12 months. Three respondents (Wales, London and Eastern England) preferred to distribute questionnaires on our behalf. The aim was to sample 100% of active lay members in the UK. The sample size and response rate are shown in Table 3.2.

Table 3.2: Lay chairs and panel members (Questionnaire survey)

	Sample size	Response	Response rate
Lay chairs and panel members	767	474	62%

Clinical Assessors

3.9 Where a complaint before an independent review panel concerns clinical judgement the panel must be advised by at least two independent clinical assessors.

3.10 We drew a sample at random from the central (UK) list of clinical assessors. The achieved response of 44% to a postal questionnaire is higher than we expected in light of the fact that the central list includes individuals who have never acted as assessors.

Table 3.3: Clinical assessors

(Questionnaire survey)

	Sample size	Response	Response rate
Clinical assessors	300	132	44%

Health Councils

3.11 The health councils in the UK (community health councils in England & Wales, local health councils in Scotland and health & social services councils in Northern Ireland) play an important role within the complaints procedure. They are a source of information and support to complainants, and because of their role have an important perspective on the operation of the current procedure.

3.12 We sent a postal questionnaire to all of the health councils in the UK. It focused primarily on the work of the councils in helping complainants and on their views of the strengths and weakness of the current system.

Table 3.4: Health Councils
(Questionnaire survey)

	Sample size	Response	Response rate
Health Councils	226	130	58%

Complainants and Staff Complained Against

3.13 An important element in the research was a series of interviews with complainants and NHS staff who had been the subject of complaint. A larger sample of complainants and staff also received a postal questionnaire. In order to ensure that the sample of complainants was unbiased we selected this sample at random.

3.14 The starting point was to select a UK-wide random sample of 20 health authorities/boards and 30 trusts (Table 3.5). Organisations were numbered and a sample selected by drawing numbers at random (without replacement) from the population.

- The authority/board sample size ranged from 10% (in England) to 50% (in Northern Ireland). In Scotland and Wales the sample was 40%. The higher sampling proportion in the smaller countries was dictated by the decision to select at least two authorities/boards from each.

- The trust sample was stratified within each country in order to ensure a balance of different types of trust (acute, community/mental health (C/MH), mixed and ambulance trusts). In England the sampling proportion was 5%. In the other countries the proportion varied because of the decision to select at least one of each type of trust.

- We also selected an approximate 10% sample of the general medical (GMP) and general dental practices (GDP) in the 20 sample health authorities/boards (332 practices in all).

3.15 We contacted the chief executive and the complaints manager of each of the authorities/boards and trusts in the sample and asked them to send a questionnaire on our behalf to *all* individuals who had complained to the organisation in the period January-March 1999 (inclusive) and to all of the staff who were the subject of those complaints. The period was chosen to ensure (as far as possible) that complaints were no longer active. Replies came directly to the research team (Table 3.6).

3.16 Eleven organisations (of the 50 contacted) were either unable or unwilling to take part in the research: 1 ambulance trust (England), 6 other trusts (England), 3 health authorities (England and Wales) and 1 health board (Scotland).

- Because the sample of organisations was selected at random, the sub-set of all complainants to those organisations in a defined period provides as near as we can get to a random sample of complainants. The fact that 11 organisations (22%) felt unable to take part is a problem, but we have no particular reason to believe that these organisations were atypical. Because we were often notified very late of the decision not to take part in the evaluation it was not possible to replace those who withdrew.

- In order to maintain confidentiality we asked organisations to contact complainants and staff on our behalf. Unless complainants chose otherwise, questionnaire replies were completely anonymous. We were not able to identify the organisation or even the country from which replies were received, although we did know how many individuals had been contacted by each organisation.

- We asked complainants and staff to complete a short questionnaire and also to indicate if they were willing to be interviewed as part of the research. Those who indicated their willingness to be interviewed were contacted directly by members of the research team.

3.17 As part of the same process we also contacted the manager of each of the general medical and general dental practices selected from the health authority/board sample: 332 practices in all. We asked practitioners or practice managers to complete a short questionnaire dealing with their own experiences of the complaints procedure. We also asked them to send a questionnaire on our behalf to all individuals who had complained to the practice in the period January-June 1999 (inclusive).

Table 3.5: Sample frame

	UK Total*		England		Wales		Scotland		N Ireland	
	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)
Authorities/ boards	16.3	20	10.1	10	40.0	2	40.0	6	50.0	2
Trusts	7.4	30	5.2	18	26.7	4	14.3	4	22.2	4
Acute		10		7		1		1		1
C/MH		9		6		1		1		1
Mixed		7		4		1		1		1
Ambulance		4		1		1		1		1
Practices	10.0	332	10.0	188	10.0	40	10.0	80	10.0	24
GMP		177		101		17		44		15
GDP		155		87		23		36		9

* % of total population/sample size

Table 3.6: Complainants and staff complained against (Questionnaire survey)

	Sample size	Response	Response rate	Agreed to be interviewed
Trust and HA/HB Complainants	884	271	31%	165
Trust staff complained against	364	134	37%	60
HA/HB staff complained against	40	10	25%	3

3.18 The response is shown in Table 3.7. A total of 63 practices responded (19%). All but 15 of these reported having received no complaints in the six month period. Of the practices that did receive a complaint, seven agreed to distribute a total of 27 questionnaires on our behalf. Eleven complainant questionnaires were returned. Five complainants and 10 FHS contractors agreed to be interviewed.

Table 3.7: General medical and general dental practices (Questionnaire survey)

	Sample size	Response	Response rate
Practices	332	63	19.0%
• General medical	177	35	19.8%
• General dental	155	28	18.1%
Complainants	27	11	40.7%

3.19 Because the number of FHS complainants which we were able to identify by the preferred random method was so small we asked all of the health councils in the UK to send a questionnaire on our behalf to any individuals who had complained about general medical (GMS) or general dental services (GDS) in the period January-June 1999. These individuals were also asked if they were willing to be interviewed. A total of 137 completed questionnaires were received.

3.20 The majority of complaints do not proceed beyond local resolution. In order to ensure that we had adequate coverage of views on the independent review process, we also asked the health councils to write on our behalf to individuals who had requested independent review. A total of 137 completed questionnaires were received.[5]

Table 3.8: Complainants contacted through Health Councils in the UK (Questionnaire survey)

	Responses received
Complainants about general medical/general dental services	137*
Complainants requesting IR	137

*148 including those identified through practices (Table 3.7)

3.21 On the basis of responses received to the questionnaire surveys it was possible to interview 276 complainants and 39 staff complained against. Complainant interviews were carried out face-to-face in their home. Interviews with NHS staff were carried out by telephone. Interviews took place throughout the UK.

Table 3.9: Complainants and NHS staff complained against (Interviews)

	Number interviewed
Complainants	276
Staff complained against	39

Family Health Services Contractors

3.22 More than 300 general medical and general dental practices were asked to take part in the questionnaire survey. In the event the response rate was low (19%, Table 3.7). We conducted nine focus groups with FHS contractors and others involved in primary care: three in England and two each in Scotland, Wales and Northern Ireland. Attendees included GPs, GDPs, opticians, pharmacists, practice managers, health council and health authority/board representatives. Eighty-three individuals attended these groups.

[5] These are separate from the GMS/GDS respondents. The fact that the same number replied in both groups is coincidental.

Table 3.10: FHS Focus Groups

Venue	Attendance
England Wales Scotland N Ireland	22 20 20 21
Total	83

Workshops

3.23 Nine stakeholder workshops were held at the beginning of the research: three in England and two each in the other countries. The aim of the initial workshops was to help to identify the key research questions and to establish a Reference Group in each country. Members of these groups offered comments at different stages of the research.

3.24 Four interim workshops (one in each country) were held at the end of the first year and a final series of workshops was held at the end of the study.

Other Methods

3.25 We have augmented the main questionnaire surveys and interviews in a number of ways

- We have received a large number of written submissions from individuals and representative organisations. We are very grateful to all of those who have taken the trouble to contact us in this way. All of this evidence will be passed to the research commissioners along with the other outputs of the study.
- We have carried out additional questionnaire surveys of patient interest groups (n=12/34) and conciliators (n=25/50).
- Finally: we have attended a large number of meetings of complaints managers, convenors, conciliators and others and have held a number of informal meetings with individuals with experience of the complaints procedure. We are grateful to all of these people for giving their time.

CHAPTER 4: VIEWS OF THOSE USING THE COMPLAINTS PROCEDURE

4.1 This chapter summarises the views of those with experience of the operation of the complaints procedure: complainants, staff complained against, health councils and patient interest groups.

Views of Complainants

Local Resolution

4.2 In the postal questionnaire survey and in interviews we asked complainants about their experience with the complaints procedure. The sample of complainants is divided into three sub-groups, two of which are relevant here. Because the vast majority of complaints in these two groups did not proceed beyond the local stage, the opinions expressed relate primarily to local resolution.

- Group 1 is a sample of complainants drawn from a random sample of 50 health authorities/boards and trusts in the UK. The sample size is 271 and 96% of the complaints in this group did not progress beyond local resolution (11% requested independent review).

- Group 2 is a sample of complainants concerned with family health service (FHS) contractors. The sample size is 148 and although 54% of complainants in this group had requested independent review, the majority (70%) did not proceed beyond local resolution. This group was contacted through health councils (137) and practices (11).

Table 4.1: Complainants-Questionnaire survey

Subject of complaint	Group 1-All (%)	Group 2-FHS (%)
Hospital and community health services	73.48	-
Ambulance service	7.95	-
Health authority/board	5.68	-
General medical	4.17	55.4
General dental	2.65	17.6
Optician	-	1.40
Pharmacist	0.38	2.00
More than 1	5.68	23.60
Total (%)	100.00	100.00
Total (n)	271	148
Requested independent review (%)	10.7	53.5
Resolved at local resolution (%)	96.0	70.0

4.3 Complainants were asked whether they agreed or disagreed with a number of statements describing their experiences with the complaints procedure. Responses are summarised in Table 4.2.

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Table 4.2: Complainants-Agreement or disagreement with the following statements

	Group 1-All		Group 2-FHS	
	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)
My complaint was handled well	30.35	49.41	34.3	46.9
I was satisfied with the time it took	29.81	47.06	19.6	***58.6***
I was satisfied with the outcome	23.63	***58.26***	19.2	***63.2***
The process was fair	25.51	***54.25***	22.8	***56.7***
The process was unbiased	22.45	***51.02***	22.9	***60.3***
The process was not stressful	18.6	***65.51***	7.9	***79.9***
The process was not distressing	19.12	***65.34***	7.9	***82.1***
Sample size (n)	271		148	

Agree = agree or strongly agree. Disagree = disagree or strongly disagree.
Rows may not add to 100% because some respondents answered 'neither agree nor disagree'. Figures in italics: more than 50% disagree with the statement.

4.4 The overall results are consistent across the two sub-groups. They show a level of dissatisfaction with present procedures which is surprising in view of the fact that the vast majority of these complaints had apparently been resolved.

- When asked whether their complaint had been handled well, only around one-third (30-34%) of respondents agreed that it had. In both of the sub-groups more respondents disagreed than agreed that their complaint had been handled well.

- The extent of dissatisfaction is even more evident when respondents were asked whether they were satisfied with the time taken to resolve their complaint. Only between 20% and 30% of respondents were satisfied. The mean (median) time taken to resolve the complaints in the sample was 22.3 (10) weeks: the maximum was 148 weeks.

- In both of the sub-groups a majority of respondents (58-63%) were dissatisfied with the outcome of their complaint. This is the case despite the fact that the vast majority of these complaints did not proceed beyond the local stage.

- A majority of respondents thought that the complaints process was either unfair or biased. This type of response might have been expected among complainants with experience of independent review, but is unexpected in these groups.

- All respondents found the process to be stressful and distressing. Although some level of stress is to be expected in pursuing a complaint, the level of the response here is surprising.

The sample of complainants was selected to ensure, as far as possible, that their complaints were no longer active. References here to a complaint being **resolved** mean only that the complaint is no longer being pursued. The fact that a complaint is resolved does not imply that either party is content with the outcome
Among other things, we asked complainants if they agreed or disagreed with statements such as: 'I was satisfied with the time taken to resolve my complaint'. When we talk about complainants being **satisfied** or **dissatisfied** with aspects of the current procedure, this is the context in which these words should be interpreted.

4.5 We also asked complainants about the single most important change to the current procedure which would have made their experience better. A summary of responses is shown in Table 4.3.

4.6 Not all of those who responded to the questionnaire answered this question. The proportion in each sub-group is broadly in line with the proportion expressing dissatisfaction with their experience of the current system. These factors represent the things which, if not done well, lead to dissatisfaction among complainants. The themes are consistent.

- A very common and pervasive source of dissatisfaction among complainants is poor attitudes of staff-including both clinical and managerial staff. Complainants often mention lack of respect; lack of sympathy and understanding; patronising, aggressive and arrogant attitudes. A call for staff to listen to complainants and to be more honest is common. Whilst most staff appear to deal well with complainants,[6] it is clear that poor attitude can be a source of distress and dissatisfaction to complainants in many cases.

- A second common theme is the need for complaints to be dealt with quickly and for communication with complainants to be better. This is captured in the view that complainants prefer to deal personally with staff rather than remotely. For example, complainants prefer their complaint to be acknowledged by a telephone call on the day of receipt rather than by a letter. Similarly, complainants believe that their complaint can best be settled by a face-to-face meeting arranged as quickly as possible after the event. There is compelling evidence that a complaint can be escalated and positions entrenched by poor initial handling by front-line staff or managers.

[6] The questionnaire asked complainants whether they agreed that staff were helpful when they first complained. More respondents agreed than disagreed [40% agreed/33% disagreed (Group 1) and 52% agreed/ 34% disagreed (Group 2)]. We also asked whether staff were sympathetic [35% agreed/36% disagreed (Group 1) and 48% agreed/30% disagreed (Group 2)].

Table 4.3: Single most important change which would have improved your experience (Percent of responses)

	Group 1-All (%)	Group 2-FHS (%)
Better attitude of staff More honesty	27.86	21.65
Quicker response Better communication More personal	38.57	30.93
Better information Support with complaint	15.00	16.49
Apology Explanation	7.14	10.31
More independence	8.57	19.59
Other	2.86	1.03
	n=140 (52%)*	n=97(66%)

*52% of questionnaire respondents answered this question, 140 in all.

- Although these complainants do not appear to have found it difficult to obtain the information they needed to pursue a complaint, lack of information and support are important in specific cases. The community health councils and their equivalent play an important role as a source of information and support. We found that 48% of complainants who responded to the questionnaire had contacted their local health council about their complaint. More than three-quarters of those (77%) reported that the involvement of the health council was helpful to them. For around a quarter of all respondents (23%) a health council was the first point of contact when they wanted to complain.

- Greater independence in procedures for dealing with complaints is particularly mentioned by FHS complainants. It is often difficult for complainants to accept that their complaint will be investigated impartially even at local resolution and complainants are sometimes inhibited by the perceived imbalance of power between themselves and those complained against.

Independent Review

4.7 Very few complainants have experience of independent review because on average more than 90% of complaints do not proceed beyond the local stage. In an attempt to obtain the views of this group we have constructed a third sub-group of complainants.

- Group 3 is a sample of complainants, all of whom had requested independent review. The sample size is 137. Fifty-three percent of complaints (73) proceeded to an independent review panel (IRP). The sample is fairly equally balanced between complaints about hospital and community services (40%) and complaints about GPs (33%)(Table 4.4).

Table 4.4: Complainants-Questionnaire survey

Subject of complaint	Group 3-Requested IR (%)
Hospital and community health services	40.10
Ambulance service	0.70
Health authority/board	3.60
General medical	32.80
General dental	7.30
Optician	-
Pharmacist	-
More than 1	15.3
Missing	0.20
Total (%)	100.0
Total (n)	137
Requesting independent review (%)	100.0
Resolved at local resolution (%)	47.0

4.8 Complainants were asked if they agreed or disagreed with a number of statements relating to their experience of the complaints procedure. Results are summarised in Table 4.5.

Table 4.5: Complainants-Agreement or disagreement with the following statements

	Group 3-Requested IR	
	Agree (%)	Disagree (%)
My complaint was handled well	22.6	***64.7***
I was satisfied with the time it took	9.5	***77.8***
I was satisfied with the outcome	12.9	***77.6***
The process was fair	13.1	***71.3***
The process was unbiased	12.7	***74.6***
The process was not stressful	4.6	***89.3***
The process was not distressing	6.2	***88.5***
Sample size (n)	137	

Agree = agree or strongly agree. Disagree = disagree or strongly disagree.
Rows may not add to 100% because some respondents answered ‘neither agree nor disagree’. Figures in italics: more than 50% disagree with the statement.

4.9 The results are very similar to those reported for the other sub-groups of complainants which were described in the previous section.

- When asked whether their complaint had been handled well, around a quarter (23%) of respondents agreed that it had. This compares with 30% of all complainants and 34% of FHS complainants (Table 4.2).

- No more than 10% of respondents were satisfied with the time taken to resolve their complaint and only around 13% were satisfied with the outcome.

- Almost three-quarters of respondents believed that the complaints procedure was either unfair (71%) or biased (75%). This compares with 50-60% of complainants whose experience is restricted to local resolution (Table 4.2).

- A very significant majority of respondents (89%) found the process to be stressful or distressing. This is higher than either of the other two sub-groups (all complainants = 65%. FHS complainants = 80-82%).

4.10 Bearing in mind that these are complainants who have been through the process of local resolution and have been sufficiently dissatisfied with the outcome to request an independent review, the high levels of dissatisfaction and distress may not be surprising. However, the important point is that dissatisfaction remains *after* these complainants have been through the convening stage and most have been through an independent review.

4.11 Asked about the most important changes required in the current procedure, respondents consistently mentioned two factors:

- The convening decision and the review process itself should be more impartial.

- An organisation which is the subject of independent review should have less discretion to decide whether and in what way the recommendations of a review panel will be implemented.

Case Studies

4.12 We have received a large number of written submissions, including submissions from individuals with direct experience of the complaints procedure. Seven cases are summarised here and at the end of this chapter. These cases are not typical of all complaints, but they do illustrate many of the points which are consistently repeated by complainants in questionnaire and interview responses.

4.13 In particular, it is clear that the process can be very slow. It is not uncommon for a complaint to take 2-3 years to pass through all of the stages in the procedure. There are delays at local resolution, often caused by difficulties in arranging a date for staff to attend a meeting with the complainant or delays in obtaining information. There are delays in the convening decision, often caused by problems in obtaining clinical advice and there are delays once a panel is convened.

4.14 One of the most common characteristics of protracted cases is the singular failure to deal adequately with the complaint at the outset. In many cases it appears to be almost impossible for clinicians or managers to admit that a mistake has been made and to offer a genuine apology. The evidence suggests that the culture of defensiveness and blame which was supposed to have characterised the complaints system prior to 1996 has not been dispelled. Poor initial handling of a complaint often makes the situation significantly worse, adding to the distress of complainants and to

the costs of the procedure. It is arguable that claims for medical negligence are increased by poor handling of complaints in the crucial first few days.

CASE 1
This case involved a complaint against a hospital made in April 1997. A request for independent review in March 1998 took six months to decide and was refused. An investigation by the Ombudsman took sixteen months. From the date of the complaint to the report of the Ombudsman (January 2000) took almost three years.
CASE 2
The complaint was made in February 1997. A request for independent review made to a health authority in September 1999 (at the end of the local resolution phase) had not been decided by February 2000, five months later and three years from the date of the original complaint.

4.15 However, it is also true that some complainants may be impossible to satisfy and these complainants impose significant burdens on an organisation. We have received evidence of cases of this kind. It is also clear that complaints, particularly those following an unexpected death, can be very traumatic for staff and it is important that the support needs of staff are not ignored.

Views of Staff Complained Against

4.16 A postal questionnaire was sent to NHS staff who had been the subject of a complaint. A total of 144 responses were received (93% from trust staff). Interviews were also carried out with 39 staff. Most of the complaints (77%) did not go beyond local resolution. A small proportion (2%) reached an independent review.

4.17 The questionnaire asked for the opinions of staff on the same range of questions asked of complainants. The difference in experiences (Table 4.6) is marked.

4.18 The majority of staff felt very positive about their experience of the complaints procedure, although the process was acknowledged to be stressful. A majority of staff thought the complaint against them had been handled well and they were satisfied with the outcome and the time taken to resolve the complaint. They were well supported by professional and managerial colleagues. The majority agreed that the process was both fair and unbiased.

4.19 The only statement which elicited significant dissent was ‘I was kept informed throughout the process’. This theme was reinforced in the interviews. A number of respondents noted that they were initially unaware that a complaint had been made against them and others felt that they were not sufficiently involved from the outset. The most common criticism was lack of involvement and poor communication. A significant minority of respondents to the questionnaire (15%) said that they were not informed of the outcome of the complaint.

4.20 The most common suggestion for improvement was for staff to be involved from the outset and to be kept informed throughout the process. Staff should be supported more with information about the various stages in the complaints procedure and assisted in preparing reports or evidence.

Table 4.6: NHS Staff–Agreement or disagreement with the following statements

	Trust staff		HA/HB staff	
	Agree (%)	Disagree (%)	Agree (%)	Disagree (%)
The complaint was handled well	68.2	15.5	57.2	28.6
I was satisfied with the time it took	64.0	16.0	55.5	22.2
I was satisfied with the outcome	58.1	19.4	50.0	37.5
I was given all the information I needed	68.5	22.8	77.7	22.2
Professional colleagues were supportive	65.2	13.9	87.5	12.5
Managerial colleagues were supportive	64.9	18.3	66.6	33.3
I was kept informed	38.3	44.6	44.4	33.3
The process was fair	58.7	17.4	50.0	25.0
The process was unbiased	63.5	15.0	75.0	-
The experience was not stressful	16.1	***71.0***	22.2	***66.7***
Sample size (n)	134		10	

Agree = agree or strongly agree. Disagree = disagree or strongly disagree.
Rows may not add to 100% because some respondents answered 'neither agree nor disagree'. Figures in italics: more than 50% disagree with the statement

Views of Health Councils

4.21 We asked health councils for their views on the operation of current procedures. A total of 130 councils (58%) responded. Forty-two percent of these had a dedicated complaints officer who spent an average of 70% of their time dealing with complaints. In those organisations without a complaints officer the chief officer/principal officer was most likely to deal with complaints, for an average of 37% of their time. The organisations in the sample each dealt with an average of 108 new complaints in 1999.

4.22 We asked respondents for their views on local resolution, request for independent review (convening) and independent review. Views on local resolution are summarised in Table 4.7.

Local Resolution

4.23 The views of health council respondents on local resolution differ depending on the type of service involved. For hospital and community health services, a majority of respondents rate the local resolution process either good or satisfactory in meeting its objectives.

4.24 In the case of primary care a substantial majority of respondents believe the current system performs poorly or very poorly against each objective, particularly that of ensuring that services improve following a complaint and identifying serious clinical problems or professional misconduct.

- The success of local resolution depends on the attitude of individual practitioners and practice staff. Whilst many practices operate good procedures and deal well with complaints, there is a variation in performance between practices. There is nothing within the complaints procedure to reduce this variation.

- There is no formal mechanism to ensure that action follows from a complaint or that lessons are learned. Nor is there any guarantee that serious clinical issues will be identified. Although health authorities and health boards are supposed to receive information on practice complaints there is no standardisation in how complaints are recorded and present reporting procedures offer little relevant information.

Table 4.7: Views on local resolution-Which of the following best reflects your view of how well the system of local resolution meets the objectives stated?
(Percent of respondents (n=130))

	Primary care			Other services		
	Well (%)	Satisf-actorily (%)	Poorly (%)	Well (%)	Satisf-actorily (%)	Poorly (%)
Meeting the reasonable expectations of complainants	12.5	35.9	***51.6***	16.3	44.2	39.5
Improving services as a result of complaints	11.2	18.4	***70.4***	21.7	38.0	40.3
Identifying serious clinical problems and/or professional misconduct	11.7	25.0	***63.3***	20.0	31.7	48.3

Well = ‘well or very well’. Poorly = ‘poorly or very poorly’

Convening

4.25 The views of health council respondents on the role of the convenor are clear (Table 4.8). A majority believe that the current system performs poorly or very poorly against the two objectives stated. There is no difference between primary care and other services.

Table 4.8: Views on request for independent review-Which of the following best reflects your view of how well the process for deciding on independent review meets the objectives stated?
(Percent of respondents (n=130))

	Primary care	Other services

	Well (%)	Satisf-actorily (%)	Poorly (%)	Well (%)	Satisf-actorily (%)	Poorly (%)
Meeting the reasonable expectations of complainants	12.0	23.9	***64.1***	7.2	27.2	***65.6***
Identifying serious clinical problems and/or professional misconduct	11.9	24.8	***63.3***	12.0	23.9	***64.1***

Well = 'well or very well'. Poorly = 'poorly or very poorly'

- A majority of convenors are non-executive directors of their respective organisation. It is clearly difficult to meet the expectation of complainants that the convenor should be impartial.

