healthwatch

Improving the health and social care complaints systems

Background and position briefing

November 2013

1. The complaints system in health and social care

For decades, people have struggled to raise a concern or make a complaint about their health or social care service. Those who have raised a concern frequently find that it is not taken seriously and nothing happens to improve the service they receive.

When concerns are ignored, isolated incidents soon escalate into the shocking events that occurred under Mid Staffordshire and Morecambe Bay Trusts and at Winterbourne View Hospital. Despite this, making a complaint about health or social care remains a confusing and intimidating experience.

Complaints are handled both local and national levels, and can involve a host of different regulators, ombudsmen and authorities. There are so many different organisations involved in handling complaints that the process can be nearly impossible to navigate unassisted and many people concerns are lost in system. In many cases you have to exhaust a local resolution before you can take your complaint to a national body.

For example, if you are upset because you believe your GP has prescribed a drug in a dangerous manner, you might potentially file a complaint with the doctor, the doctor's complaints manager, NHS England (as the organisation which commissioned the GP's services), the Medicines & Healthcare Regulatory Agency (to raise concerns about the drug), the Parliamentary Health Ombudsman (if you are not happy with the local procedure), General Medical Council (as the licensing authority for doctor), and several other organisations based on how your complaint was handled. If you have had such poor treatment that need to seek financial compensation, you may also need to bring a legal case on top of the other complaints procedures you are engaged in.

As the consumer champion for health and social care, Healthwatch England has explored the public's experience of the health and social care complaints systems.[1]

We found that consumers faced significant challenges using the system:

- Many people do not know where to turn when they have a concern or complaint about a health or social care service. There are multiple local and national complaints system, regulators and contact points, meaning the system is hard to navigate and few people are able to find a timely resolution for their complaint.

- 3 in 5 of the public do not feel they have a clear way of providing feedback, and half have no trust in the system.

- Over half of the public never report their problems with health and social care, primarily because they did not have any confidence that their complaints would actually be dealt with.

[1] Healthwatch England annual report; YouGov complaints survey.

Independent reports on patient complaints in hospitals[2] and patient safety and the quality of care in the NHS[3] investigated problems with the current procedures relating to filing complaints. The reviews paint a troubling picture of a complaints handling which is overly antagonistic, pushes people away, and delivers deeply unsatisfactory resolutions.

These review found:

a. Barriers to people being able to raise a concern or make a complaint:

People do not know where to go to make a complaint, lacking basic information to guide them through the process.[4] Most people report that they do not want to complain, and the process is very challenging for them.[5]

Many people are scared to file a complaint, worrying that staff will retaliate against them.[6] For people dealing with serious health issues or who have been bereaved, the challenges of finding out how to complain can be so great that they give up. Particularly for those with chronic medical issues or facing long treatment pathways, this concern can be a powerful force in silencing people even in serious cases.

b. An overly complex complaints systems:

Even those who do manage to file complaints find the process overly complicated and difficult to understand.[7] People often lodge a complaint with one organization, only to be told that they need to go elsewhere to air their concern. Being sent from one agency to another, and having to learn each subsequent step of the process can be stressful and causes many people to feel frustrated.

Many people find that their complaints are ignored or misunderstood, both by front-line staff and complaints managers,[8] and that staff handling complaints can be insensitive towards people and their families.[9] Consumers and families should have the opportunity to communicate their concerns to those providing care, but they instead often find a lack of interest in their problems, dismissive treatment and no help in learning about the complaints process.

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[2] Department of Health. (October 2013). Report of handling of complaints by NHS hospitals in England by Ann Clwyd MP and Professor Tricia Hart, *A review of the NHS hospitals complaints system: putting patients back in the picture* (hereafter, "Clwyd-Hart review") Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

[3] The Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013) (hereafter, "Francis report"). Available at: http://www.midstaffspublicinquiry.com/report ; Department of Health. (August 2013). Berwick review into patient safety. *A promise to learn - a commitment to act: improving the safety of patients in England*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf ; NHS. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. *Keogh report* Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

[4] Clwyd-Hart review at 19-20, 28, 30.

[5] Francis report at 3.125, 3.127.

[6] Clwyd-Hart review at 20-21, 28; Francis report at 3.124.

[7] Clwyd-Hart review at 22, 26.

[8] Berwick review at 8; Clwyd-Hart review at 21, 28; Francis report at 3.26 (extending to the Board level), 3.113.

[9] Keogh report at 41; Clwyd-Hart review at 21, 28.

c. A lack of adequate support to make a complaint:

Support for making a complaint is insufficient and hard to locate.[10] Reports have found substantial variation in services meant to support people in different organisations, with many feeling that support is absent. Even where support exists, it is not necessarily independent: in some hospitals, there is no separation between advocacy and complaints management services. Worried bystanders are also prevent from making complaints by current rules, so outside voices which might work to protect people are never heard.

d. A lack of independence and accountability in complaints investigation and resolution:

Currently, the NHS received over 162,000 written complaints last year, or more than 3,000 complaints per week.[11] 45% of these complaints were upheld in 2012/13,[12] and the Parliamentary and Health Service Ombudsman dealt with around individual 16,000 complaints.[13] In contrast, the Local Government Ombudsman dealt with just over 1,000 complaints from the public about adult social care in 2012/13, which represents just 12% of their case load.[14]

People believe the complaints system is not independent, with organisations being able to "mark their own homework".[15] Investigations into complaints against practices and hospitals are usually conducted by the organisations' own staff, who are not seen as being neutral arbiters. Additionally, there is little outside scrutiny of local complaints processes by outside parties.[16] The sense that the process is biased is prevalent throughout users' accounts of the complaints system.