- Respondents are also doubtful that the current procedures are adequate to ensure that complaints which raise serious clinical issues will be identified and acted on promptly.

Independent Review

4.26 Two issues which recur throughout the comments of health council respondents are the need to speed-up the process and the need to ensure that lessons are learned as a result of a complaint. These are the two most commonly cited improvements required to the system of independent review. Other important factors are:

- The fact that clinicians are not compelled to attend a panel hearing or otherwise to co-operate with an independent review. This is particularly the case with FHS practitioners because of their status as independent contractors.[7]

- The fact that an independent review is not truly independent of the organisation which is the subject of complaint because it is serviced by staff of the organisation.

Table 4.9: Views on independent review-Which of the following best reflects your view of how well the process of independent review meets the objectives stated?
(Percent of respondents (n=130))

	Primary care	Other services

[7] The terms of service of FHS practitioners requires that they co-operate with an independent review panel. The issue is whether this requirement is enforced.

	Well (%)	Satisf-actorily (%)	Poorly (%)	Well (%)	Satisf-actorily (%)	Poorly (%)
Meeting the reasonable expectations of complainants	18.1	33.3	48.6	12.0	43.6	44.4
Improving services as a result of complaints	14.6	29.1	***56.3***	14.9	44.7	40.4
Identifying serious clinical problems and/or professional misconduct	18.8	30.2	***51.0***	17.0	36.8	46.2

Well = 'well or very well'. Poorly = 'poorly or very poorly'

Views of Patient Interest Groups

4.27 The patient interest groups included in the questionnaire survey are those which may be contacted by complainants for advice or support on health related issues. All of those responding to the questionnaire had experience of dealing with individuals who had complained or who had wanted to complain about some aspect of NHS services.

4.28 Most respondents agreed that complainants typically want an explanation for what has gone wrong, an apology and reassurance that lessons have been learned for the future, although in some cases complainants expect to have a decision reversed (for example, to give access to services which have been previously denied). The current procedure is seen to have a number of strengths (the existence of a clear procedure, set time targets and a thorough approach) which offer the potential to bring about real improvement.

4.29 However, respondents are very critical of the current procedure. The perceived failure relates primarily to the way in which it is operated:

- Poor initial handling, for example failure to offer an adequate explanation at the outset, can lead to a complaint becoming more serious and creating further distress for the complainant. This appears to be a problem particularly where a complaint involves a bereavement or other serious incident.

- Failure to act on the lessons learned from a complaint or failure to communicate changes to the complainant makes it difficult to 'close' a complaint.

- Respondents also noted that: 'a substantial number of our clients have potential complaints but many choose not to complain because they fear the consequences (ie, that services will be withdrawn or reduced or they cannot cope with the complex procedure)'.

A number of these points are demonstrated in the case studies summarised at the end of this chapter.

4.30 Suggestions for improvement include better staff training, better access for complainants to information and support, improved mechanisms to audit action taken as a result of a complaint and more independence in the procedure.

Summary

4.31 Many complainants express a high level of dissatisfaction with the operation of the current procedure. This is true for complaints which do not proceed beyond local resolution as well as those which give rise to a request for independent review. All of the complaints to which these comments refer had been 'resolved' at the time the questionnaire was completed.

- Among individuals whose complaint was dealt with locally, only one-third believed that their complaint had been handled well. No more than 20%-30% were satisfied with the time taken to deal with the complaint and a majority were dissatisfied with the outcome. A majority thought that the current procedure was either unfair or biased and a high proportion found the process to be stressful and distressing.

- Among individuals who had requested an independent review, around a quarter believed that their complaint had been handled well. No more than one in ten were satisfied with the time taken to resolve their complaint and only 13% were satisfied with the outcome. Almost three-quarters believe that the complaints procedure is either unfair or biased. A significant majority found the process to be stressful or distressing.

4.32 The main causes of dissatisfaction among complainants are operational failures: unhelpful, aggressive or arrogant attitudes of staff, poor communication and a lack of information and support. The most important structural failure is the perceived lack of independence.

4.33 The views of NHS staff who have been the subject of complaint are in marked contrast to those of complainants. A majority of staff thought that the complaint against them had been handled well and they were generally satisfied with the outcome. Staff were well supported by professional and managerial colleagues and the majority thought that the process was both fair and unbiased. The only consistent source of dissatisfaction was that they were not always kept informed of the progress of a complaint against them. A number of respondents noted that they were initially unaware that a complaint had been made against them.

4.34 In their comments on local resolution health council respondents highlight the difference between primary care and other services. A majority of respondents believe that, *in primary care*, the current system performs poorly or very poorly in meeting the reasonable expectations of complainants, in ensuring that services improve as a result of a complaint and in identifying serious clinical problems or professional misconduct.

4.35 One reason for the particular focus on primary care may be the fact that, in comparison with other organisations in the NHS, most practices are relatively small

and informally managed. In this situation the success of local resolution is very dependent on the attitude and approach of the professional staff involved. Without significant external influence it is not surprising that there is wide variation between practices.

4.36 Patient interest groups draw attention to the fact that, in their experience, some potential complainants are deterred by the fear that services will be withdrawn or reduced. This is more likely where the provider has a personal relationship with the patient and where a complaint may be thought to signal a breakdown of trust. Some complainants have been removed from a practice list on this basis.

4.37 A majority of health councils believe the current system for deciding on a request for independent review performs poorly or very poorly, primarily because of the perceived lack of impartiality of the convenor. Similarly, an independent review panel may not be seen by complainants to be independent of the organisation complained against.

CASE 3
Involves a complaint against a GP practice concerning the care and treatment of a patient who subsequently died. The events took place in January-July 1997. Following unsuccessful attempts to achieve local resolution, a request for independent review was lodged in November 1997. The first request was refused. A review was eventually granted and the panel reported in August 1998 (nine months from the first request and thirteen months from the events referred to). The complainants were dissatisfied with the outcome of the review and referred the case to the Ombudsman. An investigation was carried out and the Ombudsman reported in March 2000. His decision upheld the complaint.
These comments by one of the complainants were made in November 1998, and were addressed to the chief executive of the health authority following the report of the independent review panel. They are taken from a detailed and cogent critique of the complaints procedure containing a number of practical suggestions for improvement. *Over the past fifteen and a half months I have pondered at length and in-depth about the traumatic week which led up to my mother's death* […]. *Our natural grieving process has been aggravated and distorted by the NHS complaints procedures. I have sought to understand how procedures designed to clarify a situation and assist those involved could go so badly wrong that they have actually made it harder for me to grasp what happened and to deal with my bereavement in any normal sort of way. I have concluded that lodging a complaint on top of the bereavement is a terrible added complication; and that if the local resolution fails the protracted road to a panel is so distressing that the pain, grief and anger associated with it can barely be understood by those organising the procedures…* These comments refer to a meeting in September 1997 which was designed to promote local resolution of the complaint. *I should like you to know that my father and I had simple wishes for this meeting. We wanted an admission by the doctors of their inability to diagnose my mother's condition, an acceptance by them of their ignorance and an acknowledgement of it to us, and an apology for what had happened* […]. *You should know that had the doctors concerned offered this, no further proceedings would have ensued, and we should, in all probability, have been able to get on with our grieving.* *In order to cope with the effects of the meeting* [of September 1997] *and the prolonged delays in the procedures we have had to expend an extraordinary amount of time, energy, emotional strength and money learning about the complaints procedures and seeing our complaint through. This has disrupted our lives and distorted our grieving.*

CASE 4
Involves a complaint against an acute trust following breast surgery (which later proved to be unnecessary). The complaint concerned the information given to the patient before the operation and the subsequent cosmetic consequences of the procedure. A complaint was first made in July 1998. The chief executive replied in August refuting most of the points in the complaint. The complainant requested an independent review in the same month. A meeting was arranged with the consultant in October and three months after the initial request a review panel was refused (in November 1998). In February 1999 the solicitor acting for the complainant requested a written apology and £5000 in damages. In March 2000 (more than a year later) the NHS Executive offered an apology and agreed to pay £5000 plus costs in an out-of-court settlement.
These comments were offered by the complainant as part of a detailed critique of the handling of her case. [Local resolution]. *This was an example of administrative incompetence and medical arrogance. The consultant made no real attempt to explain why things had gone so wrong and he obviously thought I was unreasonably upset about the appearance of my breast. This part of the complaints procedure took almost four months. Had I received a genuine apology and an offer of a small sum (possibly £1000) to cover my hugely increased future expenditure* […], *I should have been delighted to conclude matters at this stage.* [NHS Executive Regional Medico-Legal Service]. *This part of the process took thirteen months. Letters were answered very tardily (typically 2-4 months) and inadequately. The approach was to deny everything and to refuse all attempts at early settlement and resolution of the dispute* […]. *Pursuing the matter took all of my medico-legal knowledge* [the complainant is an academic lawyer], *plus additional research, and a vast amount of emotional energy* […]. *Given that the apology confirms all my grounds of complaint, it is difficult to see why it took so long.* *The money* […] *became increasingly important to me as my irritation at the NHS's attitude grew. I reached a point where I would happily have undergone a day in court* […] *in order to get every penny of damages I could. All I originally sought was an unconditional apology, realistic compensation for my actual past and future expenses, and an assurance that no other woman would be treated as I had been.* *The inadequacies of every stage of the NHS complaints procedure exacerbated and prolonged the trauma immeasurably.*

CASE 5
This case involves a complaint against a GP practice by the parents of a four-year old girl who died of pneumonia. In the five days leading up to her admission to hospital, she was seen by three different GPs on four occasions. She died two days after admission.
The child died in July 1995 but no formal complaint was made until May 1996. The complaint concerned the way in which the parents had been treated in their attempts to understand what had happened in the period before their daughter died. These comments were written by a hospital chaplain who was acting as a bereavement counsellor to the parents. *My own assessment of this sad situation is that up until some time last October,* [the parents] *were making some progress in their traumatic bereavement. Unfortunately, once they asked their GP* [Dr…] *if they could see* [their daughter's] *medical records, that progress halted and regression began. The alleged response to that request and subsequent conversations and actions by the practice have engendered such anger within this couple, that it seems likely that it will be many years before they begin to come to terms with the loss of their beloved daughter.* Following a meeting at the practice in December 1995 which failed to resolve the situation, the parents were struck-off the practice list. They complained to the health authority in May 1996. An independent review panel (which was held in February 1997) did not uphold their complaint against the practice. The parents were denied access to the minutes of the panel hearing by the health authority on the grounds that 'disclosure could harm frank internal debate'. These comments were written by an occupational health psychologist who was assisting the parents and who attended the panel hearing. *Overall, I must say that in my opinion, this case has not been handled well. The manner in which* [the parents] *have been treated leaves me with little faith in the ability of the Health Service to deal sensitively and fairly with tragedies such as this. It appears to me that the review process is primarily concerned with the protection of the Health professionals and not with the patients who raise concerns and who, after all, are the ones who really suffer.*

CASE 6
This case involves a complaint against three trusts about the care received by the mother of one of the complainants in the period leading up to her death. The initial complaint was made in July 1997. An independent review was granted and the report of this review was produced in May 1999. The Ombudsman did not agree to investigate the case.
These observations on their experiences of the complaints procedure were made by the complainants. *Now, we have exhausted the normal procedures, yet we still feel very dissatisfied because there remain many fundamental questions unanswered. We feel that the NHS system has been grossly unfair, that there is little accountability in the case of consultants, that procedures are far from being user friendly or designed to get at the truth, no matter what is uncovered, so that the complaints process becomes one of a battlefield between unequals. Many who have legitimate complaints are daunted by the prospect of pursuing a case against the increasingly large trusts. Others choose to go to the newspapers* […] *whilst others turn to the law. We have not pursued either of these routes but with hindsight would be tempted to exploit these latter two avenues. We feel that a much tougher approach might have been more effective in getting at the truth and for a semblance of justice being seen to be done.*

CASE 7
This case concerns the care received by a patient in hospital just before his death. The complaint was brought by the patient's daughter.
These comments record the perceptions of the complainant about a meeting at the hospital with a consultant involved in the case. The purpose of the meeting was to promote resolution of the complaint. *When Mr X* [consultant] *arrived and had made himself comfortable lounging in a chair to my left he launched himself from this semi-recumbent position into what appeared to be an oft repeated student lecture based around the background and nature of my father's illness, research and statistics* […].*However, none of this had any bearing on the issues I had raised but I listened patiently and quietly even though I felt this was a waste of valuable time. When I was finally allowed to ask one or two questions that were pertinent I was not afforded the same courtesy. I was constantly interrupted, talked over; words put in my mouth and simply not listened to. Mr X's attitude towards me was condescending and contemptuous* […]. *However, the very worst was his contemptuous comment that I must have gained my knowledge from watching ER on television. I have over 20 years nursing experience..*

CHAPTER 5: VIEWS OF THOSE OPERATING THE COMPLAINTS PROCEDURE

Introduction

5.1 In this chapter we summarise the views of those operating the complaints procedure: chief executives, complaints managers, convenors, lay chairs, family health service contractors and regional complaints leads.[8]

5.2 Prior to 1996 complaints were handled under a number of different procedures. Complaints about clinical judgement were dealt with separately from those involving other aspects of care. Complaints about family health service contractors were handled separately from those about hospital staff. One of the important changes embodied in the new procedure was the introduction of a single system for handling complaints about all aspects of NHS care.

5.3 In the case of FHS practitioners, procedures for dealing with complaints and procedures for exercising discipline in relation to a contract of service were combined. Service Committees were responsible for considering both. One of the most important principles underlying the procedures introduced in 1996 was the separation of complaints-handling from disciplinary procedures:

The new complaints procedure will be concerned only with resolving complaints, and not with disciplinary matters (*Acting on Complaints*, March 1995).

5.4 We asked complaints managers how the current procedure compares with the systems in operation pre-1996 on four criteria: impartiality, ease of operation, flexibility and ability to encourage better practice to avoid a repeat of the circumstances leading to a complaint (Table 5.1).

5.5 Respondents judged the current system to be superior on each criterion except one: ease of operation. Less than 40% of respondents rated this aspect better than pre-1996 and a substantial proportion judged the current procedure to be worse. This is particularly the case for health authority/board respondents. Sixty-eight percent of health authority/board complaints managers judged the current procedure to be worse on this criterion.

5.6 There are no material differences between countries in the views of complaints managers on this topic. The mean responses shown in Table 5.1 are representative of the views of respondents in each country.

[8] Where possible results are reported separately for each country.

Table 5.1: How the current procedure compares with the systems in operation pre-1996
(Percent of respondents expressing a view*)

	Complaints manager		
	Better	Same	Worse
Impartiality	52	38	10
Ease of operation	38	22	41
• (HA/HB)	(17)	(15)	(68)
• (Trust)	(45)	(24)	(31)
Flexibility	47	27	25
Avoid repeat	67	30	3

* 30% of complaints managers had no experience of procedures pre-1996

5.7 Although there are naturally qualifications, the consensus view among the professional organisations which have submitted evidence to this study is that the current procedure is an improvement.

The BMA is generally supportive of the new procedures and is firmly committed to ensuring that they work well (British Medical Association, July 1999).

But, on the whole, we believe the new procedure is working. It has meant that most members who would have appeared before a service committee under the old system have been spared a protracted, stressful and adversarial process and have been able to resolve matters to their patients' and their own satisfaction, speedily and in-house (Price & Lee, Medical Defence Union, June 1999).

In line with recent research which has been done we have found that the complaints procedure is better than that which it replaced (National Pharmaceutical Association, June 2000).

General Views of the Current Procedure

5.8 Despite the fact that the current system is thought to be better than what it replaced, there is still scope for improvement. We asked convenors, complaints managers and lay chairs if they agreed with the proposition that the current procedure needs a radical overhaul. With a few exceptions, more respondents agreed than disagreed with this statement (Table 5.2).

5.9 Almost half of convenors (45%) agreed with the proposition. The proportion among convenors in health authorities/boards was substantially higher (63%) than among trust convenors (39%). There are also differences between the four countries. In Scotland and Wales more convenors disagreed than agreed with the proposition.

5.10 The views of complaints managers were similar: 41% overall agreed that the complaints procedure needs a radical overhaul. This view is particularly prevalent among health authority/board managers (62% agree). There was more variation between countries. More complaints managers in Scotland and Northern Ireland disagreed than agreed with the proposition: in England and Wales the proportions were reversed. In Wales more than 50% believe the procedure needs radical change.

5.11 In each country more chairs agreed than disagreed that the procedure needs a radical change: in England, Wales and Northern Ireland more than 50% agreed with the proposition.

Table 5.2: The current complaints procedure needs a radical overhaul
(Percent of respondents)

	Convenor (%)		Complaints manager (%)		Lay chair (%)	
	Agree	Disagree	Agree	Disagree	Agree	Disagree
All	45*	35	41	39	47	34
HA/HB	63	23	62	30	-	-
Trust	39	39	35	43	-	-
England	47	33	42	38	50	35
Scotland	23	50	33	56	38	32
Wales	30	40	53	20	50	31
N. Ireland	67	33	8	67	57	43

*Rows do not necessarily sum to 100% because some respondents neither agreed nor disagreed with the proposition.

Chief Executives

5.12 Chief executives are supportive of the new procedure. A large majority of respondents (82%) believe that the current procedure is cost-effective: this is true for chief executives of both trusts and health authorities/boards. When asked what aspects of the current procedure work particularly well, the most commonly cited aspect is the process of local resolution. This was mentioned by 84% of those who answered this question. Positive aspects of local resolution include the encouragement to respond promptly and the opportunities offered by a local complaints procedure to improve the quality of services and to meet complainants. More than 85% of chief executives said that they had met face-to-face with complainants in the previous twelve months and the average number of contacts was 12.1 (3.2 in health authorities/boards and 13.9 in trusts).

5.13 We also asked about elements which need to be developed. Table 5.3 shows the five topics most commonly cited by chief executives. With the exception of the need for better guidance to deal with vexatious complainants, the same issues feature in each country.

- *Independent review*. Reform of the process of independent review was mentioned by 33% of chief executives: this is the most commonly cited problem with the current system. When asked directly, approximately 50% of respondents stated that the independent review process is not impartial or that complainants do not believe that it is.[9]

[9] England: 48%; Scotland: 71%; Wales: 40%; Northern Ireland: 30%.

Table 5.3: Aspects of the complaints procedure which need to be developed
(Percent of respondents mentioning each item)

	All (%)	England (%)	Scotland (%)	Wales (%)	N. Ireland (%)
Independent review*	33	31	36	89	18
Too time-consuming	15	15	9	11	18
Performance targets unrealistic	12	12	9	22	18
Vexatious complainants-better guidance	9	10	-	-	9
Monitoring of action following a complaint	15	15	18	-	9

*Independent review process/need for greater impartiality
Each respondent may mention more than one item, totals may sum to more than 100%.

- The process is *too time-consuming*. The views of chief executives on the ease of operation of the current procedure echo those of complaints managers noted above (Table 5.1). Less than 30% of chief executives agreed that the procedure is easy to operate. A majority (65%) believe that it is time-consuming and bureaucratic.

- *Performance targets are unrealistic* in some cases. Further details are given in Chapter 7.The main issues relate to independent review. Target times for the convenor to reach a decision on a request for independent review, for a panel to be appointed and for it to complete a report are all thought to be unrealistic.

- Better guidance and/or procedures are needed to deal with *vexatious complainants*. This was not mentioned by chief executives in Scotland or Wales.

- There should be more *monitoring of action* to ensure that necessary or agreed changes actually take place following a complaint.

Complaints Managers

5.14 The views of complaints managers are similar to those of chief executives. Most believe that the current procedure is better than the systems which it replaced, but there is support for the view that the independent review process could be improved. In particular: it should be more independent, performance targets need to be more realistic and this part of the process should be less time-consuming. A majority of complaints managers agree that improvements need to be made in procedures for auditing complaints and monitoring action taken to ensure that services improve.

5.15 Complaints managers are the staff group with the most comprehensive overview of the operation of the complaints procedure. Most agree that the current procedure is better than the pre-1996 systems which it replaced. However, a majority of those

working in health authorities/boards (68%) believe that the current procedure is not better in terms of ease of operation. A majority of this same group (62%) believe that it needs a radical overhaul.

5.16 Complaints managers working in health authorities/boards deal mostly with complaints about FHS contractors.[10] Compared with those working in trusts, the health authority/board complaints managers in our sample dealt with a higher average number of complaints each year (311 compared with 206) and a higher number of requests for independent review (14.6 compared with 5.1 - Appendix A, Table A1.7). The views of this group of respondents on the costs of operating the current procedure appear to be influenced primarily by their experiences of independent review in primary care.

5.17 We asked about the costs involved in operating the complaints procedure. The most common responses were that the complaints procedure is time-consuming and costly, particularly independent review. One of the important issues associated with independent review is the time it can take to contact a lay chair or clinical assessor. Improved access is one of the ways in which respondents would like to see better support from the centre, particularly in England (Appendix A, Table A 1.11).

5.18 Table 5.4 reflects views on procedures which need to be improved. Improved complaint handling by front-line staff and better access to clinical assessors are mentioned by complaints managers in all countries. Access to lay chairs and handling complaints involving health and social services are particular issues in England and Wales. In Scotland, particular issues include providing administrative support to convenors and panels, and monitoring action taken as a result of complaints.

5.19 Most of these issues are procedural. We also asked about other improvements which respondents would like to see. These relate more to the structure of the complaints procedure.

- The (independent review) procedure should be *more independent*. This was the second most commonly cited improvement, mentioned by 15% of those who answered this question.[11] Forty-one percent of complaints managers agree that it is difficult for a convenor who is also a non-executive director of the organisation complained against to be impartial (46% disagree).[12] More than 60% of complaints managers in each country agree that complainants believe that a convenor is not impartial.[13]

Table 5.4: Procedures which need to be developed as a priority
(Percent of responses)

	All	England	Scotland	Wales	N. Ireland

[10] Since October 1999 complaints about FHS contractors have been dealt with in Scotland by primary care trusts.
[11] This was mentioned by complaints managers in all countries except Northern Ireland.
[12] In Scotland and Wales more complaints managers agreed than disagreed with this statement. In England and Northern Ireland more disagreed. In Northern Ireland two-thirds (67%) disagreed with this proposition.
[13] England: 62%; Scotland: 73%; Wales: 67%; Northern Ireland: 67%.

	(%)	(%)	(%)	(%)	(%)
Complaint handling by front-line staff	44*	41	67	56	71
Access to clinical assessors	32	33	25	33	29
Deciding action to take following a complaint	28	29	21		43
Access to lay chairs and panel members	23	26		22	
Complaints involving NHS and social services	22	24		22	
Providing admin support to convenors and panels	16		33		
Monitoring action taken as a result of complaints	11		17		

*Respondents may mention more than one item, totals may sum to more than 100%

- *Extend performance targets*. More than 25% of complaints managers believe the performance targets should be relaxed. This was mentioned in all countries.

- The procedure should be *simplified and less bureaucratic* (not mentioned in Northern Ireland).

- More guidance should be available on dealing with *vexatious complainants* (mentioned in all countries except Scotland).

- There should be more *education* for the public on the complaints procedure (mentioned in England and Scotland).

5.20 Finally, we asked complaints managers if they agreed with a number of statements about the current procedure. A substantial majority in each country agreed that: ‘mechanisms for auditing complaints need to be improved’ (79%); ‘systems for ensuring that services improve as a result of complaints need to be developed’ (86%) and ‘there need to be better systems for monitoring action taken as a result of complaints’ (84%).

Convenors

5.21 Convenors have particular experience of the operation of independent review. More than 60% of health authority/board convenors (and 45% of all convenors) think that the complaints procedure needs a radical overhaul (Table 5.2).

5.22 The experience of an average health authority/board convenor is greater than those working in trusts (26.19 requests for independent review compared with 9.43. Appendix A, Table A2.5). They have also been longer in this position (mean 35.4 months compared with 27.6 months).

5.23 We asked about improvement which convenors would like to see. In order of importance:[14]

- *Convenors should be more impartial.*[15] This is the single most commonly mentioned improvement. More than one in three convenors who commented on this question (55 convenors in all) suggested that the convenor should be more independent of the organisation complained against. The majority of these respondents (49) were trust convenors. The vast majority of convenors (66%) did not agree that it is difficult for them to be impartial. Nonetheless, only 21% disagreed with the proposition that complainants feel that a non-executive convenor will not be impartial.

- The independent review procedure should be *more flexible and less cumbersome.*[16] When asked to comment on the costs associated with independent review, the single most common response from both health authority/board and trust convenors was that it is time-consuming and costly. A number made the point that it would be even more costly were it not for the fact that convenors do not get paid specifically for the significant contribution they make. Analysis of questionnaire responses from convenors and chairs suggests that an average convening decision requires between 13 and 35 hours. An average independent review panel requires between 17 and 38 hours of the convenor. The time of the chair and other lay members, clinical assessors, complainant and staff complained against will be additional.

- *Performance targets should be more realistic.*[17]

- Organisations should ensure that *lessons are learned* from complaints.[18] Sixty-three percent of respondents agree that mechanisms for auditing complaints should be improved, 83% think changes are required to ensure that services improve as a result of a complaint and 80% agree there need to be better systems for monitoring action taken as a result of a complaint.

Lay Chairs and Panel Members

5.24 Lay chairs have an important role in convening decisions and chairs and panel members are central to the independent review process. In aggregate almost half of respondents (47%) agree that the current procedure needs a radical overhaul and

[14] Because of the small number of responses to this question from convenors in Scotland (15), Wales (2) and Northern Ireland (2) we have not classified responses separately for these countries. Where conclusions are different in these countries this is highlighted.
[15] Mentioned in all countries except Northern Ireland.
[16] Mentioned in England and Scotland
[17] Mentioned in England.
[18] Mentioned in England and Scotland

Scotland is the only country in which less than half of lay members agree with this proposition (Table 5.2).

5.25 The suggestions of this group cover three areas: (1) improvements in the complaints procedure itself, (2) improvements in the reimbursement of lay members and (3) improvements in opportunities for training, feedback and networking. The priorities for changes in the complaints procedure are similar to those identified by other groups:

- *The convening decision should be seen to be impartial.* Either the convenor should be seen to be impartial and/or the chair should have a greater role in decisions on independent review. A third of respondents (123 individuals) made this point. Almost 60% of respondents agreed (a) that it is difficult for a non-executive convenor to be impartial[19] and (b) that complainants do not believe that a convenor is impartial.[20]

- *The process is too time-consuming.* The time input of a chair averages 4 hours for the convening decision and between 17 and 38 hours for a panel. Total costs will be higher because this does not include the time inputs of other participants.

5.26 Other factors mentioned included better training for front-line staff and more emphasis on conciliation (all countries except Wales).

Table 5.5: Improvements required in the complaints procedure
(Percent of responses)

	All (%)	England (%)	Scotland (%)	Wales (%)	N. Ireland (%)
More impartiality of the convening decision	30	29	35	40	25
Procedures less time-consuming	22	20	21	50	-

5.27 Panel members, including lay chairs, are entitled to receive travel expenses plus loss of earnings and subsistence allowances. Approximately half of the lay members in our sample (48.6%) were not in paid employment and as such were not entitled to compensation for loss of earnings. Responsibility for paying lay members lies with the trust or health authority/board which is dealing with the complaint.

- Chairs and lay members should receive *a fixed fee per case* rather than compensation for loss of earnings. Half of the respondents in our sample made this point. The issue here is less about the amount of reimbursement than the principle that members should be treated the same whether or not they are in paid employment and irrespective of the organisation they are working for. Recruiting chairs is a problem in some areas (particularly in England) and poor reimbursement may be an issue.

[19] England: 59% agree; Scotland: 67%; Wales: 63%; Northern Ireland: 57%.
[20] England: 58% agree; Scotland: 62%; Wales: 63%; Northern Ireland: 71%.

5.28 Responsibility for recruiting and training lay members lies with the regional offices in England and Wales and the relevant local health board in Scotland and Northern Ireland. These organisations are also responsible for managing the performance of chairs and for facilitating networking meetings.

- There should be *additional opportunities for training*. The average amount of training offered to chairs in our sample was 3 days (in total). Around 70% of respondents believed the training they received was sufficient. Nonetheless, a majority said they would like to have additional training on topics such as report writing (58%), the NHS complaints procedure (51%) and the role of a lay member (51%).[21]

- *Chairs should receive better feedback on panel reports*. One of the functions of the regional office/health boards is to manage the performance of lay chairs by, for example, offering feedback on panel reports or on other aspects of the performance of the chair. Only 22% of respondents said they had received feedback on reports they had produced. Ninety-seven percent said they would like to receive feedback.[22]

- *Chairs should receive feedback on the outcome of complaints* in which they have been involved. Sixty-five percent of respondents stated that they never received feedback on the outcome of complaints (11% always received it). Ninety-eight percent said they would like to receive feedback, and this was the single most important improvement which respondents wanted to see in the support offered.[23]

- *More opportunities should be available for lay members to network*. We asked chairs and other lay members how frequently they were able to meet with others involved in the complaints procedure. Forty-six percent met annually, 20% met more frequently and 34% met less frequently than once a year (18% said they had never met with others). Sixty percent said they would like to meet more frequently, with a majority favouring a meeting once every 3-6 months.[24]

Family Health Service Contractors

5.29 We held a series of focus groups with GPs, GDPs, opticians, pharmacists, practice managers, health council and health authority/board representatives in different parts of the UK. Eighty-three individuals attended.

5.30 A detailed summary of the issues raised in the focus groups is given in Appendix B. Here we report the main suggestions for development which emerged from the groups.[25]

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[21] Appendix A provides separate analysis for each country (Tables A3.5/A3.6).
[22] Appendix A provides separate analysis for each country (Table A3.7)
[23] Appendix A provides separate analysis for each country (Table A3.8/A3.9).
[24] Appendix A provides separate analysis for each country (Tables A3.10)
[25] These are the views of the participants, not of the research team.

- The production of more detailed written information about, for example, costs in dentistry and out-of-hours service delivery in general practice could serve to avoid queries turning into complaints. There is scope for a more creative approach to dealing with common requests and misunderstandings involving patients.

- There should be a system for recording different types of comments, suggestions and complaints from service users that incorporates a range of options for dealing with the latter. If data on complaints are to be utilised it is important that systems are in place to encourage the production of more accurate and meaningful records.

- A balance needs to be struck between a bureaucratic system that generates unproductive pressures and the need to monitor and learn from issues as they arise. There is likely to be some resistance to attempts to formalise what may be viewed as an effective informal approach to dealing with complaints.

- While there need to be time-scales for dealing with complaints some flexibility has to be built into the system. It is important that the necessary administration is promptly executed, but there needs to be an acknowledgement that receiving responses from a number of sources will be a lengthy process. Building in to the time-scales a commitment to providing regular updates to complainants and staff may be beneficial.

- It is important that there are safeguards and checks built into any system for recording complaints as well as a mechanism for learning from them.

- There are, clearly, implications for training staff at all levels about the most effective way to deal with service users. Focused sessions, perhaps using role-play, would be welcomed.

- Effective communication that does not escalate the situation was recommended. Hasty or ill-judged responses need to be avoided and staff need to be clear about strategies for contact with complainants or potential complainants.
- Accurate recording of complaints requires a system of thresholds (e.g. if an event is not written down by either side it would not rank as a complaint). There needs to be a systematic approach to logging information and a clearly understood mechanism for collating it centrally.

- A local forum for key stakeholders would provide opportunities to discuss how complaints are handled and how lessons can be learned. Focused meetings of this kind could generate a collective response to some of the difficulties and misunderstandings raised in the focus groups.

Regional Complaints Leads

5.31 In England the regional offices of the NHS Executive are responsible for recruiting and training chairs and other lay panel members; for nominating chairs, lay members and clinical assessors when requested by a convenor and for providing general advice and guidance to trusts and health authorities on the operation of the

complaints procedure. In addition, the regional offices have a performance management function. The regional office complaints lead is expected to monitor the performance of lay chairs and, to a lesser extent, clinical assessors, and to offer guidance and/or additional training where appropriate. In Scotland and Northern Ireland these functions are discharged by the health or health and social services boards, and in Wales by the office of the National Assembly.

5.32 We interviewed each of the regional complaints leads in England. A summary of the points arising from those interviews is given in Appendix C. Briefly, the main issues arising in relation to the regional role are:

- It is the responsibility of the individual regional offices to decide how best to discharge their responsibilities. As a consequence there are wide differences in the seniority of staff and in the level of (staff) resources available to the complaints function. In part this reflects the priority given to complaints management in different areas. It would be useful to review resource requirements in the light of the required functions of regional offices and to establish norms centrally.

- The availability of resources is reflected in the amount of support which the regional office is able to give to chairs and other lay members (for example, training or regular meetings) and to the time it takes to respond to a request from a convenor. In one region it is expected to take 2-3 weeks to respond to a request for a lay chair.

- Shortage of resources is one of the reasons why the training and performance management of chairs appears inadequate but some regional leads are also reluctant to criticise those working on a voluntary basis. In most cases there is no formal mechanism to obtain the views of convenors on the performance of chairs or clinical assessors. There is an acknowledgement that better feedback is required. There would be merit in reviewing systems which could be put in place across the UK to monitor the performance of chairs and to offer support where necessary. Linked to this there should be a discussion of the financial allowances which are available to lay chairs.

- There are differences in the ease with which areas are able to recruit suitable chairs. In some areas a shortage of chairs contributes to the delays in responding to requests from a convenor. Other areas report no difficulties in filling vacancies. There is no apparent reason for this difference.

- The work of clinical assessors is not routinely monitored or evaluated. A number of regional leads noted that delays in the independent review process are often caused by waiting for assessors to complete a report, and the current list of (secondary care) clinical assessors in England is problematic and in need of up-dating.

- One of the most important potential roles for the regional offices is to monitor action taken in response to a complaint, particularly following an independent review. The procedures in place locally, and the priority which is given to

proactive monitoring of action plans, varies widely between areas. It is acknowledged that there should be a more systematic approach.

- There appears to be a general recognition that many of the performance targets in the current procedure, particularly those relating to primary care, are unrealistic. However, these targets are less important than ensuring that a complaint is handled sensitively and well.

Summary

5.33 Complaints managers judge the current system to be superior to the systems in place pre-1996 on most criteria. Chief executives in particular are supportive of the principles of local resolution and most believe that this aspect of the complaints procedure works well. Positive aspects include the encouragement to respond promptly to a complaint, the opportunity offered by complaints to improve the quality of services and the opportunity to meet complainants face-to-face.

5.34 Among those responsible for operating the procedure there is a broad consensus about the elements which need to be improved:

- There is a wide measure of agreement that independent review should be more independent and should be seen to be so. Irrespective of the impartiality of a convenor, it is accepted that complainants do not perceive the current procedure to be independent.
- There is a perception that current procedures, particularly those involving independent review, are time-consuming and costly to operate.
- Performance targets relating to the convening decision, the appointment of panel members and drafting a report of a panel are all perceived to be difficult to meet.
- There is agreement that procedures need to be improved to ensure that services improve following a complaint.

- Procedural improvements include the need for quicker access to clinical assessors and (in England and Wales) to lay chairs. Lay chairs in all countries would like to have better feedback on panel reports and on the outcome of complaints, and more opportunities for networking and training. The desire for additional networking and training is common to almost all of the groups involved in operating the procedure.

5.35 FHS contractors have suggested a number of ways in which the operation of the current procedure could be improved from their perspective. Particular issues are the need for flexibility in applying performance targets, the need for support with training and in facilitating networking meetings with other interested practices and the need for agreement on the definition and recording of complaints.

5.36 Interviews with regional complaints leads have highlighted differences in the priority and resources available to the complaints function in different areas, with consequent implications for their capacity to fulfil their functional responsibilities.

CHAPTER 6: POLICY IMPLICATIONS – Local Resolution

Background

6.1 The aim of local resolution is to facilitate a rapid response designed to satisfy the complainant. The recommendations of the Wilson committee were based (in part) on evidence that satisfaction with how a complaint is handled is reduced dramatically the more contacts the complainant has with the organisation (Wilson, 1994: 130) and is enhanced by personal contact. For example, contacting complainants by telephone (even where they have complained by letter) tends to increase satisfaction (Para: 132). Thus the emphasis on resolving complaints quickly, on providing training for front-line staff in dealing with complaints and on encouraging personal contact with complainants.

6.2 The committee believed that conciliation is an important method of resolving disputes and recommended that it should be widely available throughout the NHS (Para: 203). In the context of local resolution, the committee recommended the offer of conciliation where an immediate response appeared to be inappropriate or where the complainant was not satisfied with an immediate response (Para: 255).

6.3 It was also recognised that there will be circumstances in which it is necessary for a senior officer (such as the chief executive) to become personally involved in a complaint. For example, if the issues raised are serious or if the complainant is not satisfied with previous responses. Because there is no equivalent to a chief executive for family health services the committee recommended that health authorities and boards should employ 'complaints executives' with responsibility to respond to family health services complaints not resolved within the practice (Para: 263).

We recommend there should be a full range of options at the discretion of the Complaints Executive or Chief Executive: conciliation; detailed investigation of the complaint-which might include obtaining independent advice or establishing an independent enquiry. (Wilson,1994: 264).

6.4 The way in which the first stage of the complaints procedure was implemented in 1996 is close to the recommendations of the Wilson committee. The new procedure placed emphasis on resolving complaints as quickly as possible through immediate action by front-line staff or through investigation or conciliation. Staff were to be empowered to deal with complaints as they arise 'in an open and non-defensive way.'(NHS Executive, March 1996: 2.4).[26]

6.5 The new procedure acknowledged the importance of conciliation and established complaints managers to fulfil the role of the 'complaints officer' detailed by the Wilson committee. However, there are no 'complaints executives' or their equivalent in the new procedure, and the role of the health authority or board in dealing with

[26] For consistency, all references to the guidance are to the English version. However, unless stated otherwise, the same point is included in the guidance produced in the other countries.

family health services complaints is different from that envisaged in the Wilson report.

Where, for example, a complainant does not wish…to have a complaint dealt with by the practice, or is having difficulty in getting the complaint dealt with by the practitioner, health authorities will, if both parties agree, act as 'honest broker' between the complainant and the practitioner to resolve the complaint at practice level. (NHS Executive, March 1996: 5.15).

6.6 The key differences are that the health authority can only intervene if both parties agree and the emphasis is still on resolution at practice level. The health authority does not have authority to initiate an independent investigation of the complaint. In Scotland it appears that health boards have traditionally interpreted their brief more broadly and have been more willing to act proactively on behalf of complainants. This responsibility has now passed to the Scottish primary care trusts.

Assessment of the Current Procedure

6.7 There is support for the principle that complaints should be resolved as quickly as possible. There is also recognition of the potential value of complaints as a source of information for service improvement and agreement that the emphasis on local resolution is an important feature of the current procedure.

- Chief executives most commonly cited local resolution when asked which aspects of the current procedure work well (paragraph 5.12).

- We know that the vast majority of complaints do not proceed beyond local resolution. For example: there were 86,000 written complaints about hospital and community health services (HCHS) in England in 1998/99 and 1,800 requests for independent review. In the same year there were 39,000 written complaints about family health services and 1,430 requests for independent review (Department of Health, March 2000). These figures imply that between 96% and 98% of written complaints do not proceed beyond the local stage. Even allowing for the fact that some complainants may be discouraged from pursuing a complaint beyond the first stage even if they are not satisfied with the outcome, there is evidence that the current process works adequately in many cases.

6.8 This is also the view of the professional associations which have submitted evidence to this study. Although these associations have proposed a number of improvements to the way in which local resolution works, they are nonetheless supportive of the principles underlying the current procedure.

The increased use of in-practice complaints procedures to obtain resolution of complaints at a local level works well. Many complaints are dealt with within the practice, which allows speedy resolution and gives the practice the opportunity to improve its services (British Dental Association, May 2000).

The GPC's [GP Committee's] *overall experience is that the in-house procedures in particular have proved very satisfactory to both complainants and practitioners in terms of resolving complaints quickly, giving the complainant a clear explanation of what has*

happened, and avoiding situations in which entrenched attitudes and aggressive behaviour become the norm (British Medical Association, July 1999).

Most practitioners, in the MDU's experience, have now embraced the ethos of the procedures and adopt a conciliatory, sympathetic and positive approach to local resolution of complaints (Medical Defence Union, May 2000).

Most practitioners, in the MDU's experience, have now embraced the ethos of the procedures and adopt a conciliatory, sympathetic and positive approach to local resolution of complaints (Medical Defence Union, May 2000).

Similarly the local resolution stage requirement that contractors are required to acknowledge receipt of a complaint within two days and reply substantively within 10 days seems to work very well and our experience is that very few complaints generally go beyond that stage (National Pharmaceutical Association, June 2000).

6.9 However, many complainants express a high level of dissatisfaction with the operation of the current procedure (Table 4.2).

- Among respondents whose complaint was resolved locally, only around one-third believed that their complaint had been handled well. No more than 30% were satisfied with the time taken to resolve the complaint and a majority were dissatisfied with the outcome. A majority thought that the current procedure was either unfair or biased and a high proportion found the process to be stressful or distressing.

6.10 The main causes of dissatisfaction among these complainants are operational failures: unhelpful, aggressive or arrogant attitudes of staff, poor communication and a lack of information and support. Poor initial handling of a complaint often makes the situation worse.

Policy Implications

6.11 Because the process of local resolution is internal to the organisation, how well it works varies between organisations depending on the training and attitude of individual members of staff and on the culture of the organisation itself. There is no mechanism to *ensure* that complaints are adequately addressed or that necessary action follows from a complaint. Thus views on the current procedure differ depending on the experience or viewpoint of the individual.

6.12 The key to improving performance will be to raise the standards of all organisations to the level of the best. The culture of the organisation must be such that satisfactory resolution of complaints is an important objective and information generated by the complaints process is valued. Resources must be appropriate to ensure that front-line staff are adequately trained and supported and that complaints can be investigated promptly and with authority. The organisation should be held accountable for its performance in handling complaints and for ensuring that serious mistakes are not repeated:

- Those with responsibility for managing the performance of chief executives and chairs should be required to demonstrate that complaints-handling is an explicit part of the performance management framework.

- The board of every NHS organisation should be held accountable for the performance of the organisation in handling complaints. In particular, the board should ensure that: (a) all staff are adequately trained to deal with complaints and are supported in the event of a complaint being made against them. Training in handling complaints should be a compulsory part of induction and continuing education; (b) staff managing complaints are appropriately trained, have adequate administrative resource and access to senior managerial supervision and support; (c) the complaints procedure is integrated into the clinical governance/quality framework of the organisation.

- Consideration should be given to the development of a National Service Framework or its equivalent for the management of complaints. A service framework would provide clear guidance to NHS organisations on the standards which are expected and it would establish a framework for performance management.

Clinical governance

6.13 The culture of an organisation is set by the chief executive and the board. In order to raise performance it is essential that the chief executive and the board view complaints procedures as an integral part of the structure of clinical governance and risk management.

6.14 Clinical governance is about using information as a basis for managing processes to ensure the effectiveness and safety of clinical outcomes. Information may come from clinical audit, untoward incident reporting, complaints procedures, risk management and a number of other sources. Under the proposals outlined in *A First Class Service* (Department of Health, June 1998) chief executives are accountable for the quality of trust services and must provide their board with regular reports on quality. One of the functions of the Commission for Health Improvement will be to scrutinise arrangements for clinical governance through a rolling programme of local reviews of NHS trusts (including primary care trusts). In Scotland the Clinical Standards Board will publish reports on the performance of individual NHS trusts in relation to the achievement of agreed national standards (*Our National Health*, Scottish Executive, 2000).

6.15 Current guidance requires that the board of a trust or health authority/board must receive a quarterly report on complaints

….in order to

- *monitor arrangements for local complaints handling*
- *consider trends in complaints*

- *consider any lessons which can be learned from complaints, particularly for service improvement* (NHS Executive, March 1996: 10.1).[27]

6.16 In principle the guidance ensures that information on the quality of services is received regularly by the board and is used as part of the process of risk management and service improvement. In practice this is not the case. Most complaints reports are merely a record of the number of complaints received, without adequate analysis or comment. The value of this information is limited. The quarterly report to the board should provide an analysis of the causes of complaints, emerging trends and the action taken (or proposed) to prevent recurrence. This report should be presented to the board in person by the complaints manager or the chief executive.

FHS Complaints

6.17 Among complainants about family health services the level of dissatisfaction is higher on most measures than it is for other services (Table 4.2). A majority of health council respondents believe that in primary care, local resolution performs poorly or very poorly in meeting the reasonable expectations of complainants, in ensuring that services improve as a result of a complaint and in identifying serious clinical problems or professional misconduct (Table 4.7).

6.18 Issues highlighted by complainants are: (a) the power imbalance inherent in the patient/professional relationship often makes it difficult for patients to complain, (b) some individuals are inhibited by fear of the consequences of complaining for continued access to care, and (c) because most practices are not open to external monitoring, there is no guarantee that information from a complaint is used to ensure that mistakes are not repeated.

6.19 One reason for the particular focus on primary care may be the fact that, compared with other NHS organisations, most practices are small and do not have formal management systems. In this situation the attitude of an individual practitioner in shaping the success of local resolution is more decisive than it is in a larger, more formal organisation. In addition, there is sufficient evidence to justify the fear that a complainant may be removed from a practice list.

6.20 In the context of primary care there is a need to ensure more openness and to offer complainants an opportunity to avoid the need to complain directly to the practice. We believe that the best way to achieve this is to encourage practices to work together to share information and to offer support in providing acceptable procedures for handling complaints. With jointly-agreed procedures in place there should not be the same concern about the right of a practice to remove a patient from the list.

6.21 The same principles should apply to family health services as to other services. The board of a primary care group (PCG), (local health group (LHG) in Wales) or primary care trust should have the responsibility in relation to complaints against contractors which currently lies with the health authority. In particular:

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[27] The same requirement applies in Scotland, Wales and Northern Ireland.

- The board should work with practices in order to assist members in ensuring that acceptable procedures are in place to deal with complaints

- The board should receive information quarterly from practices on the causes of complaints and on action taken or proposed.

- Where appropriate, the board should offer support to practices in dealing with complaints.

6.22 As currently established, primary care trusts (PCT) in England have responsibility for handling complaints relating to their roles as service commissioners and as providers of community services. On the other hand, complaints about services provided by FHS contractors within the PCT are handled by the health authority. It is difficult to see how this will improve complaints-handling within a PCT.

6.23 One of the issues which has been raised in relation to complaints about FHS contractors is the fact that patients may find it difficult to complain directly to the practice. This is a concern which has emerged in our research and which was recognised by the Wilson committee in 1994. Similar issues have been raised more recently (Select Committee on Public Administration, April 1999,[28] Health Committee, November 1999[29]).

- The board of a PCG/LHG/PCT should be responsible for providing access for complainants to a named individual whose responsibility it is to handle complaints about member practices.

6.24 The principle that complaints are dealt with separately from matters of discipline is important and this principle should not be jeopardised. Removing responsibility for handling complaints against FHS contractors from health authorities reinforces this principle. Matters of discipline and contract remain with the health authority while practitioners themselves assume responsibility for complaints.

6.25 Where primary care groups do not yet exist (as in Northern Ireland), alternative approaches might be considered to improve the handling of FHS complaints. For example:

- Practices operating in a local area should be encouraged to work together to share information and to provide support in handling complaints.[30] The local health and social services board should work with practices and should offer training to practice staff.

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[28] 'We recommend….that the Department of Health consider how Primary Care Groups might establish within their member practices effective complaints mechanisms..' (Public Administration, April 1999: 30)

[29] 'However, we believe that there should be an alternative route for complainants through the primary care group, trust or health authority, and recommend that this should be addressed as a matter of urgency' (Health Committee, November 1999: 106).

[30] This suggestion was also made by the Select Committee on Public Administration: 'We recommend that groups of practices are encouraged to operate joint complaints-handling systems.' (Public Administration, April 1999: 30).

- Health and social services boards should be more proactive in facilitating the resolution of complaints where individuals do not want to approach a practice directly.

Primary care trusts in Scotland

6.26 Primary care trusts (PCTs) were established in Scotland in April 1999. The Health Act 1999 made it possible to delegate responsibility to PCTs for the full range of functions in relation to primary care contractors. From October 1999 all of the functions of a health board in relation to the operation of the complaints procedure were delegated to PCTs (Health Act, 1999, Section 47).[31] In particular:

- Primary care trusts are required to appoint a convenor, whose responsibility is to decide on requests for independent review involving FHS contractors in the PCT.

- Primary care trusts have the role of 'honest broker' which was previously the responsibility of the health board. In Scotland it appears that this role is interpreted more positively than it is in England. A patient who is unwilling to complain directly to a practice may approach the PCT. This offers a parallel route of access and overcomes some of the perceived problems of restricted access in primary care.

- Reports of an independent review panel are received by the PCT rather than the local health board.

6.27 There is criticism (for example, from the British Medical Association in Scotland) that PCT convenors are not seen to be independent, although the independence of the convenor is an issue which is not unique to primary care trusts. Nonetheless, the Scottish example illustrates the fact that it is possible to delegate full responsibility to a PCT for handling complaints involving practices in the trust. If the aim is to improve complaint-handling in primary care, this model should be considered in other parts of the UK.

Monitoring

We believe that it will be vital to ensure that the various agencies involved in ensuring and monitoring quality in the NHS work together to provide an efficient system for checking performance and following up failures in practice (Public Administration, April 1999: 47)

6.28 One of the characteristics of local resolution is the fact that the process of investigating a complaint, deciding on action and monitoring outcomes is *internal* to the organisation. Current mechanisms are inadequate to ensure that action is appropriate or that changes actually take place. This is a significant weakness of the current procedure.

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[31] Health boards continue to be responsible for providing conciliators and for maintaining lists of lay chairs, lay panel members, clinical advisers and clinical assessors.

6.29 In England and Wales health authorities and trusts are required to publish an annual report on complaints handling and to send copies to the regional office of the NHS Executive (in England) or the National Assembly for Wales *and* the local community health council. In Northern Ireland trusts and boards produce a report which is copied to the Department of Health, Social Services and Public Safety and the local health and social services council. In Scotland, trusts and health boards produce an annual report which is copied to the Scottish Executive and the local health council.

6.30 Trusts and health authorities are also required to provide statistics to the Executive centrally on the number and type of complaints. General medical and general dental practitioners are required to provide health authorities/boards with information on the number of complaints received in each practice. Each country produces an annual report on complaints handled by trusts, health authorities/boards and FHS practices.

6.31 Aggregated annual returns, often produced many months after the period to which they refer,[32] are of limited value in identifying clinical or professional problems. In addition, the requirement to provide information on the *number and type* of complaints rather than on underlying causes or on action which has been taken to prevent recurrence further limits the relevance of routine data.

- The board of an NHS organisation, including a primary care trust, should insist on receiving appropriate information at least quarterly on the causes of complaints and on the action which has been taken, or is proposed, to prevent recurrence. The board should take responsibility for ensuring that agreed actions are implemented. Information on complaints will be one of many sources of feedback which should be considered as part of the broader clinical governance agenda.

- The quarterly report to the board should be copied to the local health council (or equivalent). The chief executive of the trust or health authority/board should invite the health council to monitor the implementation of action plans agreed in response to complaints. The NHS Plan (Department of Health, July 2000) announced the introduction of a new patient advocacy and liaison service (PALS) and a Patients' Forum in each NHS trust and primary care trust in England.[33] The Forum should receive the same report which is presented quarterly to the board and should have a responsibility to monitor the implementation of agreed actions. In Scotland new accountability arrangements are being implemented to involve patients and the community in NHS decision-making.[34] Procedures for local

[32] For example, national complaints statistics relating to the financial year 1998-99 were published in March 2000, almost one year later.
[33] A health plan for Scotland was published in December 2000 (Scottish Executive, December 2000). There is no proposal for the introduction of a Patients' Forum or PALS in Scotland. Similarly, the health plan for Wales (January 2001) does not include plans for a Patients' forum or PALS.
[34] *Our National Health*, Scottish Executive, December 2000, Pg 55. The Scottish plan also includes proposals to develop a Patients' Project, designed to provide a source of patient information and advice.

monitoring of complaints-handling should be provided as part of these arrangements.

- The regional offices of NHS Executive in England and the appropriate central NHS bodies in Wales, Scotland and Northern Ireland should be required to demonstrate that complaints-handling is an explicit part of the performance management of chairs and chief executives. These bodies should ensure that the information available to them is timely and relevant to this responsibility.

Role of the complaints manager

6.32 The main role of a complaints manager is to oversee the complaints procedure. Details of role and function are decided by the board of the organisation concerned, but will typically include investigating complaints and offering support and advice to front-line staff. In the best organisations the complaints manager has responsibility for training front-line staff, for dealing personally with complainants and staff complained against, for investigating complaints (including complaints arising from adverse or unexpectedly poor clinical outcomes) and for screening complaints in order to ensure that those relating to problems which could jeopardise patients are dealt with quickly by the appropriate authority. To fulfil their role properly a complaints manager must have sufficient seniority and experience.

The complaints manager may be:

- *the chief executive,*
- *a senior manager reporting to the chief executive, or*
- *particularly in large trusts, a senior manager reporting to the chief executive through another director, but with personal access to the chief executive when appropriate* (NHS Executive, March 1996: 4.17).[35]

6.33 Evidence from the survey of complaints managers (Appendix A) shows that there is considerable variation between organisations in the salary of complaints managers, in their line manager and in the amount of time spent on complaints.

- Most complaints managers (91%) work full-time, but almost 60% of trust complaints managers and 40% of those in health authorities/boards spend less than 50% of their time on complaints (Appendix A, Table A1.5). Other responsibilities typically include risk management, clinical negligence and litigation, quality standards or clinical governance (Table A1.6).

- The average number of written complaints dealt with by complaints managers in our sample was 311 (health authority/board) and 206 (trust) in the year April 1998 to March 1999. Health authority/board managers dealt with an additional 14.6 requests for independent review (trusts: 5.1)(Table A1.7). For a health authority manager spending half of their time on complaints the workload is equivalent to dealing with 3 written complaints per working day and a request for independent review every 8 days.

[35] Similar guidance applies in Scotland, Wales and Northern Ireland.

- One third of complaints managers (34%) report directly to the chief executive. A further third to a director (31%) and the remainder to other managers (Table A1.4). Forty-one percent of complaints managers received an annual salary of £24,000 or less. Sixty-two percent earned less than £27,000 (Table A1.3).

- Complaints managers in our sample received an average of 5.6 days of training for their role (Table A1.9).

6.34 One of the most important ways to improve local resolution is to improve complaint-handling by front-line staff and to ensure that complaints are dealt with appropriately. The complaints manager has a crucial role in achieving this.

6.35 Some complaints arise as a result of adverse clinical outcomes or outcomes which are unexpectedly poor. It is vital for the complaints manager to ensure that such cases are investigated thoroughly and to identify those situations in which it is necessary to refer the complaint to another body (such as the relevant professional association) for investigation.

6.36 At present it is for the trust or health authority/board to decide the exact role of its complaints manager. As a result the level of responsibility, seniority and authority varies between organisations, as does the amount and content of the training offered. The extent of this variation should be reduced. Less discretion should be available to individual organisations to decide the functions of, and resources available to, the complaints manager. More detailed guidance should be offered from the centre, based on an analysis of current best practice.

6.37 The complaints manager should play a central part in ensuring that front-line staff are adequately trained and supported in dealing with complainants. Training should be provided on a regular basis.

Conciliation

6.38 The Wilson committee believed that conciliation is an important means of resolving disputes and recommended that it should have a central role in the new procedure. In the past conciliation had been restricted to disputes involving family health services contractors and the training available to conciliators was limited. The committee recommended that the use of conciliation should be extended to include all NHS services, including hospital and community services.

6.39 Health authorities/boards are required to make conciliation available to assist in the resolution of FHS complaints in response to a request from the complainant or the practice. However, in principle, any organisation could offer conciliation at the local resolution stage. Responsibility for appointing lay conciliators lies with the organisation concerned.

6.40 Our evidence suggests that conciliation is offered in around 25% of cases, and is more likely to be available for complaints involving FHS contractors. Only a

relatively small proportion of trust complaints managers or convenors have experience of conciliation.

- 40% of complaints managers and convenors who responded to the questionnaire said that they had used conciliation services. However, 95% of health authorities/boards had used conciliators compared with 20-25% of trusts.

- Just less than 10% of complainants overall had experience of conciliation. It appears that conciliation was offered in around 25% of cases and was accepted by complainants in 4 cases in 10. Conciliation was more likely to be offered to complainants about family health services.

6.41 There is evidence that conciliation can be helpful in resolving a complaint.

Lay conciliators when used early in the complaints resolution process can be a very effective method of satisfactorily resolving a complaint, and because of their truly independent status are more acceptable to both practitioner and patient. All health authorities should recruit conciliators and offer conciliation services at the earliest opportunity (British Dental Association, May 2000)

6.42 The Medical Defence Union report mixed experience with the use of conciliation. Outcomes are dependent on the skills of the conciliator and these naturally vary between individuals. Nonetheless: *the greater use of conciliation would be welcomed by the MDU* (Medical Defence Union, May 2000).

6.43 In responses to our questionnaire survey, the majority of complainants with experience of conciliation (60-70%) believed that it was helpful in their case.

- 95% of convenors and 64% of health councils agreed that conciliation is helpful in resolving a complaint. A majority of health council respondents (57%) said that there were difficulties in finding trained conciliators locally.

- Conciliation is most helpful if offered early in the process, before positions become entrenched. It has a particular role to play when communication is poor between complainant and those complained against.

6.44 The evidence in favour of conciliation appears strong, but it also appears to be difficult currently to gain access to conciliators with sufficient experience and skill. Trusts in particular do not appear to make wide use of conciliation[36]. The process of local resolution would be improved if better use was made of conciliators, particularly in trusts.[37] Each organisation should review its policy on offering conciliation and should assess the availability of trained conciliators locally. Trusts and health authorities/boards, in conjunction with the relevant regional or central NHS bodies, should then address remuneration, recruitment and training needs.

[36] Recent guidance to trusts in Scotland and Northern Ireland encourages greater use of conciliation.
[37] ‘We would welcome greater use of conciliation within the complaints procedure where appropriate, and recommend that this is encouraged’ (Public Administration, April 1999: 25). ‘We recommend that existing conciliation practices are evaluated to enable good practice to be identified and disseminated’ (Health Committee, November 1999: 83).

Performance targets

6.45 We asked complaints managers whether, in their experience, current performance targets were realistic. Most of the targets relating to local resolution are regarded as achievable, but there is one exception: a full response should be provided to a written complaint within 10 working days of receipt by a FHS practitioner or 20 working days for other services. Less than a third (30%) of health authority/board complaints managers regard the FHS target as realistic (Table 6.1). In practice, this target is met in approximately 54% of cases. Less than half of complaints managers working in trusts (44%) believe that the target is realistic for complaints about trust services, although it appears this target is met in around 76% of complaints (Table 6.2).

6.46 There does not appear to be any compelling reason why the target for a full response should be shorter for FHS contractors, and in the absence of such it would appear reasonable that the targets should be the same in all sectors (20 days).

Table 6.1: Complaints managers-performance target is realistic (local resolution only)
(Percent in agreement*)

	Trust or Health Authority/Board			Family Health Services		
Oral complaint	On the spot or referred			Same		
	All	HA/HB	Trust	HA/HB		
	94%	97%	93%	94%		
Acknowledgement of written complaint	2 working days of receipt or full reply in 5 working days			Same		
	All	HA/HB	Trust	HA/HB		
	97%	98%	97%	97%		
Full response	20 working days of receipt			10 working days of receipt		
	All	HA/HB	Trust	HA/HB		
	50%	73%	**44%**	**30%**		

*Percentage of those expressing a view

6.47 There is some information available nationally on the proportion of written complaints which are handled within the performance targets, although this information does not include FHS contractors because the ability of the NHS to monitor FHS targets is limited. Table 6.2 shows the proportion of written complaints receiving a full response within 10 (FHS) or 20 working days of receipt. National data are from the most recently available annual statistical returns.

Table 6.2: Written complaints-Full response within performance targets (local resolution)
(Percent of written complaints)

	England (1998/99)	Wales (1997/98)	Scotland (1998/99)	N Ireland (1998/99)	CM Survey*
FHS	-	-	-	-	54%

Other services	62.5%	72.3%	75-88%	72%	76%

*Questionnaire survey of complaints managers

Time limits

6.48 The complaints procedure contains time limits for complainants, including the requirement that a complaint should normally be initiated within six months of the incident to which it refers and the requirement that a request for independent review should be made within 28 days of the completion of local resolution. It has been suggested that these limits should be relaxed or abolished.

6.49 The guidance includes discretion to extend these time limits and makes clear that this discretion *should be used flexibly and with sensitivity* (NHS Executive, March 1996: 4.12). It is not reasonable that staff should be subject indefinitely to the threat of a complaint and, subject to the exercise of discretion in appropriate cases, the existing time limits should be retained.

Vexatious complainants

6.50 We asked staff operating the complaints procedure which elements they believed were most in need of development. Improving the guidance/procedures available for dealing with vexatious complainants was high on the list of both chief executives and complaints managers, particularly in England.

6.51 Although the number of vexatious complainants is probably quite small,[38] dealing with them can involve significant costs in terms of staff time. More importantly, there is a need to ensure that staff are protected against malicious complaints. On the other hand, some mental health patients (for example, those with severe mental illness or personality disorders) and individuals suffering bereavement may appear vexatious but are actually in need of more rather than less support. There is a need to improve current procedures in order to ensure (a) that individuals in need of special help are identified quickly and are offered support outside of the complaints procedure; and (b) complaints procedures can be terminated where the complaint is vexatious or malicious.

6.52 Some NHS organisations have already developed guidance locally and the Scottish Executive and the HPSS Executive in Northern Ireland have produced and disseminated guidance regionally. Central NHS bodies in England and Wales should disseminate existing examples of good practice.

[38] A recent survey suggests that less than 1% of complainants are defined as vexatious (0.6% of trust complainants and 0.2% health authority complainants). (NHS Complaints Management Survey Report, 2000).

CHAPTER 7: POLICY IMPLICATIONS – Independent Review

Background

7.1 The Wilson committee believed that the main focus of complaints handling should be on establishing effective procedures to ensure that complaints are resolved locally. For cases not dealt with in this way the committee recommended a further stage:

We recommend that arrangements are put in place for those complaints which are not adequately dealt with under 'internal' procedures. These arrangements should take the form of screening followed by panel consideration (Wilson, 1994: 295).

7.2 The purpose of screening is to decide whether or not a panel is appropriate. A panel will normally have three members and should always have a lay majority, including the chair. The committee offered a range of options for the organisation of the Stage 2 procedure and recommended that a final decision be made by the Secretary of State for Health and other UK Health Ministers.

Wilson Committee: Options for the Organisation of the Stage 2 Procedure
Option A: The chief executive of the organisation complained against is responsible for setting-up and servicing the panel. For complaints involving FHS contractors the health authority or board holding the contract would be the responsible authority. Panel members might be drawn from a national list established for the purpose. *Option B*: Panels are established and serviced by individual health authorities or boards, or by consortia of authorities/boards. Panel members would normally be non-executive members of the authority. *Option C*: Panels are appointed and serviced by the regional offices of the NHS Executive. Servicing might be delegated to an individual health authority or board acting as agent for the regional office. Panel members would normally be drawn from the non-executive directors of health authorities/boards. *Option D*: Panels are established by a national Complaints Commission from a national list of independent members. Panels would be serviced by regional offices of the Commission.

7.3 In Scotland, England and Wales the model which was selected is consistent with Option A. The screening decision is made by a convenor who is typically a non-executive of the organisation which is the subject of complaint (except in the case of complaints against FHS contractors).[39] The convenor sets the terms of reference for

[39] In England & Wales decisions about FHS complaints are made by a convenor from the local health authority. In Scotland, primary care trusts appoint a convenor to consider requests for independent review concerning practices in the trust.

the panel and the complainant organisation is responsible for hosting and for servicing the panel.

7.4 In Northern Ireland responsibility for the Stage 2 procedure lies with the four health and social services boards. The boards are responsible for appointing a convenor and for organising reviews covering complaints about FHS contractors and trusts, as well as complaints about the purchasing role of the boards themselves. This model is consistent with Option B.

Assessment of the Current Procedure

7.5 Our evidence suggests that the views of those operating the complaints procedure (chief executives, convenors, complaints managers and lay chairs) are consistent. A number of themes emerge from the responses of these groups (Chapter 5):

- There is recognition that the independent review process is not perceived by complainants to be impartial. Improving this aspect of the current procedure is the single most commonly cited suggestion for reform.[40]

- There is also concern that the current procedure is time-consuming and costly to operate. Some of the performance targets are thought to be unreasonable.

- There is recognition that the lack of a mechanism to enforce the recommendations of an independent review panel (IRP) is a significant weakness.

7.6 Similar views are expressed in the evidence submitted by the relevant professional associations.

In contrast to local resolution, independent review, after nearly four years, still raises a number of serious problems in a significant number of cases for members of the MDU (Medical Defence Union, May 2000).

7.7 The MDU offers a number of criticisms of the current system, but a fundamental issue centres on the fact that the background, training and experience of panel members varies greatly. As a result, the ability of a panel to resolve clinical conflict (which is in any case a very demanding task) varies and panels do not always command the respect of practitioners. The MDU suggests:

There is a continuing and urgent need for proper training of high calibre candidates to serve on independent review panels. Proper remuneration would no doubt help (Medical Defence Union, May 2000).

[40] This has been a common theme among recent commentators on the current procedure. For example: 'We consider that it is vital that the NHS complaints procedure is made more open and transparent and that the system is seen to be fair and independent'. (Health Committee, November 1999: 88). A similar view was expressed by the Committee on Public Administration: 'We believe that the independence of the complaints procedure is something which needs to be reaffirmed, and we recommend that the Department of Health should consider ways of signalling more clearly its independence'. (Public Administration, April 1999: 24).

7.8 The need for more consistency in training is echoed by the BMA:

The main weakness of the system [of independent review] *is that there are no centralised arrangements for training and performance review of those involved in the implementation of the system, including clinical advisors and assessors, lay members and chairmen of panels, and health authority staff…..The BMA believes that a properly structured ongoing training programme is essential* (British Medical Association, July 1999).

7.9 The BMA offers a number of other recommendations for ways in which the current procedure could be improved. These include the need for clarity about the role of the convenor; the need to maintain a distinction between clinical advisers and clinical assessors; the need for further guidance on the criteria for the selection of panel chairs and an increase in the fees paid to clinical assessors and advisers. The BMA also notes that there is considerable variation in the conduct of panels and in the level of seniority of staff involved in handling complaints.

7.10 The British Dental Association (BDA) makes the point that reports of independent review panels are not routinely copied to the local dental committee (LDC). This restricts the ability of the profession to learn from and to disseminate important issues arising from complaints. Subject to safeguards on confidentiality: *LDCs should receive feedback from health authorities on the outcomes of all Independent Review Panel hearings involving dentists* (British Dental Association, May 2000).

7.11 In Scotland primary care trusts (PCT) appoint a convenor. This convenor has responsibility for deciding on requests for independent review relating to the practices in the trust. The Scottish Office of the BMA makes the point that the independent review process needs to be seen to be independent and the perception of independence is not helped by the fact that convenors are appointed by the PCT. They recommend:

There should be a national Scottish panel of Convenors made up from the different Health Boards. Each Convenor would hear many more complaints and this would facilitate a more consistent approach across Scotland (British Medical Association, Scottish Office, October 2000).

7.12 The Scottish BMA also points to the need for more training for convenors and lay members, clinical assessors and conciliators involved in the complaints procedure.

7.13 Complaints involving pharmacists or opticians are unlikely to proceed beyond local resolution because complainants are frequently more interested in obtaining compensation than in pursuing a complaint. Pharmacists are regulated by the Royal Pharmaceutical Society and it is open to an individual to complain directly to the Society. Opticians have established the Optical Consumer Complaints Service to deal with complaints against community opticians. The service is independent (lay members constitute a majority of the board of management) and it is funded by the profession. The NHS complaints procedure has little impact on community opticians.

7.14 On the evidence of complainants with experience of independent review, the current procedure does not perform well (Chapter 4). Of those who requested independent review, no more than one in ten was satisfied with the time taken to resolve their complaint and only 13% were satisfied with the outcome. Almost three-quarters believed that the complaints procedure was either unfair or biased.

7.15 The views of individual complainants are also reflected in the responses of the health councils and other patient interest groups:

- The current procedure lacks the independence necessary to give confidence to complainants.
- It is not always possible to compel clinicians (or managers) to attend a panel hearing.
- Recommendations of an IRP cannot be enforced.

Policy Implications

7.16 One of the potential drawbacks of local resolution is the fact that the process of investigating a complaint, recommending action and monitoring outcomes remains internal to the organisation and is not subject to external scrutiny. For this reason it is important that in cases in which local action fails to resolve a complaint there should be an opportunity for the case to be independently reviewed. Independent review offers two important safeguards:

- It provides an additional opportunity to identify clinical or professional problems that may be overlooked when complaints are dealt with internally.

- So long as the review process is linked to a system of monitoring, review offers an opportunity to ensure that lessons are learned from a complaint and that mistakes are not repeated.

7.17 In order to offer these safeguards the review process must be *independent* and it must have the *authority* to ensure that recommendations are enforced. The current system does not meet these requirements.

- There is no automatic right of review within the current system. A decision on whether to grant a request for independent review is made by a convenor who is typically a non-executive director of the organisation complained against. Although the convenor must consult a lay chair, the final decision lies with the convenor. Irrespective of the actual impartiality of the convenor, a process of this kind lacks the guarantee of independence which is required

- Responsibility for acting on the report of an independent review rests with the board of the organisation complained against. There is no external body with authority to monitor the extent to which an action plan produced by the organisation in response to an IRP report is reasonable, or that the plan itself is implemented. Current management procedures for chairs and chief executives are not applied consistently.

Criteria for independent review

7.18 Because of the expected costs, it is unlikely that a right to independent review could be automatic. If a decision is to be discretionary it is important to ensure that the criteria are clear and that the process is demonstrably impartial.

7.19 The criteria for granting a review should be publicised and applied consistently throughout the NHS.[41] Appropriate criteria might be:

- Where there is no reasonable expectation that further attempts at local resolution, including the use of conciliation, are likely to lead to an outcome which will satisfy the complainant; *and*
- Where there is reason to believe that the underlying circumstances which have led to the complaint have not yet been fully exposed; *or*
- Where the response of the organisation to the complaint appears to be unreasonable.

7.20 Unless there is a reasonable expectation that the complainant can be satisfied through further attempts at local resolution, a referral back to the organisation is unlikely to improve the outcome. It is reasonable that a review should be granted in these circumstances even if prior procedures have not been exhausted. On the other hand, a review is only likely to be justified if there is an expectation that the initial investigation did not uncover the underlying problem or if, having uncovered the problem, the response to the complainant was inadequate.

Enhancing independence

7.21 On the basis of the evidence, enhancing the independence of the second stage is probably the single most important change required to the current procedure. We have identified four options for reform.

Options for Reform of the Stage 2 Procedure
Option A: A decision on whether to hold a review is made by a convenor from a trust or health authority/board other than the one which is the subject of complaint.

[41] Existing guidance includes criteria for deciding on requests for independent review. However, these criteria are not necessarily known to complainants.

Responsibility for servicing and hosting the review remains with the organisation complained about.

Option B: A decision on whether to hold a review is made by a convenor from the host health authority/board. There are no trust convenors. Responsibility for servicing and hosting the review lies with the host health authority/board.

Option C: A decision on whether to hold a review is made by three members drawn from a regional or sub-regional lay panel appointed for the purpose. Responsibility for conducting and servicing a review is with the panel and the review is held at a neutral (non-NHS) venue locally.

Option D: The independent review procedure is abolished. A complainant who remains dissatisfied at the conclusion of local resolution has a right of appeal to the Health Service Commissioner (as now). Local resolution *may* include an additional right of appeal to the board of the organisation complained against.

7.22 *Option A*: The main advantage of this option is that the convening is more independent insofar as the convenor has no formal relationship with the organisation which is the subject of complaint. However, there are a number of obvious disadvantages:

- One of the reasons for having a non-executive or trustee convenor is to establish a link between the complaints procedure and the board of the organisation. Having complaints considered by a convenor who is independent of the organisation means that this advantage is lost.
- So long as the convenor is a non-executive director or trustee of any NHS organisation it is unlikely that complainants will perceive the convenor to be independent, irrespective of the organisation involved.
- If a review is granted, responsibility for the review will remain with the organisation complained against. In most cases this will mean that the review still takes place on trust or health authority/board premises.

7.23 *Option B*: This is the procedure which is in place in Northern Ireland. It has the advantage that the convenor is independent when dealing with trust complaints and complaints about FHS contractors. Where a review is granted it will take place on authority/board premises. Since the number of complaints dealt with by a convenor is likely to increase, this option offers an opportunity for convenors to gain more experience. However:

- A health authority/board convenor is not independent in dealing with complaints about decisions of the authority/board itself.
- So long as convenors are non-executive directors or trustees it is unlikely that complainants will perceive them to be independent, irrespective of the organisation involved (as Option A).
- In Northern Ireland there is less criticism of the process of independent review than in other parts of the UK, but the evidence in favour of this option is not

compelling. Even in Northern Ireland there is recognition among complaints managers and lay chairs that complainants do not believe the convenor is impartial.[42] A quarter of lay chairs in Northern Ireland suggested that the convening process needs to be more independent.

7.24 *Option C*: The main advantage of this option is that both the screening decision and the conduct of a review are independent of the NHS. A regional complaints panel would have its own budget and would provide its own clerical/secretarial support. Reviews would be held locally at a neutral (non-NHS) venue.

- Convenors will no longer be required, but it will be necessary to appoint additional lay members to serve on regional or sub-regional panels. Existing lay chairs and panel members could transfer but there will still be a need to recruit additional members. This may be difficult in some areas.
- The procedure may cost more in budgetary terms than it does at present because the (unpaid) time of the convenor and the (unrecorded) costs of providing a venue and secretarial and clerical support will shift to the panel and will need to be budgeted.

7.25 *Option D*: One of the criticisms of independent review is that it is time-consuming and costly to operate. There is also support for the view that independent review is not particularly successful in satisfying complainants (Table 4.5). This option has the effect of removing the second stage altogether and allowing complainants to move more quickly to consideration by the Health Service Commissioner. Part of this option might involve the introduction of a right of appeal to the chair of the board of the organisation complained against as an additional element in local resolution.

- The Health Service Commissioner (HSC) can investigate complaints about all NHS services, including services provided by FHS contractors and services provided to the NHS by the private sector. The HSC has the powers of the High Court to require attendance and the production of information. The Commissioner can make recommendations but has no formal power to enforce compliance.
- The integrity and independence of the HSC are rarely questioned, although there has been criticism in England of the relatively small number of cases which are dealt with annually and of the length of time required to complete an investigation.[43] It would not be feasible to remove the current second stage of the NHS complaints procedure unless the resources available to the Health Service Commissioners were significantly increased.[44]

A preferred option

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[42] 67% of complaints managers and 71% of lay chairs in Northern Ireland agree that complainants do not believe that the convenor is impartial.

[43] Collcutt, April 2000; Public Administration, April 1999.

[44] In England there were 3268 requests for independent review in 1998/99. There were approximately 300 requests in total in Wales and Scotland in the same period. The Health Service Commissioner received 2869 new complaints in England, Wales and Scotland in 1998/99 (Health Service Commissioner, June 1999).

7.26 A decision will need to be made in each country about which option is most appropriate, bearing in mind the perceived weaknesses of the current arrangements.

7.27 We believe that if the second stage is to continue, Option C offers the best way forward because it ensures that the procedure is genuinely independent and it builds on the extensive pool of experience and good-will which already exists. Organising panels on a regional or sub-regional basis[45] makes it possible for the panel to meet regularly to discuss its work, it makes the process accessible to complainants and it makes it possible to bring local clinical advisers within the panel. In order to encourage commitment, members (including clinical advisers) should be paid an annual retainer and expenses at nationally agreed rates.

7.28 The panel will need to be seen to be independent and for this reason it should have its own budget and powers to direct the way it operates (within national guidance). The panel should fund its own secretarial and clerical support. Where a review is necessary meetings will be held at a neutral venue which is convenient for the complainant and staff complained against.

7.29 Further consideration will need to be given to the accountability framework within which complaints panels will operate. Two options are outlined, although others are possible.

Options for Accountability of Complaints Panels
Option C1: Panels are accountable to the regional offices of the NHS Executive (in England) or to relevant national or sub-national bodies in Scotland, Wales and Northern Ireland. *Option C2*: Panels are accountable to regional or sub-regional offices of a new national complaints authority which is independent of the NHS locally and regionally.

7.30 *Option C1*: Responsibility for the recruitment, training and performance management of panel members would lie (in England) with the regional offices of the NHS Executive. In the other countries, this responsibility may lie with national bodies (for example, the Scottish Executive), with health authorities/boards or with groupings of health authorities/boards, depending on the agreed configuration of panels. The main advantages of this option are (a) it is consistent with existing structures and builds on the experience and knowledge which already exists locally; (b) it creates a link between the *outcome* of the independent review process and the existing performance management framework. An important potential disadvantage is that this structure may not be seen by complainants to be truly independent.

[45] The configuration of panels will be a national decision. In Northern Ireland, for example, there may be one panel for the whole country or one in each of the areas covered by the four boards. The configuration should be decided primarily on the basis of accessibility to the members of the panel (since members will typically travel to meet complainants) and on the ease with which the panel can relate to existing structures established at national, regional or local level.

7.31 *Option C2*: Involves the creation of a national complaints authority (as a Special Health Authority, for example) accountable directly to the Secretary of State or equivalent in each country. The new body would be responsible for providing the second stage of the complaints procedure through regional offices. Regional offices would be responsible for the recruitment, training and performance management of panel members locally. The main advantage of this option is the fact that it is independent of NHS organisations, and as such would be more likely to satisfy complainants. A disadvantage is the fact that it is more remote from the performance management structure. The links to performance management would be through the Secretary of State.

7.32 A decision on the appropriate accountability framework should be made in each country on the basis of the local situation. However, part of the evidence which has emerged from this study is the significant variability between regions (in England) in the level of resource and priority which is accorded to the management of the regional complaints function. There is similar variability in the extent to which complaints-handling is an important part of the performance management framework for chairs and chief executives. If regions are to be charged with greater responsibility in the future, there must be a clear statement of the minimum standards which are expected and a commitment from the centre that regional directors will be assessed on their performance in managing the independent review procedure.

7.33 Consideration might be given to developing the equivalent of a National Service Framework (NSF) for the management of complaints. A service framework would provide a statement of what is expected of trusts, health authorities and the regional/national bodies in managing complaints and it would form a basis against which to assess performance.

Review procedure

7.34 The current review procedure involves a meeting of a panel, the purpose of which is to consider a complaint according to terms of reference drafted by the convenor. A panel has no power to call witnesses or to require the production of evidence. It cannot refer cases for disciplinary action and the recommendations of an independent review panel (IRP) have no statutory authority.

7.35 Guidance is not prescriptive about the way in which a panel should conduct its business. In particular, a panel has discretion about whether or not the two parties to a complaint should attend together and should have an opportunity to question the evidence presented. The Health Select Committee (November 1999) was critical of the lack of central guidance in England and also of the practice of seeing witnesses separately: *We consider that IRPs should be conducted in a more formal manner, with all parties present, and act as adjudicatory bodies* (Health Committee, November 1999: 92).

7.36 Our evidence does not necessarily support the suggestion that an IRP is more likely to be successful in achieving resolution if both parties attend together. We asked panel chairs specifically whether they agreed with the proposition that seeing the complainant and complained against separately is the most useful way to proceed

at independent review. Of 462 respondents, 381 (82%) either agreed or strongly agreed with the proposition. Thirty-two respondents (7%) disagreed.

7.37 The trade-off is between ensuring that both parties feel that they have adequate opportunity to present their case and the danger that the procedure becomes confrontational and counter-productive. We believe this particular issue needs to be considered further before a final decision is made. It should be possible to find a compromise which protects the interests of all parties.

7.38 The Health Committee also suggested:

….panels should have the power to summon witnesses and take evidence. Trusts and health authorities should be required to make a formal response to panel recommendations. IRPs should refer any major concerns to the Commission for Health Improvement and report annually to the Health Service Commissioner. They should be able to recommend that disciplinary action may be necessary (Health Committee, November 1999: 94).

7.39 The suggestion of the Health Committee that the conduct of an IRP should be more formal raises issues about the appropriate method of investigation in different circumstances. The Health Service Commissioner (HSC) already has powers to summon witnesses and to take evidence. On the other hand there may still be a role for a less formal investigatory mechanism as an interim stage between local resolution and consideration by the HSC. The choice will be between a mechanism which is more flexible and less time-consuming but with fewer formal powers, and one which has more powers but which may be less flexible.

7.40 We do not have the evidence to make a judgement about the most appropriate means of conducting an independent review. The suggestion of the Health Committee should be considered separately from this evaluation. However, it is important that the method of investigating a complaint is appropriate to the circumstances of the case. Where a convenor (or complaints panel) believes that the formal investigatory style of the HSC is more appropriate in a particular case, it should be possible for that case to be referred directly to the Commissioner without the need to complete an IRP. The Health Service Commissioner should be consulted about the feasibility of a 'fast-track' procedure and, if appropriate, might be asked to suggest a protocol for referral.

Monitoring

7.41 The final report of an independent review panel must be sent (in England) to the regional Directors of Public Health and Performance Management at the NHS Executive, in Northern Ireland to the Department of Health, Social Services and Public Safety and in Wales to the National Assembly. In Scotland the IRP report is sent to the relevant health board but not to the Executive. The guidance does not require a chief executive to provide a copy of an action plan produced in response to an IRP report to the regional or national office.[46]

[46] In Wales the National Assembly does receive copies of action plans.

7.42 Our evidence suggests that the extent to which regional and national offices are able to monitor the implementation of IRP reports varies widely. In part this is due to differences in the level of resources devoted to complaints management, in part it is due to differences in priority.

7.43 The lack of a consistent mechanism to monitor the outcome of an independent review is a significant weakness of the current procedure.

- The board of an NHS organisation should take *active* responsibility for all aspects of complaints-handling. The board should receive a copy of an IRP report relating to the organisation (or to a member practice in the case of a PCG/LHG/PCT). The report may be abbreviated to maintain anonymity. The board should accept responsibility for ensuring that an action plan is produced and that agreed actions are implemented.

- The regional and national bodies responsible for NHS performance should ensure, through the performance management framework, that an acceptable action plan is produced following recommendations of an IRP and that the plan is implemented. Regional and national bodies should receive copies of all relevant IRP reports *and* the action plan which is produced in response to a report.

- IRP reports and action plans should be copied to the local health council (or equivalent), the proposed Patients' Forum in England and equivalent organisations which may be established in Scotland, Wales and Northern Ireland. One of the functions of the local health councils/Patients' Forum should be to monitor compliance with agreed action plans. New accountability arrangements proposed in Scotland should ensure the involvement of patient and community representation in monitoring proposed actions.

- In England, a report of an independent review panel, together with the agreed action plan, should be copied to the Commission for Health Improvement.

Training

7.44 Responsibility for training complaints managers and convenors lies with the individual organisation for whom they work. Responsibility for training chairs and lay panel members lies with the regional offices of the NHS Executive (in England) or the National Assembly for Wales, with local health boards in Scotland and with health and social services boards in Northern Ireland.

7.45 The Health Service Commissioner has been critical of the quality of the training offered to convenors (Health Service Commissioner, Annual Report for 1996/97 and 1997/98). The Select Committee on Public Administration (Public Administration, April 1999) and the Health Committee (Health Committee, November 1999) have both been critical of the training of all of those involved in the complaints procedure.[47] The reports of both of these Committees note that trusts and health

[47] 'One point which can be widely accepted…is the need for more training for those involved in the complaints procedure.' (Public Administration, April 1999: 23). 'We have referred several times to the

authorities/boards should do more to improve the amount and quality of training. The Committee on Public Administration also suggested that the regional and national bodies responsible for the NHS should play a more active role in co-ordinating, funding and providing training for all of those involved in the complaints procedure:

We recommend that the NHS Executive, and its counterparts in Scotland and Wales, review the provision of training in the operation of the complaints procedure and consider whether more organised, if not prescriptive, training is required. We would expect this to include training in forensic skills, and in how to make the judgements required, and also training in the sort of skills necessary to ensure that complainants accept that the process gives them a genuine opportunity to have their case heard (Public Administration, April 1999: 23).[48]

7.46 Details of the training received by complaints managers, convenors, chairs and lay panel members are given in Appendix A. The average amount of training received by respondents was 5.6 days (complaints managers), 15 hours (convenors) and 3 days (chairs and lay panel members). A significant minority had never received training at all, and a majority in all groups would like to have additional training. Our evidence is consistent with the need for a fundamental review of the training offered to all of those involved in the complaints procedure. In particular, there is a need for more central guidance in order to reduce the extent of variability between organisations in the amount and type of training which is offered. There may also be a need to make some training compulsory, particularly for convenors, chairs and other lay panel members.

Performance targets

7.47 The fact that performance targets are unrealistic is a common criticism of the current procedure (Chapter 5). Such national data as are available confirm that targets relating to independent review are more frequently missed than otherwise (Table 7.1). In England, for example, of complaints which proceed to independent review, no more than *one in ten* relating to FHS and *one in five* relating to other services resulted in a panel report within the target time. In Wales performance was considerably better in respect of non-FHS complaints. No comparable information is available about performance in Scotland or Northern Ireland.

7.48 We asked complaints managers for their views on each of the targets contained in the current procedure (Table 7.2). Targets which are within the control of the organisation itself (acknowledgement of a request for IR and providing a response to an IRP report) are generally thought not to cause difficulty. However, those involving the appointment of clinical experts, chairs and other lay members are problematic.

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need for proper training of staff. In relation to the complaints procedure we have found that right through the system-from the initial investigation to independent review-staff training has not been given priority nor has it been of sufficient depth….Staff cannot be expected to function without continuous, properly resourced training.' (Health Committee, November 1999: 104).

[48] This proposal is consistent with the views of many of the professional associations (paragraphs 7.6-7.12 above).

7.49 The convening decision and the appointment of panel members are the two targets which are most difficult to meet. We asked convenors what were the main causes of delays. These were: (a) delays in contacting a chair; (b) delays in appointing a clinical adviser; and (c) delays in waiting for a report from a clinical adviser. Beyond the convening stage other causes of delay are the time required to appoint a suitable clinical assessor, the time required for an assessor to produce a report and the time required by the panel itself to conduct its business and produce a report.

7.50 The Executive centrally is responsible for maintaining a national list of clinical assessors. In Scotland and Northern Ireland the list of clinical assessors was recently updated but in other parts of the UK it is acknowledged that the list is out-of-date and in need of significant revision. Irrespective of the option which is selected for the future operation of the second stage procedure, ready access to an up-to-date list of clinical assessors is essential. This should be addressed as a matter of urgency by the NHS Executive centrally. Consideration should also be given to whether current fee rates for assessors and advisers are adequate.

7.51 Some areas have difficulty in recruiting sufficient chairs and lay panel members to meet requests without delay. There is a need for concerted local action to ensure that there are sufficient lay members to ensure that performance targets can be met.[49] Remuneration may be an issue. Chairs and other lay members are entitled to receive travel expenses, compensation for loss of earnings and subsistence allowances. The basis on which expenses and subsistence allowances are reimbursed is decided by the organisation hosting a review and as a result arrangements vary case by case.

7.52 The average amount of loss of earnings compensation paid to chairs in 1999 was in the range £100-£500 per case (for an average of 34 hours). Just over half of the chairs and lay panel members (51%) who responded to the questionnaire survey were in paid employment. The remaining 49% were not, and as such were not entitled to receive compensation for loss of earnings.

[49] This point has been made before: 'We are concerned about the lack of sufficient numbers of suitably qualified personnel available to serve on independent panels, and recommend that the Department review the procedures for recruiting panel members, and for compensating them for their time."(Public Administration, April 1999: 19).

Table 7.1: Independent review-Final report of the panel within performance targets
(Percent of cases)

	England (1998/99)	Wales (1997/98)	Scotland (1998/99)	N Ireland (1998/99)	CM Survey*
FHS	10.5%	7.7%	n/a	n/a	34%
Other services	22.5%	63.8%	n/a	n/a	51%

*Questionnaire survey of complaints managers. n/a = not available

Table 7.2: Complaints managers-Performance targets are realistic (independent review only)
(Percent in agreement*)

	Trust or Health Authority/Board			Family Health Services		
Acknowledge request for independent review	2 working days of receipt			Same		
	All	HA	Trust	HA		
	90%	89%	91%	96%		
Convening decision	20 working days of receipt of request			10 working days of receipt of request		
	All	HA	Trust	HA		
	39%	**25%**	**44%**	**12%**		
Appointment of panel members	20 working days of decision			10 working days of decision		
	All	HA	Trust	HA		
	29%	**28%**	**29%**	**27%**		
Draft report of the panel	50 working days from appointment of panel and assessors			30 working days		
	All	HA	Trust	HA		
	40%	**27%**	**45%**	**22%**		
Final report of the panel	10 further working days			Same		
	All	HA	Trust	HA		
	39%	**27%**	**44%**	**25%**		
Response by trust or health authority/board to the report	20 working days from receipt of final report					
	All	HA	Trust			
	72%	78%	71%			

*Percent of those expressing a view

7.53 Irrespective of the option which is selected for the future operation of independent review, consideration should be given to standardising expenses and subsistence payments for chairs and lay members and to replacing loss of earnings compensation with an annual retainer or a fixed fee per case.

CHAPTER 8: CONCLUSIONS

8.1 Judged on the available evidence, the current complaints procedure is not working particularly well. Complainants and those responsible for operating the procedure agree that improvements are required. This chapter summarises the main findings of the research and brings together the policy implications discussed more fully in previous chapters.

Local resolution

8.2 Because the process of local resolution is internal to the organisation, how well it works varies between organisations depending on the training and attitude of individual members of staff and on the culture of the organisation itself. Current mechanisms are inadequate to *ensure* that complaints are adequately addressed or that necessary action follows from a complaint.

8.3 Thus views on local resolution are equivocal. On the one hand there is support for the principles of local resolution and recognition of the potential value of complaints as a source of information for service improvement. There is also evidence that local resolution works well in many cases. On the other hand, many complainants express a high level of dissatisfaction and this is indicative that the current procedure also frequently fails. The key issue is lack of consistency.

8.4 Among complainants about family health services the level of dissatisfaction is higher on most measures than it is for other services. A majority of health council respondents believe that in primary care, local resolution performs poorly or very poorly. One reason for the particular focus on primary care may be the fact that, in comparison with other NHS organisations, most practices are relatively small and informally managed. In this situation the attitude of an individual practitioner in shaping the success of local resolution is more decisive than it is in a larger, more formal organisation.

8.5 In order to improve performance the culture of all NHS organisations must be such that satisfactory resolution of complaints is an important objective and information generated by the complaints process is valued. Resources must be appropriate to ensure that front-line staff are adequately trained and supported and that complaints can be investigated promptly and with authority. The organisation should be held accountable for its performance in handling complaints and for ensuring that serious mistakes are not repeated. Three factors in particular are likely to be central to improving performance:

- Those with responsibility for managing the performance of chief executives and chairs should be required to demonstrate that complaints-handling is an explicit part of the performance management framework.

- The board of every NHS organisation should be held accountable for the performance of the organisation in handling complaints. In particular, the board

should ensure that: (a) all staff are adequately trained to deal with complaints and are supported in the event of a complaint being made against them. Training in handling complaints should be a compulsory part of induction and continuing education; (b) staff managing complaints are appropriately trained, have adequate administrative resource and access to senior managerial supervision and support; (c) the complaints procedure is integrated into the clinical governance/quality framework of the organisation.

- Consideration should be given to the development of a National Service Framework or its equivalent for the management of complaints. A service framework would provide clear guidance to NHS organisations on the standards which are expected and it would establish a framework for performance management.

8.6 In the particular context of primary care there is a need to ensure more openness and to offer complainants an opportunity to avoid the need to complain directly to the practice. We believe that the best way to achieve this is to encourage practices to work together within the structure of a primary care group (or primary care trust) to share information and to offer support in providing acceptable procedures for handling complaints.

- Complaints about family health services should be handled in the same way as complaints about all other services provided by the NHS. The board of a primary care trust or its equivalent should have the responsibility in relation to complaints about family health services contractors which currently lies with a health authority/board. Primary care trusts in Scotland already have this responsibility.

8.7 We have suggested a number of changes which, taken together, are likely to lead to improvements in the way in which complaints are handled locally. Many of these changes are already possible within the current procedure, and part of the emphasis in the future must be on ensuring that current mechanisms are properly enforced. A complete list of suggested changes is given at the end of this chapter.

Independent review

8.8 As a second stage in the complaints procedure, a system of review offers two important safeguards: it provides an additional opportunity to identify clinical or professional problems which may be overlooked when complaints are dealt with internally and, so long as the review process is linked to a system of monitoring, it offers an opportunity to ensure that necessary changes follow from complaints.

8.9 In order to offer these safeguards the review process must be *independent* and it must have the *authority* to ensure that recommendations are enforced. The current system does not meet either of these requirements.

8.10 Nor does it currently perform well. Of individuals who requested independent review, no more than one in ten were satisfied with the time taken and only 13% were satisfied with the outcome of their complaint. Almost three-quarters believed that the procedure was unfair or biased. Even those involved in the operation of the

complaints procedure agree that the review process should be more independent and less time consuming.

8.11 Suggested improvements include both procedural and structural changes (details are given at the end of this chapter). However, the fundamental requirements are to ensure that the review procedure is genuinely independent and that organisations are *actively* monitored in order to ensure that actions agreed following an independent review are implemented.

- Consideration should be given to the proposal that in future both the convening decision and the conduct of a review should be the responsibility of a regional or sub-regional lay panel appointed for the purpose. Panels may be accountable to a national complaints authority *or* to the regional offices of the NHS Executive (in England) and national or sub-national bodies in Scotland, Wales and Northern Ireland.

- The regional and national bodies responsible for NHS performance should ensure, through the performance management framework, that an acceptable action plan is produced in response to the report of an independent review and that the plan is implemented.

Summary of policy implications

Local Resolution
1. The board of every NHS organisation should be held accountable for the performance of the organisation in handling complaints. In particular, the board should ensure that: (a) all staff are adequately trained to deal with complaints and are supported in the event of a complaint being made against them. Training in handling complaints should be a compulsory part of induction and continuing education; (b) staff managing complaints are appropriately trained, have adequate administrative resource and access to senior managerial supervision and support; (c) the complaints procedure is integrated into the clinical governance/quality framework of the organisation (6.12). 2. The board of an NHS organisation should insist on receiving appropriate information at least quarterly on the causes of complaints and on the action which has been taken, or is proposed, to prevent recurrence. The board should take responsibility for ensuring that agreed actions are implemented (6.31). 3. The quarterly report to the board should provide an analysis of the causes of complaints, emerging trends and the action taken (or proposed) to prevent recurrence. This report should be presented to the board in person by the complaints manager or the chief executive (6.16). 4. The quarterly report to the board should be copied to the local health council (or equivalent), the proposed Patients' Forum in England and equivalent organisations which may be established in Scotland, Wales and Northern Ireland. The chief executive of the trust or health authority/board should invite these organisations to monitor the implementation of action plans agreed in response to complaints (6.31). 5. The regional offices of NHS Executive in England and the appropriate central NHS bodies in Wales, Scotland and Northern Ireland should be required to demonstrate that complaints-handling is an explicit part of the performance management of chairs and chief executives. These bodies should ensure that the information available to them is timely and relevant to this responsibility (6.31). 6. Consideration should be given to the development of a National Service Framework or its equivalent for the management of complaints. A service framework would provide clear guidance to NHS organisations on the standards which are expected and it would establish a framework for performance management (6.12).

Local Resolution – Continued

7. The same principles should apply to family health services as to other services. The board of a primary care group (PCG), (local health group (LHG) in Wales) or primary care trust (PCT) should have the responsibility in relation to complaints against contractors which currently lies with the health authority. In particular:

- The board should work with practices in order to assist members in ensuring that acceptable procedures are in place to deal with complaints
- The board should receive information quarterly from practices on the causes of complaints and on action taken or proposed.
- Where appropriate, the board should offer support to practices in dealing with complaints (6.21).

8. The board of a PCG/LHG/PCT should be responsible for providing access for complainants to a named individual whose responsibility it is to handle complaints about member practices (6.23).

9. Where primary care groups do not yet exist (as in Northern Ireland), alternative approaches will need to be considered to improve the handling of FHS complaints (6.25).

10. Less discretion should be available to individual organisations to decide the functions of, and resources available to, the complaints manager. More detailed guidance should be offered from the centre, based on an analysis of current best practice (6.36).

11. The complaints manager should play a central part in ensuring that front-line staff are adequately trained and supported in dealing with complainants. Training should be provided on a regular basis (6.37).

12. Wider use of conciliation should be encouraged. Organisations should review their policy on offering conciliation and should assess the availability of trained conciliators locally. Trusts and health authorities/boards, in conjunction with the relevant regional or central NHS bodies, should then address remuneration, recruitment and training needs (6.44).

13. There does not appear to be any compelling reason why targets for a full response to a complaint at local resolution should be shorter for FHS contractors. Performance targets should be the same in all sectors (6.46).

14. It is not reasonable that staff should be subject indefinitely to the threat of a complaint and, subject to the exercise of discretion in appropriate cases, the existing time limits on complaints should be retained (6.49).

15. Central NHS bodies in England and Wales should disseminate examples of good practice in dealing with vexatious complainants (6.52).

Independent Review

16. The criteria for granting an independent review should be publicised and should be applied consistently throughout the NHS (7.19).

17. Although a decision must be made in each country, consideration should be given to the proposal that in future both the convening decision and the conduct of a review should be the responsibility of a regional or sub-regional lay panel appointed for the purpose (7.27).

18. A further decision must be made in each country about the framework within which a lay panel would be accountable. Two options have been suggested:

- Panels are accountable to the regional offices of the NHS Executive (in England) or to the relevant national or sub-national bodies in Scotland, Wales and Northern Ireland
- Panels are accountable to regional or sub-regional offices of a new national complaints authority which is independent of the NHS locally and regionally (7.29).

19. If regions are to have greater responsibility for independent review, there must be a clear statement of the minimum standards which are expected and a commitment from the centre that regional directors will be assessed on their performance in managing the independent review procedure (7.32).

20. Further consideration should be given to the suggestion of the Health Committee that an independent review panel should have formal powers to summon witnesses and take evidence. In addition, the Health Service Commissioner should be consulted about the feasibility of a 'fast-track' procedure and, if appropriate, might be asked to suggest a protocol for referral (7.40).

21. The board of an NHS organisation should take *active* responsibility for all aspects of complaints-handling. The board should receive a copy of an independent review panel (IRP) report relating to the organisation (or to a member practice in the case of a PCG/LHG/PCT). The board should accept responsibility for ensuring that an action plan is produced and that agreed actions are implemented (7.43).

22. The regional and national bodies responsible for NHS performance should ensure, through the performance management framework, that an acceptable action plan is produced following recommendations of an IRP and that the plan is implemented. Regional and national bodies should receive copies of all relevant IRP reports *and* the action plan which is produced in response to a report (7.43).

Independent Review - Continued

23. IRP reports and action plans should be copied to the local health council (or equivalent), the proposed Patients' Forum in England and equivalent organisations which may be established in Scotland, Wales and Northern Ireland. One of the functions of the local health councils/Patients' Forum should be to monitor compliance with agreed action plans (7.43).

24. In England, a report of an independent review panel, together with the agreed action plan, should be copied to the Commission for Health Improvement (7.43).

25. There should be a review of the training offered to all those involved in the complaints procedure. There is a need for more central guidance in order to reduce the extent of variability between organisations in the amount and type of training which is offered. There may also be a need to make some training compulsory, particularly for convenors, chairs and other lay members (7.46).

26. In Scotland and Northern Ireland the list of clinical assessors was recently updated but in other parts of the UK it is acknowledged that the list is out-of-date and in need of revision. This should be addressed as a matter of urgency by the NHS Executive centrally. Consideration should also be given to whether current fee rates for assessors and advisers are adequate (7.50).

27. Consideration should be given to standardising expenses and subsistence payments for chairs and lay members and to replacing loss of earnings compensation with an annual retainer or a fixed fee per case (7.53).

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APPENDIX A

Characteristics of complaints managers, convenors, chairs and lay panel members

Complaints Managers

Introduction

An NHS organisation (including an FHS practice) must have a designated complaints manager (complaints officer in Northern Ireland and Scotland) who is readily accessible to the public. The main role of the complaints manager is to oversee the complaints procedure. Details of role and function are decided by the board of the organisation concerned, but will typically include investigating complaints and/or offering support and advice to staff dealing with complaints.

The Guidance is not prescriptive about the characteristics of a complaints manager, but it is clear that to fulfil their role appropriately the post must carry sufficient seniority:

The complaints manager may be:

- *the chief executive*
- *a senior manager reporting to the chief executive, or*
- *particularly in large trusts, a senior manager reporting to the chief executive through another director, but with personal access to the chief executive when appropriate* (NHS Executive, March 1996: 4.17)

Survey results

A questionnaire was sent to the complaints manager/complaints officer of every trust and health authority/board in the UK. A total of 359 responses (68%) were received. A breakdown of responses between the four countries is shown in Table A1.1

Table A1.1: Complaints managers
(Questionnaire responses)

	All	England	Wales	Scotland	N Ireland
C Mgrs	359*	305	15	27	12

* trust=274, health authority/board=85

Characteristics

The majority of complaints managers in the sample are female and aged over 40.

Table A1.2: Complaints managers-Age and gender
(Percent of respondents)

	All (n=359)	HA/HB (n=85)	Trust (n=274)
Gender	Male: 23 Female: 77	Male: 24 Female: 76	Male: 23 Female: 77
Age			
20-30	5	8	4
31-40	29	36	27
41-50	38	39	38
51-60	28	17	31
60+	-	-	-

Almost 41% of complaints managers earn less than £24,000: 54.2% in health authorities/boards and 36.4% in trusts. Those earning over £27,000 account for between 30% and 42% of all complaints managers.

Table A1.3: Annual salary
(Percent of respondents)

	All	HA/HB	Trust
<£18k	12.6	8.4	13.9
£18-20.9k	12.3	18.1	10.5
£21-23.9k	15.7	27.7	12.0
£24-26.9k	20.9	16.9	22.1
£27k+	38.6	28.9	41.6
	100.1	100	100.1

Around one-third overall (34%) report directly to the chief executive, a further 31% to another director and the remaining 35% to someone else. Almost one quarter of complaints managers in trusts report to the director of nursing.

Table A1.4: Line manager
(Percent of respondents)

	All	HA/HB	Trust
Chief executive	34.0	28.0	35.9
Director of nursing	18.9		24.0
Director of corporate affairs	12.2	28.0	7.3
Other	34.9	44.0	32.8
	100	100	100

The majority work full-time, but most spend less than half of their time on complaints. The proportion spending more than 50% time on complaints varies from 61% in health authorities/board to 43% in trusts.

Table A1.5: Time on complaints
(Percent of respondents)

	All		HA/HB		Trust	
Working full-time	91		94		90	
Time on complaints						
<25%	26		20		28	
25-49%	27	53	19	39	29	57
50-74%	24		28		22	
75%+	23	47*	33	61*	20	43*

* Working more than 50% time on complaints (percent of respondents)

Most have responsibilities other than managing complaints. The most common are clinical negligence, litigation and risk management. Almost 30% of complaints managers in health authorities/boards spend the remainder of their time on FHS disciplinary procedures.

Table A1.6: Other responsibilities

	All	HA/HB	Trust

Do you have responsibilities other than managing complaints?	Yes-88.4%	Yes-88.2%	Yes-88.5%
What are they?			
Clinical negligence, litigation, risk management.	39.8%*	20.0%	46.2%
Quality standards, clinical governance	18.8%	10.7%	21.4%
Admin support to the Board, Board secretary	12.3%	13.3%	12.0%
Corporate information, public relations	10.0%	13.3%	9.0%
Legal services	9.7%	8.0%	10.3%
Staff support, training, human resources	7.4%	12.0%	6.0%
FHS disciplinary procedures	7.1%	29.3%	-

* Percent of those with other responsibilities. Multiple answers are possible

Complaints handled

Table A1.7 shows the average number of complaints handled by the complaints managers in the sample in the year 1998/99. Managers in health authorities/boards had the highest average workload, dealing with 311 complaints in the year. They also dealt with 14.6 requests for independent review (13.4 of which related to FHS complaints).

Table A1.7: Complaints handled-Sample respondents
(Mean number in the period April 1998-March 1999)

	All	HA/HB	Trust
Written complaints concerning organisation	168	36	206
Written complaints concerning FHS	275	275	-
Requests for independent review concerning organisation	4.2	1.2	5.1
Requests for independent review concerning FHS	13.4	13.4	-
Panels convened-organisation	1.0	0.3	1.1
Panels convened-FHS	3.2	3.2	-

National data for England on the mean number of complaints handled per organisation offer a means of checking whether sample respondents are representative of the population as a whole (85% of respondents work in England). The sample means are consistent with the national figures and this suggests that the sample is not biased. Comparable data for Scotland are shown for comparison.

Table A1.8: Complaints handled-England and Scotland
(Mean number in the period 1998-99)

	England	Scotland

Written complaints concerning organisation Written complaints concerning FHS	195 392	173 181
Requests for independent review concerning organisation Requests for independent review concerning FHS	4.2 14.4	2.2 4.1
Panels convened-organisation Panels convened-FHS	0.7 3.2	0.2 0.33

Source: *Handling complaints: monitoring the NHS complaints procedures. England, Financial year 1998-99.* Department of Health, Performance Analysis Branch, 2000.
NHS Complaints in Scotland 1998/99. NHS in Scotland, Information and Statistics Division, 1999.

Training

The mean amount of training received by complaints managers in the sample was 5.6 days. This was not substantially different for those working in health authorities/boards (5.8) and those working in trusts (5.5). Around 60% believed their training was sufficient. There are differences between the four countries, with the mean amount of training higher in England by approximately 1.5 days (Table A1.9).

In Scotland, less than 40% of respondents believed that their training was sufficient to prepare them for their role.

Table A1.9: Training

	All	England	Scotland	Wales	N. Ireland
Days of training (mean)	5.6	5.8	4.3	4.1	4.2
Was training sufficient?	Yes-60%	Yes-63%	Yes-**36%**	Yes-60%	Yes-75%
Topics have had training on:					
NHS complaints procedure	**73%**	**74%**	**78%**	**67%**	**50%**
Complaints manager role	**51%**	**51%**	42%	**60%**	**50%**
Effective team work	**51%**	**50%**	**50%**	**57%**	**80%**
Analysing and interpreting complex material	29%	28%	27%	31%	**60%**
Dealing with the public	**51%**	**52%**	44%	38%	**70%**
Interpreting regulations	24%	23%	28%	29%	**50%**
Report writing	**56%**	**57%**	44%	**57%**	**64%**

Asked about requirements for additional training, topics mentioned by complaints managers in all countries were the complaint manager role, analysing and interpreting complex material, dealing with the public in difficult circumstances and interpreting regulations. In Scotland complaints managers would also like additional training in the NHS complaints procedure and report writing.

Table A1.10: Topics would like more training on

	All	England	Scotland	Wales	N. Ireland
Would like more training*					

NHS complaints procedure	-	-	67%	-	-
Complaints manager role	53%	51%	70%	50%	50%
Effective team work	-	-	67%	-	-
Analysing and interpreting complex material	66%	64%	88%	77%	50%
Dealing with the public	67%	66%	83%	57%	78%
Interpreting regulations	66%	64%	79%	79%	67%
Report writing	-	-	58%	50%	-

* Topics identified by at least 50% of respondents

Central support

We asked complaints managers whether and in what way support from the regional offices of the NHS Executive (in England) or the relevant central bodies in Scotland, Wales and Northern Ireland could be improved. The majority of respondents in each country believed that support could be improved. Table A1.11 shows the most commonly cited issues in each country.

Table A1.11: In what way could central support be improved?
(Percent of responses-top 8 responses)

	All	England	Scotland	Wales	N. Ireland
Could support be improved?	Yes- 72%	Yes- 73%	Yes- 69%	Yes- 80%	Yes- 55%
In what way?					
Accessing lay chair/lay member	24	28	-	-	-
Training	22	16	75	36	-
Provide information more quickly	16	17	5	9	50
Accessing CA/CA database*	15	17	-	9	-
Better guidance on defining a complaint					
More contact/visits	8	8	-	27	25
Interpretation of guidance	6	5	15	9	-
Feedback on complaints data	5	6	-	9	-
	4	3	5	-	25

* CA = clinical assessor

Improved central support for training is an issue in all countries except Northern Ireland. Accessing lay chairs is a particular issue in England and accessing clinical assessors is an issue in England and Wales. In Scotland complaints managers would like to have more contact/visits and in Wales and Northern Ireland providing better guidance on the definition

of a complaint is an issue. In Northern Ireland complaints managers would like better feedback on data collected centrally.

Convenors

Introduction

The role of the convenor is central in the decision to grant or refuse a complainant's request for an independent review panel. The convenor must decide within 20 working days, having consulted with a lay chair and having sought clinical advice where appropriate. In those cases in which a panel is established the convenor is responsible for drafting terms of reference. A convenor is one of the three members of the panel.

Survey results

A questionnaire was sent to the (lead) convenor of every trust and health authority/board in the UK. A total of 342 responses (65%) were received (Table A2.1).

Table A2.1: Convenors
(Questionnaire responses)

	All	England	Wales	Scotland	N Ireland
Convenors	342*	304	10	25	3

*Trust=257, health authority/board=85

Characteristics

More than 90% of respondents were a non-executive director (83% in health authorities/boards, 96% in trusts). The mean time in post was 30 months. For convenors in health authorities/boards, the mean time in post was longer (35 months compared with 28 months in trusts).

Table A2.2: Position and experience

	All	HA/HB	Trust
Non-executive director	93%	83%	96%
How long have been a convenor (months, mean values)	29.6	35.4	27.6

Most convenors are female. 75% are over 50 years of age (35% are over 60). Just over one-third (35.6%) are in employment, a quarter (24%) are self-employed and the remainder (40%) are either not in employment or are retired.

Table A2.3: Convenors-Age and gender
(Percent of respondents)

	All (n=342)	HA/HB (n=85)	Trust (n=257)
Gender	Male: 37 Female: 63	Male: 38 Female: 62	Male: 37 Female: 63
Age			
20-30	-	1	-
31-40	4	2	5
41-50	21	25	20
51-60	40	38	40
60+	35	33	35

Table A2.4: Employment status

(Percent of respondents)

	All	HA/HB	Trust
FT paid employment	13.6	19.0	11.9
PT paid employment	22.0	14.3	24.5
Self-employed	24.0	28.6	22.5
Not in employment	7.4	8.3	7.1
Retired	30.6	29.8	30.8
Other	2.4	-	3.2

Complaints handled

One of the criticisms which has been made of the current system is that because the number of complaints they deal with is relatively low, convenors are not able to accumulate sufficient experience. The average convenor in the sample handled 13 requests for independent review in a 30 month period (approximately one request per 2 months). Convenors in health authorities/boards have been longer in post and dealt with more complaints. The average health authority/board convenor has dealt with 26 requests at a rate of around 1 per 1.5 months. For trust convenors the rate is nearer one request per 3 months.

Half of trust convenors have never attended an independent review panel and of those who have, 80% have attended between 1 and 3. In contrast, only 4% of health authority/board convenors have never attended a panel. The difference is due to the higher rate of panels involving FHS contractors.

Table A2.5: Complaints handled

	All	HA/HB	Trust
IR requests handled (mean)	13.46	26.19	9.43
IR panels attended			
None	39.2%	3.6%	51.2%
1-3	35.3%	23.8%	39.2%
4-6	13.2%	29.8%	7.6%
7-9	3.9%	13.1%	0.8%
10+	8.4%	29.8%	1.2%
Mean time as convenor (months)	29.6	35.4	27.6

Training

Most convenors have received training. The average is 15 hours (20 hours for health authority/board and 12 hours for trust). The average amount of training offered was higher in Northern Ireland and England than in Wales and Scotland. Most convenors believe their training was sufficient. The main focus of training has been on the complaints procedure and the role of the convenor.

Table A2.6: Training

	All	England	Scotland	Wales	N. Ireland

Received training?	Yes-89%	Yes-88%	Yes-96%	Yes-90%	Yes-100%
Hours of training (mean)	14.52	14.82	11.30	11.88	23.00
Was training sufficient?	Yes-69.1%	Yes-71%	Yes-56%	Yes-38%	Yes-100%
Topics have had training on					
NHS complaints procedure	**89.6%**	**89%**	**96%**	**90%**	**100%**
Convenor role	**88.2%**	**88%**	**92%**	**70%**	**100%**
Making difficult decisions	**53.6%**	**55%**	42%	44%	33%
Effective team work	43.8%	46%	24%	44%	33%
Legal implications	45.7%	46%	46%	38%	**67%**
Effective communication	**51.0%**	**53%**	33%	33%	**50%**
Analysing and interpreting complex material	35.0%	37%	16%	33%	**50%**
Interviewing techniques	43.0%	46%	24%	11%	**50%**

A majority of convenors would like to have additional training, particularly in Scotland and Wales. Topics are shown in full in Table A2.7. The three topics mentioned most often were making decisions in difficult circumstances, the legal implications of the NHS complaints procedure and analysing and interpreting complex material. Approximately half of the convenors in Scotland, Wales and Northern Ireland said they would like to have more training in basic areas such as the complaints procedure itself and/or the role of the convenor.

Table A2.7: Topics would like more training on
(Percent of responses)

	All	England	Scotland	Wales	N. Ireland
Would like more training*					
NHS complaints procedure	-	-	52	57	50
Convenor role	-	-	59	-	50
Making difficult decisions	69.1	68	75	78	-
Effective team work	-	-	52	50	-
Legal implications	69.6	69	61	78	100
Effective communication	-	-	50	75	50
Analysing and interpreting complex material	57.8	58	58	75	-
Interviewing techniques	-	-	70	75	50

*Topics identified by at least 50% of respondents

Meetings with other convenors

The majority of convenors in each country have had an opportunity to meet together to discuss their work. However, a large majority would like to have more opportunities to meet regularly than are currently available.

Table A2.8: Whether have met with other convenors
(Percent of respondents)

	All	England	Scotland	Wales	N. Ireland

Have had an opportunity to meet	77	79	52	80	100
Would like to have more opportunity to meet	88	87	100	80	100

Chairs and Lay Panel Members

Introduction

Although a chair is nominated by the regional office or health board, they are formally appointed by the trust or health authority/board which is the subject of complaint. It is the trust or authority/board which is responsible for meeting the expenses of the panel, including the chair. Practice varies between organisations in the way in which the expenses and loss of earnings compensation for chairs and other panel members are determined.

Survey results

A postal questionnaire was sent to a sample of more than 700 lay chairs and panel members in the UK. The response rate was 62%. All had been involved in the past year on a panel or convening decision.

Table A3.1: Chairs and lay panel members
(Percent of respondents)*

	All	England	Wales	Scotland	N Ireland
Lay chairs	474	389	19	58	8

* The country breakdown is approximate

Characteristics

The majority of chairs and lay panel members are male. More than 80% are over the age of 50 and almost half (45%) are over 60.

Just over half (51.4%) are in paid employment. The average time in post was 35 months.

Table A3.2: Chairs and lay panel members-age and gender
(Percent of respondents)

	All	England	Wales	Scotland	N Ireland
Gender	Male: 71.5 Female: 28.5	74.8 25.2	68.8 31.2	69.4 30.6	85.7 14.3
Age					
20-30	0.6	0.6	-	-	14.3
31-40	3.2	2.8	-	6.1	-
41-50	12.2	12.0	18.8	4.1	14.3
51-60	38.7	40.7	31.3	30.6	28.6
60+	45.3	43.8	50.0	59.2	42.9

Table A3.3: Employment status and experience

	All	England	Wales	Scotland	N Ireland
In paid employment	51.4%	53.4%	43.8%	28.6%	14.3%
Length of time as a lay member (months, mean value)	35	34	40	39	43

Complaints handled

Table A3.4: Complaints handled
(Mean values)

	All	England	Wales	Scotland	N Ireland
No of IR requests	23	24	22	14	23
No of IR panels	6	6	8	3	6

Training

Chairs and lay members received an average of 3 days of training (Table A3.5). Most thought their training was sufficient (except those in Wales). Although a high proportion had received training on the complaints procedure and on their role, these were also the topics most commonly cited when respondents were asked about topics on which they would like to have more training (Table A3.6).

Table A3.5: Training
(Percent of respondents)

	All	England	Wales	Scotland	N Ireland
Days of training (mean)	3	3	3	4	4
Was training sufficient?	Yes-68.8	Yes-68.2	Yes-**43.8**	Yes-60.4	Yes-71.4
Have had training on					
Complaints procedure	**99.6**	**99.4**	**100.0**	**100.0**	**100.0**
Lay member role	**95.0**	**95.7**	**75.0**	**95.9**	**100.0**
Effective team work	37.9	39.4	33.3	28.9	**57.1**
Analysing complex material	31.4	32.2	31.3	19.6	28.6
Dealing with the public	31.1	33.4	12.5	17.8	42.9
Report writing	36.8	37.0	18.8	27.3	**57.1**

Table A3.6: Topics would like more training on
(Percent of responses)

	All	England	Wales	Scotland	N Ireland
Would like more training*					
Complaints procedure	51.0	53.8	-	53.2	-
Lay member role	51.0	51.8		60.4	57.1
Effective team work	-	-	-	-	-
Analysing complex material	-	-	57.1	50.0	71.4
Dealing with the public	-	-	53.8	60.4	71.4
Report writing	57.7	59.0	66.7	50.0	-

*Topics identified by at least 50% of respondents

Feedback

Only 22% of chairs had received feedback on panel reports. With the exception of Wales, a minority received feedback in each country. Overall, 97% said they would like to receive more feedback and this was common across all countries.

Table A3.7: Feedback on panel reports

	All	England	Scotland	Wales	N. Ireland
Receive feedback on panel reports	Yes- 22%	Yes- 20%	Yes- 30%	Yes- 50%	Yes- 29%
If receive feedback, is feedback sufficient?	Sufficient 64%	Sufficient 63%	Sufficient 54%	Sufficient 57%	Sufficient 100%
If don't receive feedback, would like to receive feedback?	Yes- 97%	Yes- 97%	Yes- 94%	Yes- 100%	Yes- 100%

In aggregate, 65% of chairs never receive feedback on the outcome of complaints they are involved in. This proportion is highest in England and Northern Ireland. In no country do more than a quarter of chairs report that they have always been informed of the outcome of a complaint. Almost without exception chairs would like to be better informed.

Table A 3.8: Frequency receive feedback on the outcome of complaints involved in

	All	England	Scotland	Wales	N. Ireland
Always Sometimes Never	11% 24% 65%	10% 21% 69%	16% 39% 45%	23% 38% 38%	14% 14% 71%
Would like to receive more frequent feedback	Yes- 98%	Yes- 98%	Yes- 100%	Yes- 88%	Yes- 100%

The situation is similar with respect to information about the action which is to be taken as a result of a complaint (Table A3.9).

Table A3.9: Frequency receive feedback on action taken as a result of a complaint

	All	England	Scotland	Wales	N. Ireland
Always Sometimes Never	13% 31% 56%	12% 33% 56%	17% 37% 47%	31% 31% 38%	20% 20% 60%
Would Like to receive more feedback	Yes- 98%	Yes- 98%	Yes- 97%	Yes- 100%	Yes- 100%

Meetings with other chairs and lay members

Approximately 80 percent of lay members have an opportunity to meet together no more frequently than once a year: one-third have met less frequently or have never met. This pattern is consistent across the four countries. Lay members would like to have more opportunities to network. A large majority in each country would like to meet at least every six months.

Table A3.10: Frequency of meetings with other chairs and lay members

Current frequency	All	England	Scotland	Wales	N. Ireland
Three-monthly	5.9%	2.4%	13.6%	-	14.3%
Six-monthly	13.9%	6.6%	20.5%	-	14.3%
Annually	46.5%	53.1%	25.0%	53.3%	71.4%
Less or Never	33.7%	37.8%	40.9%	46.7%	-
Preferred frequency					
Three-monthly	27.4%	23.8%	31.0%	20%	66.7%
Six-monthly	51.6%	55.7%	41.4%	60%	33.3%
Annually	18.9%	17.6%	27.6%	20%	-
Less frequently	2.1%	2.9%	-	-	-

Central support

We asked respondents in what way support from the regional offices of the NHS Executive (in England) or the relevant central bodies in Scotland, Wales and Northern Ireland could be improved. The issues raised in each country are similar. With the exception of Wales, providing more feedback on the outcome of complaints is the single most commonly cited improvement. Other common issues include enhanced opportunities to network with others involved in the complaints procedure, better dissemination and better support with training.

Table A1.11: In what way could central support be improved?
(Percent of responses-top 5 responses)

	All	England	Scotland	Wales	N. Ireland
Provide more feedback on the outcome of complaints	26.3	25.9	25.2	24.1	31.6
Provide more opportunities to network with other lay members	19.3	20.1	19.4	20.4	21.1
Provide more opportunities to network with others involved in the complaints procedure	19.1	19.3	16.8	27.8	21.1
Disseminate the work of other lay chairs	17.8	17.0	20.0	13.0	15.8
Organise training	17.5	17.8	18.7	14.8	10.5

APPENDIX B

Focus Groups in Primary Care

These notes summarise discussions in the nine FHS focus groups held throughout the UK. Attendees included GPs, GDPs, opticians, pharmacists and staff from health councils and health authorities/boards.

*The key themes to emerge were***:**

- Questions were raised about what the purpose of recording complaints is and about what happens to the data that are collected. There are difficulties inherent in the word 'complaint' and there were calls for a more sophisticated mechanism for dealing with responses from the public. It was felt that the current system encourages defensiveness in the professionals involved and an escalation of matters that could be resolved more effectively.

- Being the subject of a complaint is unpleasant and is seen as a reflection on one's standards of professional practice. Wanting to be able to respond effectively to potential complaints influences some aspects of practice e.g. record keeping.

- There were concerns about the feasibility of some of the time scales for responding to complaints.

- Particular problems are encountered when making a complaint to a small, potentially single-handed, organisation.

- The entrenched attitudes and working practices of some of the key players inhibit constructive responses to service users.

- The tone and style of communication is vitally important. It was agreed that complaints can take longer to work through if the content of any correspondence is ill-judged.

- There was an acknowledgement of the seemingly trivial nature of some complaints and a recognition that to the people involved these were issues that needed to be discussed and, hopefully, resolved. There were, however, some concerns that some inappropriate judgements were being made by some staff about what should or should not be taken further.

The Meaning of 'Complaining'

There was discussion about the merits of changing the word 'complaint' and having a more sophisticated mechanism for recording, and responding to, feedback organisations receive. There will be complaints, undoubtedly, but there will also be comments, suggestions and reflections from those in contact with the services. When these were all introduced under the 'complaint' umbrella there were said to be defensive reactions and opportunities to learn from what was being said were lost. A participant from a CHC was clear that: 'The problem we have got, and have got to get around, is the sense of concern and worry that professionals have about receiving a complaint, in case it suddenly goes off down to their professional lay body or whatever and they find their job on the line.' Some complaints were said to be about *changes* in the service rather than simply what was provided. A practice manger, for example, noted that: 'A lot of complaints stem from when GPs retire……the new doctor has a completely different way of working and we have actually had lots of complaints instigated by the …" I don't like him" attitude'.

Issues for Staff

There was talk of the 'ideal' complaint that could be dealt with in a relatively straight-forward manner. This was described as:' something that has substance, that there was something within my power to correct and (was) presented to me in a way that I can sympathise with'. Staff were, however, likely to see themselves in more challenging situations, dealing with: 'someone who has got unrealistic expectations, who is complaining – I think I've done my duty, then it becomes a very negative experience. Therefore it doesn't enhance or help my future interactions with that patient or other patients. I want it to be a positive role. You see the word complaint at the top of your form. That is a negative experience'.

There were strongly held views about the impact of receiving complaints on the professionals involved. There were concerns that they were wholly negative encounters with, potentially, destructive consequences. As one practitioner explained: 'Complaints are unpleasant and I think one of the fallacies about the complaints procedures is that we are supposed to welcome complaints – when the truth is nobody welcomes complaints in a sense – because it is a very personal thing, it is a personal comment about your performance……when you actually complain about the health service you are making a complaint about a multitude of people who quite rightly have views and feelings about the service they are providing'.

A very different perspective was that a comment about, for example, the colour of the walls 'may sound trivial, but why not value every input as something which is about working together and being creative in our professional working relations?' In a similar vein a practitioner noted that: 'I am one of those guys (who thinks) that if you are not being complained about then you are not doing your job properly because it means to me that you are keeping people happy all of the time which is not what we are in the game for'.

Any defensiveness could impact on the tone and nature of communication. Commenting on how practitioners respond, one participant explained how: '…there is this strident element as well, because some of the letters that come back and you think to yourself "Gosh, if you had waited another two days before writing that letter, it might have been a better letter". That is the problem, it's the first contacts with patients which are the problem areas, if a complainant detects that you are a bit kind of shirty then they get shirty as well'. An initial planned response letter was recommended 'because you are not admitting anything that could be implicated towards you at a later date, you have to cool off, you have to think, sit back'.

More positively, an awareness of the possibility of receiving a complaint was said to have an impact on some aspects of service provision. A dentist, for example, noted a gradual change in expectations about record keeping: 'I would have just written LA if I had given local anaesthetic for a filling, that was all. That would be sufficient 18 years ago. Now I write down the quantity, the type of anaesthetic I used, and I would write down the fact the patient had been advised. Whereas 18 years ago LA would have done.'

On a practical note it was said that: 'Certainly the NHS dental paperwork, and I suspect the medical as well, the paperwork format is such that it doesn't encourage full note keeping. The dental cards haven't changed from 1950.' A GP remarked that he had 'the original doctors' scrawl' and described 'trying to follow up a particular clinical problem from a couple of years ago'. Such tasks were made more difficult by the way notes were recorded and he felt: 'quite strongly that the format ought to be changed to encourage better notes, and they should be bound, rather than loose bits of things floating about'.

One way to tackle defensiveness and other concerns was said to be through staff training. There was said to be limited relevant coverage in professional preparation. There were no time-tabled sessions on how to deal with service users and some input could encourage a limited perspective. One practitioner noted that: 'I know the undergraduates have a session where one of the (professional body) people come in and absolutely scare the living daylights out of them, as to what can happen if you don't keep the correct notes, which is fine, because correct note keeping and correct patient advice is obviously very important, but there is an awful lot to take on board as a new practitioner and I feel that as part of keeping a happy ship running as it were, one of the things that is important is how you speak to patients.'

A practitioner hoped that: 'someone, maybe perhaps the Health Authority, could help us, would be in terms of staff training sessions in sort of front line work, taking incoming complaints/suggestions, hearing the initial responses is crucial, that if one could have one's receptionist and deputy actually come along and have an in-house training session where it comes from some-one else as to how to handle this'. Continuing this discussion another practitioner saw similarities with how clinical contact is updated. It was said that training needs to be: 'repeated, repeated, repeated. Your staff might change, people might move on. I think it is something like asking for resuscitation on an annual basis. To reinforce, if this happens you go into automatic pilot'. Training sessions would provide an opportunity for staff to say: 'yes, something like that (a complaint) happened to me'. There could be useful lessons learnt if 'someone else has got the courage and confidence to say "That is a common problem".

Another strategy that emerged from discussion was for key players from different organisations to meet to discuss common issues in the handling of complaints. A practitioner noted that she had never met, but had received correspondence from, others in the group. In future her reaction would be quite different, having had an opportunity to hear their (constructive) perspectives on complaints. She explained that: 'If I had a letter from (CHC), and I have now met the gentleman (CHC staff) I'd think 'Great, no problem'. Another participant felt that: 'I think perhaps what we need is to get together more often, all the people involved in complaints and talk to each other about how we go about things, and then if you have got any moans about the way I've done something, you can have a moan to me about it, I'm always ready to think it through and change the way we go about things if it makes life more helpful for everybody'.

Complaints and Small Organisations

It was clear that there were particular difficulties in making a complaint to a small, potentially single-handed, provider. This was cited as an issue in pharmacy as well as general practice. The value of the procedure for small organisations was queried, as in: 'I personally would see that (a further structure) as an imposing cast iron mechanism which may be appropriate for a big organisation, but is totally inappropriate for small organisations where total personal interpersonal, face-to-face contact is very frequent and there are mechanisms for dealing with those very rapidly and personally and I don't see, maybe I'm missing it, but I don't see that people aren't able to complain….people are very able and willing to complain.'

There were opportunities for the communication to become very 'personal'. One participant noted that: 'in a large organisation like a Trust you go to the designated complaints person, there is a buffer between the person who is complaining and the person who is being complained about'. (It was emphasised that the buffer was a two-way process in that 'it is very unpleasant to have a complaint made against you'). It was noted that when a

complainant writes to the named person in a practice they are then disconcerted to receive a response from the person who was the subject of the complaint.

When discussing these issues it was made clear that what was said was not, necessarily, a criticism of the professionalism of the staff involved, rather it was an acknowledgement of the problems of dealing with conflict in small organisations. It was said to be very difficult for practice mangers to maintain that distance. A participant from a Health Authority/Board spoke of these mangers' tendency to 'explain' what has happened, giving the complainant the impression that they are not 'hearing' the complaint. The point was not that what happened in Trusts was, necessarily, of a better quality just that it was a process that involved a number of people, rather than an individual or a small number of people who work closely together.

Concerns about accountability in small providers were fuelled by the practitioner who explained that: 'I wouldn't expect a member of my staff to be doing something that I wouldn't know about and didn't authorise, for obvious reasons. So you are in a position where there is an employee/employer relationship and most people would work to that'.

The Recording of Complaints

It was clear that the number of recorded complaints varied from practice to practice, for unknown reasons. There was no system for categorising them. A representative from a Health Authority/Board noted that: 'We are obliged to collect (the) number of complaints, that's a statutory thing to do, just numbers. Some practices don't ever seem to have any complaints at all….. It was felt that some practices 'could be quite strict and they handle it all as a complaint'. It was felt that there were 'bound to be different definitions of complaints'. There was some discussion about all 'serious' complaints being written down, but there were exceptions to this. One participant explained that :you can get very serious complaints verbally, which I always follow up – I always follow up every complaint or gripe, but I think it is important to categories them'. There was an issue about the severity of the complaint. As one participant noted: 'I think you could have 15 complaints of a very minor nature, and a practice could have three complaints of an extremely serious nature'.

It was agreed that the role of the Health Authority/Board was limited, given that they were not able to investigate differences in the recorded level of complaints. As one of their representatives explained: 'We have to have a return every year from doctors and dentists of how many complaints they've had. Now all I do is add them up and send them off to the Department of Health, because that's my role. But it is interesting, that some practices you can tell they have put down everything. Whereas others may not even have admitted to the ones (complaints) that I have spoken to them (practitioners).' The reluctance to report was said to be due to concerns about being seen as professionally incompetent.

Staff in Health Authorities/Boards spoke of being able to identify trends and act accordingly. As one of their representatives explained: 'if you receive more than two complaints about a practitioner within a fairly short space of time, you become very suspicious, because, certainly in my experience, you very rarely receive more than one complaint about the practitioner, within a short space of time'.

One practice manager defined a complaint as any response from a patient that was drawn to her attention, whether it was written or not. Another participant explained that in a previous post in secondary care every such case was recorded as a complaint. Continuing to do so in general practice meant that 'far too many' were on record. Being clearer about what was recorded and how it was lodged was seen as valuable and as a way of encouraging compliance. One participant explained that: 'It's not always the practitioner's fault that

someone has complained….it's not really a complaint at all in fact. You don't pick that up from complaints, you don't pick up how many weren't really valid complaints to start with. We need somehow to record all that kind of stuff'.

One practice manager explained that complaints should not be seen as 'something to be feared'. She noted that in her practice: 'I have a book that is available at reception and I ask my own staff to put every little incident, even if somebody is being a bit annoyed about waiting. I ask them to put it in the book, it helps me to get an overview of the practice and what is happening'. It was unclear, however, how distinctions were made about what was a complaint. In this case the figures that go to the Health Authority/Board are those that the practice manager has been involved in, be they face-to- face or written.

Some reluctance was expressed about a more systematic system for recording feedback from patients, some of which might involve a complaint. There was a concern that this was too 'fussy' and was impossible given the day to day demands of service delivery. It was felt that at the local level discretion was appropriate. The size of practice was seen as significant: 'in a small practice the doctor or professional might know every individual, a relationship which allows them to say things perhaps more informally. Whereas a large organisation, where perhaps there is more of a distance or scattering of information, then a more formal system might be more essential to ensure all the people who need to be apologised to or explained to, or whatever, are covered. In a smaller surgery 'it may be entirely appropriate and sufficient to deal with it on a quick word with somebody on the 'phone after surgery, or at a time that fits in with people's schedules'. A formal system was seen to potentially act as an 'impediment'.
There were prolonged discussions about how a feasible system for recording complaints accurately could be instigated. It was clear that it had to be: 'something fairly quick that the average practitioner can do over a cup of coffee. It's got to be short, concise with no kind of blame aspect, no threat aspect…….the negativity has got to be somehow taken out of it, that is by no means easy. I think you know where the most areas of complaint lie – the top 10 – you could just say 1 to 10 and how serious it was.'

It was widely agreed that there were a number of influences on the number of recorded complaints in different organisations. An illustration of the complexities was that people may be recommended to a 'switched on, caring practice' when they have: 'either clinically difficult problems to solve, coupled with unrealistic expectations of what could be done, and then if their expectations are not realised they then feel "I'm going to complain, because I thought you were really brilliant and so and so says you are, and you haven't done anything for me". I think this again can possibly explain why a seemingly better practice can have more complaints'.

'Informal' Resolution

There was a clear tension between an unregulated, informal system that allowed complaints to be resolved easily and quickly and an official procedure that, it was felt, could lead to unhelpful escalation. An emphasis on keeping the system informal sometimes obscured the desirability of recording the nature and outcome of complaints and of seeing them as contributing to service development. The potential value of feedback about how services are received was only discussed briefly during these groups.

This need for an informal, swift response was illustrated by the comment that:'….if it is something that hasn't gone quite right, you do take time out and you are very focused on making sure that you have followed the letter of the law if you like. I think more often than not it is misunderstandings which if they were properly nipped in the bud in the first place

wouldn't grow into something more of a confrontation situation………Again, I think this is where if we had this sort of front line staff training it could help quite a lot'.

There was concern that to enter a formal process e.g. a meeting with the practice manager, the staff complained about and the complainant too early could mean that an issue became 'out of proportion'. It was seen as important to have a responsive first stage to seek to clarify what could have been a misunderstanding between a member of staff and a patient. A considered and informative telephone call could serve to provide the information or explanation a patient was seeking and no further action would then be required. In relation to letters a practitioner expressed the view that: 'I have only ever used the letter system once with one patient. Other than that I have managed to sit down with patients in a room on my own and talk to them and that usually works. I think the letter system, most practices have now got something like this, I think that perhaps is a little bit over the top…..'

An informal, unwritten and unrecorded response, that was said to have satisfied the patient was outlined: A complainant had brought in her son and he had tonsillitis 'and the receptionist hadn't been aware, he wasn't given an appointment the next day, and there was a lot of 'phone calls saying this is terrible…..and I spoke to the lady and I went out of my way to speak to her in person, not on the 'phone, and I dealt with that in an appropriate way and she, in the end, expressed her contentment with the explanation. While there was satisfaction here the participant noted that: 'I still haven't fully complied with the guidelines it gives us for dealing with it in writing and making a written response to her complaint and in that sense the matter hasn't been totally dealt with, but I feel that dealing with it in writing is an extra layer on to a system which bureaucracy requires, yet the patient is happy I think, and I feel we have dealt with it.

The potential limitations of this informality were highlighted by the participant from a Health Authority who noted that: 'We tend as a Health Authority to record everything, even an enquiry. Because quite often these things will bounce back……we record it just in case two weeks, three months in the future that person comes back having considered all the factors and they do want to make a complaint. It's very difficult from a Health Authority point of view to decide what is a complaint and what is an enquiry. So we write everything down because you don't know when people are going to come back, and some of them will.'

The potential for misunderstandings when responding to a complaint was discussed. It was sometimes difficult for staff to know how to respond appropriately. One example of an unexpected escalation was where an optometrist received a complaint from a patient about the pain they were experiencing. It was felt that the professional showed 'too much concern' by ringing the patient a number of times to enquire about their recovery'. The patient interpreted this as evidence of clinical negligence.

Participants spoke of the desirability of a situation where professionals could say 'We all make mistakes' and then feel able to apologise. There was agreement that the situation for pharmacists and opticians was different in that if people were not satisfied with the service they would go elsewhere. It was clear that the expectation was that complaints in pharmacy, as with the opticians would be dealt with in-house. The retail pharmacy perspective was that: 'I have very rarely had any dealings with any of the Health Authorities/Boards – I always look to settle the issue in-house and I think that is the response to what patient/customers expect, in the same way as they will complain about photographs or whatever'.

There were some suggestions for strategies to deal effectively with what *were* complaints:

- a mediation service

- a system whereby two senior GPs will ‘meet patients, look at the records, chat to them and explain to them what’s gone on, what the GP has been trying to do, and that has been very useful. Some of the GPs have been retired from practice so therefore they are neutral as well and that has been a very useful system where people haven’t understood’.

- easy access to professional advice e.g. the professional standards inspector for pharmacists, given that ‘most complaints are misunderstandings’.

Time-scales

There was a consistent message that the time-scales were problematic, given that there were a number of staff to involve. As one practitioner noted: ‘Certainly from a GP point of view, if it’s about somebody’s clinical care it may be that the doctor wants to check with the hospital about results of tests or just check appointment dates ……and it is difficult to get all the information back and a full explanation to the complainant within 10 working days. It seems very short and obviously when we go into the bigger arena of independent reviews it gets worse, because of getting all the bodies together at a given time.’ Another commented that: ‘Independent reviews are never on time. We have never had one that has actually hit the national time-scales…….that’s because you are actually having to have people from all over the area…..to compile reports, be available for meetings etc.. It just doesn’t work very well’.

A balanced approach to time-scales was important. As one participant noted: ‘…..the practices get extensions on their times, but then all of a sudden the complainant has to answer within 28 days. The GPs are ever so good at doing this, they’ll take two months and then write back and say if you are not satisfied you have got to come back within 28 days. Of course the complainant goes ballistic about that. Some get worried. We need flexibility, but on the other hand we also need to make sure there are set limits.’

There were additional practical problems for small organisations. Where there was not a practice manager: ‘You suddenly have 48 hours to acknowledge (a complaint) and …..typing out a letter, it might put pressure on the dentist to actually sit down and dictate that letter first’. Some frustrations were expressed. One practitioner noted that in the correspondence: ’ you respond to the first five points, you get ten points back. You respond to that they (complainants) move the goal posts completely’. One reflection on this was that ‘sometimes people raise additional queries because they realise in the first instance they didn’t ask the right questions’.

Access to the Complaints Procedure

Basic information about how to complain was said to be available by some participants. There were some concerns that there were those with ‘genuine’ complaints who do not complain as well as some who are difficult to satisfy and who know how to use the system expertly. There were, however, some concerns raised about how the system would cope with an increase in the numbers of cases and about ‘encouraging’ people to complain. One practitioner explained that: ‘If we were to advertise the complaints procedure and stick it up (information) we would get endless complaints. I think you’ve got to give them (patients) respect, if they have a complaint then they know it, they’ll come to us’.

While a consistent theme across all the groups was that local resolution was the ideal it was acknowledged that not having any complaints proceed beyond that point did not mean universal satisfaction. In pharmacy, for example, the point was made that prior to the

introduction of the Complaints procedure there had been virtually no complaints beyond the local stage and there had been a subsequent increase which could reflect 'greater awareness of the public that they can'. There was more information available about how to make a complaint and health councils had provided support to some, as required.

One weakness of an accessible system for local resolution was felt to be that it encouraged more complaints. As one participant explained: 'if the complaint is justified then I have no problem with taking it through that procedure, but we are getting niggly little complaints…..' 'it is a misunderstanding between the doctor and the patient or other staff and the practice and the patient, but it can be dealt with very quickly and then you are kind of getting yourself stuck into this rigmarole'. A more challenging perspective was that of the practitioner who felt that 'genuine' complainants would not want to go to the complaints procedure, preferring instead to have the problem resolved on the spot. The complaints procedure was said to give those with a grievance 'a big stick and a megaphone'.

Information for Patients

There were examples where a lack of information could lead to a complaint. In the dental world, for example, there were queries which might go on to be complaints for money and it was felt that it 'would be in everybody's interest if we could encourage the practitioners or the practices to spend a little bit more time explaining to patients why something costs what it does.' That doesn't happen and you can argue the practice is too busy and doesn't take the time, while the patient is standing in the waiting room and is a bit embarrassed by querying, but anyway they come away and reflect upon it and very often ring the Health Authority/Board or whatever.

It was also clear that there were complaints that arose because of misunderstandings about service provision. Home visits and referrals to specialists were cited as areas where patients' perceptions were at odds with what the service was delivering. One solution was to provide this information. One participant felt that: 'perhaps if some effort were made to enlightening (sic) the population of patients as to what their impediment (doctors' constraint) actually is or the contract that has been made…….some sort of understanding of the actual basis for the service provision, maybe we should be providing that'.

Some examples of useful written information were cited: 'One of the ones that has been particularly helpful is an advice sheet for when people have had a dental extraction, because it dramatically cuts the problems post-operatively, first of all it helps the practice, because you are not having to fit people in who are in trouble, and also from your practice point of view people aren't getting pain post-operatively which again is good for everyone'.

In pharmacy the issue was that people were not aware that the prescription charge was a tax, rather than something that could be recouped from the pharmacy. Similarly many would be unaware of the independent contractor status of GPs. They were sometimes said to 'assume that because you are in the health service that you are working for somebody'.

Action as a Result of Complaints

A few participants felt that: 'lessons are learnt, we would discuss complaints at a practice meeting so everyone is aware. I think we learn from it.' There was no evidence of feedback to patients about action taken as a result of their complaint. A practice manger would 'explain to the patient that I value them bringing this to our notice, because obviously if something happened to them has happened to other patients and they have brought that to our

attention I would thank them for doing that. Apart from that we wouldn't go back to them after we had discussed it'.

An important distinction was raised by the manager who reflected that: 'I think we are more inclined to learn from admin. mistakes than general practice. How somebody has been treated by a particular practitioner, depends on the practitioner, some are more receptive…….. It was felt to be difficult in that while it was easy to tell GPs what was said 'It very much depends on their character whether they would take it'. It was clear that: 'It's very difficult to change attitudes and to expect somebody who is employed by the practitioner to somehow change the practitioner's attitude. That's a very tall order'. Complaints were seen as an issue for the complained about to deal with as an isolated act. There were few references to the potential of complaints in providing information for service development and improvement. There was little discussion of how the complaints procedure was part of a system of delivery. In many situations there was not a critical mass of complaints so that reflection on them could become a regular feature. In relation to dentists one participant noted that:' the volume there isn't enough that this has any noticeable effect. I'm not advocating that we should have a lot more complaints, but the theory of every practice getting half a dozen complaints a year, you will soon learn from the experience, that doesn't happen.'

Dealing with a complaint with an explanation could obscure any feedback on performance. As an example, it was noted that a receptionist could apologise to people who wait a long time for their consultation. However, there may be merit in seeing this as an opportunity to reconsider the appointment system. Another perspective on what could be gained from complaints was: 'I think the process becomes a bit pointless unless you can believe that redemption is possible if you see what I mean – if you think that the practitioner can change then it is worthwhile going through the process and I think that is true at all levels, whether it is a very major thing about deaths or whether it is the colour of the walls'.

There were some instances where lessons have been learnt and policies have been changed in relation to the doctors on call service. The complex situation complaints may be in was illustrated by the explanation that: following and Independent Review (IR) 'the doctors had already begun to change their practice as a result of the complaint, it was to do with the administration and the recording of calls in for assistance at weekends and stuff, which they hadn't got properly sorted out. They were changing all that, before the IR began, now I feel pretty contented with that, the lady wasn't because her husband had died, but he didn't die because of that particular arrangement at the doctors…….what complainants want most of all is that something has altered……and that somebody else isn't going to go through that particular difficulty again.'

Issues for Complainants

There was some heated debate about how to decide what comments from patients should be pursued. One participant noted that: 'you have got to, no matter how hard it is – look at every complaint and deal with it as though it is a serious complaint – a complaint, no matter how silly it might seem to anybody else – there are issues that need to be resolved'. A practitioner responded that the priority was to treat patient, not to deal with unreasonable complaints, given that some 'patients complain that they don't like the colour of the wallpaper'.

There was some discussion about complainants' expectations that Health Authorities/Boards should be able to become involved when an issue arises, rather than having to wait until the first, practice-based, stage has been worked through. A representative from a Health

Authority/Board explained that: 'Some people find it hard to accept that the local resolution procedure is practice-based and feel that the Health Authority/Board should be able to jump in there and to actually do an investigation……..I think probably some people may be put off by the fact that the procedure is practice-based……we tend to get those comments coming to the Health Authority/Board.'

The role for the Health Authority/Board was said to be frustrating at times. As one participant from one of these organisations explained: 'my personal experience is that by the time a complaint gets to a request for independent review usually attitudes are very entrenched at that stage and it is very hard to satisfy people………Once it goes beyond local resolution it is difficult to satisfy anybody.' Linking this to the previous situation it was explained that: 'It is probably better than the previous system, the previous system was very fragmented and for different types of complaints you had different types of review. I think it is probably, people if they want a review probably have a better chance of getting a panel, but I still don't know whether that necessarily satisfies people'.

Those taking part were aware of a small number of people who have been removed from GPs lists. They might come to the complaints procedure presenting this removal, but it was felt that the events leading up to the removal were the real issues. It was clear that there were some very difficult situations. As one participant recalled, probably four or fives times a year: 'we get these horrified people who come in. "I've been struck off because I made a complaint. Does that mean I'll not get a response to my complaint?"……….It's a difficult situation to be in. You think there is obviously more to this than meets the eye'.

There were challenges for both 'sides'. Staff could be frustrated with: 'the people who are never satisfied and seem to know all about procedure and so on (who complain) and in a sense you feel will not please those people with an apology or even an investigation. 'Similarly, the patient was felt to be in a difficult situation. They are 'nervous, their minds aren't working totally clear, things are happening they don't quite understand and whether a practice could ever have them relaxed enough that they would get all their queries, ask all the queries, get all resolved, we never get that'.

The view was expressed that when a case was 'resolved' i.e. ended after independent review that did not mean that it was a satisfactory outcome for all participants, notably the complainants. Acting as a family member when there had been a bereavement linked to the complaint was particularly difficult.

One participant expressed concern about people not being able to pursue their complaint effectively. They explained that: we (Health Authority/Board) 'go through the letters that people receive back from the practice and it is that terrible feeling that people often get that the practitioner has been so clever in their answer that they feel "well there is no point in continuing" and I think that is one of the things that we really have to work on is how to provide an answer that allows people to be empowered to the complaints process – so you want a more mature relationship, so that both parties feel that they have got some value out of that complaint'.

There was some discussion of the need to simplify the situation for complainants. An example would be where an optometrist issues a prescription for spectacles, but they are made up by an optician. It is not clear who to take any problems up with. The person who gave the prescription can respond with: 'Well, who is going to pay me for starting all over again?' An optometrist explained that the profession's view was that their colleague had a duty to deal with the problem. The Optical Consumer Complaints Society was established to

deal with complaints that could not be resolved in-house. This is an independent organisation that receives only a very small number of cases to consider.

As far as dentists were concerned, again local resolution was the ideal and was estimated to be possible in 'about eight out of ten' cases. It was with the two that were more difficult that the system did not work as well.
Independence

It was seen as crucial for any complaints to be dealt with by someone independent of the issue under discussion. A practice manager responded to a query about her independence with the assertion that: 'I don't find it difficult at all. I place myself in the same position as the person that complained and (how) I would want to be dealt with and it's not a problem. There was some discussion about whether such objectivity was realistic.

The 'honest broker' role of the Health Authority/Board was valued. It may have meant reassuring a complainant that it was acceptable to approach a single-handed practitioner with their concern. For pharmacy it could be 'that they are not going to get them (pharmacists) into trouble and if they can sort things out between them that's fine. It was seen as 'fair' fro them to support the complainant: 'That sort of levels the playing field otherwise perhaps the complainant would be a citizen who is very unsure and a practitioner would be getting quite helpful advice from the Protection Society'.

It was explained that there were constraints on independent reviews for complaints concerning dentists. There was some dispute in the groups about whether it was preferable to have a second opinion in the early stages or at independent review. What was agreed by all was that it was extremely difficult and expensive to access an independent examiner. Complainants were said to approach the case from the perspective of 'look I don't think this is right and he's saying this is right. Can I have an independent person looking at it?' This was acknowledged to be a reasonable stance, but one that was difficult to satisfy. The examiner's role was seen as 'passing judgement' on colleagues which was a 'tricky role' to be avoided. A representative from a Health Authority/Board described the situation as 'a nightmare'.

Implications for Development

- The production of more detailed written information about, for example, costs in dentistry and out-of-hours service delivery in general practice could serve to avoid queries turning into complaints. There is scope for a more creative approach to dealing with common requests and misunderstandings involving patients.

- There were calls for a system for recording different types of comments, suggestions and complaints from service users that incorporates a range of options for dealing with the latter. If data on complaints are to be utilised it is important that systems are in place to encourage the production of more accurate and meaningful records.

- A balance needs to be struck between a bureaucratic system that generates unproductive pressures and the need to monitor and learn from issues as they arise. There is likely to be some resistance to attempts to formalise what may be viewed as an effective informal approach to dealing with complaints.

- While there need to be time scales for dealing with complaints some flexibility has to be built into the system. It is important that the necessary administration is promptly executed, but there needs to be an acknowledgement that receiving responses from a

number of sources will be a lengthy process. Building in to the time scales a commitment to providing regular updates to complainants and staff may be beneficial.

- It is important that there are safeguards and checks built into any system for recording complaints as well as a mechanism for learning from them.

- There are, clearly, implications for training staff at all levels about the most effective way to deal with service users. Focused sessions, perhaps using role plays, would be welcomed.

- Effective communication that does not escalate the situation was recommended. Hasty or ill-judged responses need to be avoided and staff need to be clear about strategies for contact with complainants or potential complainants. On a related point, having a system that encouraged full record-keeping was important.

- Accurate recording of complaints requires a system of thresholds e.g. if an event is not written down by either side it would not rank as a complaint. There needs to be a systematic approach to logging information and a clearly understood mechanism for collating it centrally.

- A local forum for key stakeholders would provide opportunities to discuss how complaints are handled and how lessons can be learnt. Focused meetings of this kind could generate a collective response to some of the difficulties and misunderstandings raised in the focus groups.

APPENDIX C

Regional Complaints Leads

This section summarises interviews with regional complaints leads in England.

Working on Complaints

Those with responsibility for overseeing complaints in their Region undertake a number of key tasks. These include recruiting, training and supporting lay chairs and panel members, accessing the national database for clinical assessors and collating complaints activity figures on a quarterly basis. They also assist convenors in identifying chairs and assessors and provide advice to any of those involved on request. There are also elements of performance management in the leads' role e.g. in relation to how lay chairs operate and the action organisations take as a result of complaints. They may, for example, visit a Trust or Health Authority to discuss a specific problem that has arisen. Leads sometimes get involved in working through some of the more complex dilemmas raised by the complaints procedure. The aim then is to find a solution that is, as one lead suggested, within 'the rules and fair from a complainant's perspective'.

The more subtle aspects of the leads' activities were summed up in the statement that: 'It is part of the role of the Regional Office to ensure that there is sharing of good practice, so that people constantly question'. Similarly, a lead recounted that the parts of the job that were most satisfying were where 'I hear them talking together, be it convenors, be it complaints mangers, be it lay chairs.' The leads' aim was not to be directive, but to support learning from experience. One described their influence as 'starting from something small, rather than being prescriptive about "This is how you will handle complaints". We have a national procedure. I think what we can do is add the good practice. I don't want to set up some new hoops for people to jump through'.

There was some variation in the seniority of post held by those with lead responsibility for complaints and differing levels of administrative support were available to them. All had responsibilities for other activities as well as complaints. The highest proportion of time spent on complaints work by a lead was eighty per cent, with about one-third of a post providing secretarial support. In another Region, a personal assistant worked part-time to manage a database of lay chairs and allocate them to cases as appropriate. Here, it was possible to build up a knowledge of lay chairs' 'personal profiles and whims'. This would include whether, for example, they 'are prepared to be doing two panels at a time'. In a third, where the lead estimated that complaints work took about half their time and an administrator spent about three-fifths of their week on related activities, there was no additional secretarial or clerical support. The team on this site felt that they would need the equivalent of one-and-a-half full time posts to complete the work to the required standard. Here, unusually, the lead telephones potential chairs to ask if they are available to take on a case. The expectation is that a chair will be allocated within 48 hours. This contrasts with another area where this process was expected to take two or three weeks.

Given the resources available there were inevitable backlogs. One lead spoke of coming into post and finding a file of lay chair applications: 'that had not been handled at all, some of them going back two years, people had said "We would be interested in doing this" and nobody had ever written to them. So I felt rather bad about that, so I interviewed all of those and out of them I think I got about five or six, that was probably out of about thirty applicants'.

It was acknowledged that there was constant pressure to maintain an efficient throughput of allocations and staff were frustrated at not being able to respond as quickly as they would

like to requests. At worst there were offices that were 'weeks behind' in terms of coping with demand. Without administrative support there were a number of core activities that could not be undertaken. One lead, for example, does not read the reports from IRPs, does not meet with chairs and is only able to offer one day of training to them. There are problems recruiting chairs in this area and, consequently, there is little scope for acting on any of the feedback on their performance received from convenors. The limited contact with chairs available here contrasts with the six meetings a year another lead is able to offer.

Monitoring Performance

Influencing the performance of those engaged on a voluntary basis was identified as a problem. While many lay chairs were making an excellent contribution some, inevitably, were not and there was little evidence of systematic feedback and review. A lead spoke of one chair who had not had their contract renewed and this had been the 'easy option', because they had not *wanted* to continue. This was someone whom there had been 'so many complaints about'. There were some references to providing feedback to a few lay chairs about the style and content of IRP reports they had produced. These individuals were invited to the Regional Office to discuss any such concerns.

There were pockets of resistance to the notion of such monitoring, given their voluntary status, although, as one lead stated: 'The public deserves a good service. It has to be monitored'. There were, of course, lay chairs who were claiming the 'loss of earnings' payment, with 'one or two' of them asking for the annual limit of £5,000. There was no easy solution. One lead queried: 'What makes a good lay chair and how do you know when there is a good one and when there isn't?'

One lead, expressing concern about the lack of systematic feedback, would value national guidelines and expectations. This was because if it 'came out as a national way of working then I wouldn't have to fight it I would just say "here we go". It was important, however, to be realistic about the level of contribution that could be expected. One lead described feeling 'defensive' on behalf of lay chairs if they were criticised, to take a recent example, for not linking their recommendations sufficiently well back to the evidence'. It was unfair to submit their work to that level of professional scrutiny.

One lead described a feedback procedure in their area. It was important not to rely on informal comments from convenors, so they were given a battery of questions about the chairs' skills, the appropriateness of their advice and the extent to which they met the deadlines. Lay chairs receive an annual report, drawing on these, with a rating for key aspects of their work, averaged out across the year. This means that the convenors remain anonymous i.e. comments can not be linked to individuals. If any serious difficulties are reported the lay chair will be contacted immediately, rather than waiting for the annual report to arrive.

The need for a more systematic mechanism was clear from the comment that: 'It is a *National* Health Service and it is a *national* complaints procedure and I personally think we should be doing feedback. It doesn't have to be us. It can come from the Health Authority or the Trust. I (also) think the Health Authority and Trust should be getting feedback from the lay chairs as to what it is like from their perspective. I feel slightly uncomfortable that I should put my volunteer lay chairs through something that others don't.'

It was acknowledged, in areas where there was a potential surplus of lay chairs, that there was an optimum list size. The aim was to provide continuing training, to ensure that the chairs had sufficient cases to work on and to 'keep an eye on the standard'. Leads were also

keen to provide opportunities for informal networking and support, although there were resource implications. Leads only had limited time themselves to engage with such groups and some were unsure how much they could support networks by providing travel costs and subsistence.

The Lay Chair Role

In some areas lay chairs were recruited from advertisements. In others they were identified from the database of those who had applied for a position as a non-executive director. There was variation in how successful the former was. There were some reports of very limited responses, whereas in one Region an advertisement had produced 300 applications. Generally, the aim was to have people who were unfamiliar with the NHS. One lead wanted: 'somebody who had no contact with the health service, so we rejected quite a lot of people who had sort of either come up through the professions'. The goal was to have someone with 'an open mind, fresh ideas'. It was important to have people with 'some sort of measure of judgement'. Again, the voluntary nature of the work posed a dilemma. One lead asked how much it was reasonable to question people at interview, given that they were prepared to take on this potentially very demanding role.

While there were differences in how much work lay chairs wanted to undertake – 'there are a hard core who will 'phone us all the time, there are others who don't seem to, well they certainly don't contact us' – it was important to have a rigorous allocation process. Different mechanisms were employed for this, depending to some extent on the size and geography of the area. In one, for example, it was possible to avoid lay chairs working in the county they live in or in those that are geographically very close. As part of the working relationship with lay chairs it was clear that: 'the majority of them don't mind (travelling), but we know the ones that don't like to travel huge distances'. Another expectation was that lay chairs were not allocated to the same Trust or Health Authority within a minimum of a six-month period in one Region and two years in another.

Expecting people to travel long distances, in an attempt to maintain independence, meant that there was sometimes 'a bit of flack' from within Regional Offices about the costs of travel. The additional expenditure was, however, defended on the grounds that independence was more important. Similarly, it was said that a reasonably steady turnover of lay chairs was important. As one lead noted: 'It does the health service some good to have some new faces, so I don't want to keep necessarily the same batch forever, because I don't think they keep independent'. There were some patterns of working that leads had had to challenge. One noted a situation where: 'The Trust or a Health Authority 'phones up and says "Please could I have the same lay chair?" and that was happening in one part of the region when I came into post. That was the standard way of working, which I think is outrageous, but there you go, that is what had happened'.

Clinical Assessors

As with lay chairs it was noted that there was no system for collecting feedback on the performance of clinical assessors. While these were not voluntary positions, no systems had been set up to monitor how they were working. There were limited references to feedback being provided for individuals. There were several comments about the length of time some clinical assessors took to complete their reports after panels. The assessor role was, it was noted, in addition to their usual workload.

Another issue raised was that the database for clinical assessors in secondary care in England was problematic. This is information that all Regional Offices and the Ombudsman's office

can access. There were concerns that some of those on it were not informed of the expectations and time commitments of the role. The current list was ‘not managed. It is just a database of names and people just pluck names off’.

On a slightly different point one lead noted that: ‘I am absolutely clear that as far as the clinical assessors, it helps to have some clinical knowledge in allocating those clinical assessors. You understand, you can get into the conversation about what specialty it is, exactly what sub-specialty it is, the nuances of what might be on the database and what might not be’. Independence was an issue for hospital doctors, given that their rotational training meant that those on some specialties e.g. oncology were likely to have trained or worked together. One lead described this as very difficult for families to accept.

All Regional Offices maintain their own lists of primary care practitioners. There was some concern about the unavailability of dental assessors. One lead reported that dental panels have been inactive for over 12 months because they no dental assessors have been available

Training and Networks

Training for lay chairs would typically comprise a day of work on the complaints procedure, possibly with a further half day on report writing. External trainers were used in some areas. Some concerns were raised about the scale and content of the reports lay chairs produce. It was felt that: ‘some of these lay chairs write five sides of A4, others write a thesis. One lead felt it would be productive to explore which reports were most constructively received, for example, ‘Is it a turn-off if you get a doorstep of paper?’ In general the call was for reports that were succinct and analytical.

One lead noted how the induction programme took some time, given that those selected attended training and entered a ‘buddy’ system, observing a panel before taking responsibility for one themselves. This sometimes caused delays, given that all involved in the observed panels had to consent, but was felt to be ‘a good principle to hang on to’. While the buddy system was not standard, it was commonly expected that lay chairs would serve as a third panel member before taking on responsibility for chairing.

Convenors, of course, came under the brief of leads with responsibilities for non-executive directors. They were described as ’a key part of the process, convenors can make or break it, I think’. Training for them was said to reap great rewards.

The merit of networks for key players was raised. There were some excellent, regular meetings, providing opportunities to pool experiences and have a contribution from a relevant speaker. Some networks were less well developed e.g. where Trusts and Health Authorities complaints managers only met in two distinct groups. Leads were able to attend some of these meetings, although this was, of course, easier when the different groups met collectively.

Action as a Result of Complaints

It was noted that a minimum requirement if there was to be effective action on complaints was for organisations to pass on information about the complaints they receive. One lead noted some difficulties with this for GP practices and observed that as there was ‘no leverage’ that could be applied to them it would be beneficial to have a statutory obligation to provide a return on the number of complaints received.

There were also concerns about the Regional Offices' capacity for collating and responding to issues raised in reports from panels. One lead noted that: 'The oversight arrangements are necessarily too remote' making it impossible to 'monitor the quality'. However, another spoke of the Regional Office monitoring group that reviewed all IRP reports. Quarterly meetings of this group were used to allocate responsibilities. Clinical issues would be directed to the appropriate senior manager and anything about the report or the lay chair would go to the lead for action. Some Trusts may be written to, following one of these meetings, to request a copy of the response to the recommendations.

The reports belong to the Health Authority or Trust and the role of Region is to act as 'the belt and braces and the check behind'. In another Region the lead does not receive a copy of the reports from IRPs and responsibility for acting on them rests with two senior colleagues. These colleagues' role in monitoring was described as 'passive'. In one Region it was noted that Health Authorities had not been copying reports from IRPs to the lead because they were not required by regulations to do this.

One lead now received a copy of each IRP report, noting that previously a copy had gone to two senior post holders, but 'I won't say they weren't doing anything with it, they were perhaps glancing at it, but I wasn't sure what else was happening'. There was now a system for concerns to be raised with colleagues with responsibilities in the appropriate geographical area. These provided 'a bit of another piece of the jigsaw for their performance management' and added to the picture of the local health economy.

Follow up after the distribution of IRP reports to local areas had been tightened-up in one Region. The lead used to contact Trusts and Health Authorities on an occasional basis, but now do so for all. There were differing views on how effectively the system for recording action taken as a result of complaints was working. One lead, for example, reported that Trusts were required to produce an Action plan that they had a copy of. If a Trust refused to act on any of the recommendations this would be brought to their attention. In another area it was acknowledged that the extent to which any one Action Plan is actively monitored depends on the involvement of senior Regional staff.

There was less certainty for the lead who raised concerns about what information was presented to Trust Boards. There had been a situation where it was acknowledged that Board members were unaware that patients were dying in very unusual circumstances. The expectation in that area now is for annual reports of what has gone to the Board, to confirm that there has been some formal review of complaints at that level. The key point was that while there were systems in place, leads were still uneasy about the lines of accountability in practice. As one explained: 'There is an awful lot, unless I have completely misread the procedure, there is an awful lot of just expecting it to go to the Board and something to happen. And I think it would benefit the complainant. I think it would benefit the complained against as well to be honest if there was something a bit more robust to ensure that something had to be done about it'.

There were a few examples of issues that needed a concerted response (including from the Regional Office), but most were appropriately dealt with locally, given the recurring emphasis in the complaints on 'communication, (not) treating people like equals, poor processes'. This level of change meant 'looking at the health service from the users' perspective'. The Regional Office has a filtering role to ensure referral of a case where there are concerns about serious clinical issues.

One lead spoke of a need to be clear about how complaints can impact on the development of organisations. If there were, for example, a number of complaints about an Accident and

Emergency department it would be legitimate to target resources there to ease some of the difficulties. It was important for all those involved in the process to be informed of any outcomes and of any changed that had been introduced.

In one Region where there was already a system for monitoring trends over time a cautionary note was sounded. This layer of review was valuable, but it did not produce information on trends that could be acted upon, given the small numbers involved. There were some useful overviews: a doctor, for example, had raised an issue about the poor nurse staffing levels having resulted in a complaint and that had been fed to the performance management directorate. There was, however, unlikely to be a 'run of all the same thing s which related to the same doctor' because 'life isn't like that'. The lead noted that: 'I don't think we've identified trends in that respect, which is what we thought we might do at the beginning'.

There were issues about feedback on action in a wide range of circumstances. One example was where a parent had, perfectly reasonably, asked for information on what changes had been made as a result of a tragic situation where his daughter had died. As the lead noted: 'How do we know that anything has happened? You know the Health Authority has received the report and have noted the recommendations. I don't know. I wasn't at the Board meeting. I don't know what was discussed. How do I measure?' On a different scale there were recommendations for small changes that could, theoretically, be fed into day-to-day management, but that tended to resurface e.g. the timing of communication between primary and secondary care.

Complaints were not viewed in isolation, but rather as part of clinical governance and general management. They were part of the way in which the organisations operated. One manifestation was the written communication around complaints. One lead recalled conversations with complaints mangers about some unhelpful correspondence. The point to be made was that: 'If the rest of your letters look like this one then I am not surprised that you are having those problems.' It was important to remind staff that much escalation could be avoided by a letter ending: 'I do hope that I have answered all concerns you have raised, if you have any further please do not hesitate to get back to me'.

The theme of seeking the complainants' perspective was illustrated sharply by responses to one particular letter. A minister asked one of the leads to congratulate a chief executive on a letter, as it was the best example they had come across. It accepted that the organisation had been at fault, that the wait incurred was unacceptable, that there were no excuses and that the process had been changed. It was also acknowledged that these changes did not detract from the experience the complainant had had. It is noteworthy that the complainant had not been happy with the letter and was pursuing their case. The lead involved noted that there was little point in the professionals involved talking 'piously' about the content of letters, unless they were aware of the expectations and needs of complainants. The challenges are considerable. The complainant may be concerned about a 'lack of care and attention', a subjective perception that it is extremely difficult to make a judgement on.

Making it Work

Overall, the leads felt that the complaints procedure had much to commend it. It was operationalising it in the most effective way that was important. As one lead explained: 'I think the bits people are not as good at are local resolution. It feels that quite a lot gets escalated up. My utopia is that my lay chairs would never be used at all. Some of them would get very upset when I say that.' One useful strategy was said to be to have complaints managers routinely speaking about the procedures at induction sessions, making clear the organisation's approach to dealing with complaints.

The key concern was how the existing system was handled. The aim, one lead identified, was: ‘that every interaction with a patient, whatever it is, whether it is a letter, whether it is an appointment letter, whether it is an outpatient appointment, whatever it is, you deal with it as you would wish to be dealt with yourself. The same as when somebody complains, if this was me complaining how would I want to be dealt with? I would want to be dealt with in a timely and fair fashion’.

The consistent message from the leads was that the deadlines for responding to complaints were unrealistic, especially for those involving primary care. As one lead stated: ‘I haven’t got the time to be chasing numbers about whether people are within their time frames or not. I would rather the complaint was well handled and it took twenty three days than it took twenty days’. It was acknowledged that there were some extremely complex cases and just ‘jumping through the hoop’ of deadlines was not helpful to any party.

Handling complaints well was acknowledged to be extremely difficult, given the competing demands placed on clinicians and managers. There was considerable pressure, for example, to clear waiting lists. Acting as a clinical assessor was, similarly, an ‘extra’ responsibility. One way of encouraging an effective response was to have, as one lead suggested: ‘the complaints handling close to the chief executive. The places where it doesn’t seem to work well are where it is stuck out in quality or something, three levels down in the organisation and there isn’t a good mechanism for getting the message through.’ There was a role here for Regional Offices in encouraging chief executives to treat complaints with due importance. One lead was keen to work with complaints managers, not simply to ask for more resources, but to review where the complaints work was located in the organisation and what the channels of communication were.

It was clear that otherwise excellent clinicians may not see the importance of, or be skilled in producing, appropriate oral and written responses to complaints. While there were no excuses for staff who were’ arrogant, patronising, talking gobbledy-gook’ there were some suggestions that it was unreasonable to expect them to write the type of letters that were required, or to automatically see such a response as part of their work. There was a danger in having a separate complaints stream in organisations. While complaints managers needed to be able to ‘stand back’ and to have specific skills in relating to members of the public, it was important that they were not marginalised, so that complaints were seen by clinicians as someone else’s business.

Some issues were particularly complex in the primary arena. One lead felt that getting an effective system to include GPs was’ almost impossible’, given that ‘we are depending almost entirely on their goodwill to participate, to reflect, to take on clinical governance’.

Implications

The resources available in regional offices

There is variation in the amount of human resource allocated to the complaints work. It would be useful to review what allocation is required to sustain the demands of the work and to undertake some of the tasks that those interviewed are currently unable to do. Some leads are frustrated by not being able to provide more training and networking opportunities or to produce reports and overviews that can be used to learn the lessons from the complaints procedure. The appropriate mix of senior and junior staff and clerical support might usefully be considered in some settings.

Supporting the lay chair role

The development and management of the lay chair role is constrained by concerns about what is reasonable when a *voluntary* role in under discussion. There would be merit in reviewing what system could be put in place across the UK to review how they are operating and to provide support where necessary. Linked to this could be a constructive discussion of what financial allowances should be available to lay chairs and of the extent to which expenses could be paid to support their networking activities.

Learning from IRP reports

There was some variation in whether reports from IRPs were routinely sent to the leads. It was sometimes left to individuals to ensure that they received the necessary documents. This may be a particular issue in relation to the primary care arena. A more systematic approach would support their aim of seeking to influence action taken as a result of the reports. There were varying degrees of concern about how leads were kept informed about actions taken, or not taken, as a response to reports. Having the resources to produce annual reports highlighting clinical issues may be one way of drawing out the lessons that can be learnt from complaints.

Having an overview of complaints

Leads were aware that more could be done with the information they collate on complaints. It was clear that accurate records and returns from as many organisations as possible were essential. The current arrangements make any monitoring by the Regional Offices very remote. Another tier of resourcing, potentially a separate body with an auditing function, would be necessary to cover some of the supervisory functions they could undertake.

The workload

It was consistently stated that the time scales for dealing with complaints were unrealistic and that the emphasis needed to be on an effective response, rather than an overly quick one. However, calls to lengthen the time scales need to be considered in relation to the staffing levels. Additional resourcing could make the time scales more feasible, to the advantage of all involved. There may be scope in extending a levy on Health Authorities to resource this staffing, given the benefits for them in having a well-run system.

It may be more realistic to be clearer about what the time scale covers e.g. whether the ‘clock stops’ where letters for clarification are being sent to the different parties. It was important for those producing reports e.g. clinical assessors to be clear what the time scales were and the consequences of any delays. Concerns about time scales may be eased by regularly informing those involved of what the delay is, which part of the system is ‘causing’ it and why it is occurring.

Training

It was clear that training for convenors, lay chairs and complaints managers was crucially important. They were expected to do difficult tasks, sometimes in isolation. While the training of convenors and complaints managers is the responsibility of each Trust and Health Authority, involving the Regional Office in this would provide a more cohesive approach and encourage the sharing of good practice that they were seeking.