Complaints resolution is overly defensive, and fails to apologise to people where care has been poor.[17] Many people report they only wanted recognition that they had been treated badly and an indication that the system would work to improve service. Instead, many felt that they received only stonewalling, and their complaints failed to result in any change. People also find the length of time taken to respond upsetting and off-putting.[18]

e. People and organisations are not learning from their mistakes:

A crucial problem highlighted by all of the reports was the all-too-frequent failure to use complaints as a tool to help organisations improve.[19] Complaints are seen as something to be "managed" rather than as vital information about the

[10] Clwyd-Hart review at 22-23, 26; Francis report at 3.45-3.46.
[11] HSCIS 2012-2013 report. Available at: https://catalogue.ic.nhs.uk/publications/patient/complaints/data-writ-comp-nhs-2012-2013/data-writ-comp-nhs-2012-2013-rep.pdf
[12] HSCIS at 33. The percentage within organisations ranges widely, with individual ranges from 0-100%.
[13] PHSO, Helping more people by investigating more complaints about the NHS. The ombudsman looks more closely at approximately 4,000 cases, and took on 377 for investigation in 2012-2013.
[14] Local Government Ombudsman (2013) Annual Reports & Accounts 2012-13: http://www.lgo.org.uk/GetAsset.aspx?id=fAAxADgAMgAzAHwAfABUAHIAdQBlAHwAfAAwAHwA0
[15] Clwyd-Hart review at 24, 29; Francis report at 3.11.
[16] Francis report at 3.135.
[17] Keogh report at 19; Clwyd-Hart review at 27-28.
[18] Keogh report at 19, 46; Clwyd-Hart review at 22, 26; Francis report at 3.26.
[19] Keogh report at 40, 43; Clwyd-Hart review at 23, 27; Francis report at 3.21-3.25, 3.39, 3.121, 3.146-3.149.

performance of an organisation.[20] Without listening to people and their families and learning from what they have to say, the NHS and social care systems will be doomed to repeat their mistakes.

2. Improving and reforming the complaints system in health and social care

People have told us in no uncertain terms that they need an effective and responsive means to complain about health and social care services. Our work with consumers and sector leaders has enabled us to identify six core principles for complaint reform.[21] People told us that they wanted a system of complaints handling and advocacy that was:

- **Independent and confidential:** a service that they could trust to look at things impartially, that raising a concern does not adversely affect their treatment or care and that respects their privacy and progresses their concern or complaint to a satisfactory resolution.
- **Responsive:** a service that listens to the needs, preferences and anxieties of the people making complaints and responds to them in a timely manner, in a way that works for them.
- **Supportive:** a service that helps and supports them to navigate through any complex or difficult stages in making a complaint.
- **Simple:** a system that is easy to understand whereby people know what their rights are and what they should expect from complaints handling and advocacy services.
- **Joined up:** a system where people only have to raise a concern or make a complaint once, where any door is the right door and any complexity of case handling (like coordinating multiple complaints to a provider, professional body and regulator) all happen behind the scenes, rather than the person having to navigate this themselves. This would be accompanied by one complaints advocacy offer so you know who is supporting you from the start to the resolution of your case.
- **Transparent:** a system that is up-front about the processes that are being used and the decisions that are being made, keeping people up to date with any changes in their case.

In order to implement these principles, we have proposed to the Government immediate action to help educate the public about their right to complain and a number of changes to laws and regulations that would improve the current system.

a. Ensuring that people's voices are heard in complaints systems

We will run a consumer-facing complaints campaign with others on how to raise a concern or complaint and the standards people should expect.

[20] Berwick review at 8, 19; Keogh report at 19.
[21] Healthwatch England (2013) *Complaints: People not process* (video reports): http://www.healthwatch.co.uk/complaints

People do not know where to go to make a complaint, lacking basic information to guide them through the process.[22] As a result, over half of the public never report their problems with health and social care, and 3 in 5 feel they lack a clear way of providing feedback.[23]

Even those who manage to lodge complaints with one organization are often told that they need to go elsewhere to air their concern. Being redirected from one agency to another, and having to learn where to proceed if the resolution has been unsuccessful, can be stressful for people and causes many people to feel frustrated and with the process.[24] People must know how and where to raise their complaints, and understand their rights as health and social care consumers.

We have proposed that regulations be changed so that 'worried bystanders' can register concerns or complaints and be directed to Local Healthwatch. Anyone who sees a problem in the system should be able to report it and be heard. Current regulations shut out the voices of relatives and others who are not officially designated as representatives.

We will champion consumer interest in Rt. Hon, Oliver Letwin MP's review of complaints in the NHS, the scoping of national complaints reform and any forthcoming plans to integrate the national health and social care complaints systems. Reforms to the complaints system must be centred on the needs of the person making the complaint, and we will do all we can to bring health and social care consumers' voices to the review process.

We also believe that there needs to be a more independent account to Parliament on the state of local complaints systems.[25]

b. Improving the quality of complaints handling

Local Healthwatch have told us that they could (and many are) provide challenge and scrutiny to assess the quality of complaints handling by local commissioners and providers.

The Francis Report recommended that Local Healthwatch be given access to detailed information on complaints (to the extent permissible by confidentiality concerns) and assist in scrutinising complaints information with the local Clinical Commissioning Group (CCG) and Care Quality Commission.[26]

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[22] Department of Health. (October 2013). Report of handling of complaints by NHS hospitals in England by Ann Clwyd MP and Professor Tricia Hart., *A review of the NHS hospitals complaints system: putting patients back in the picture*, at 19-20, 28, 30 (hereafter, "Clwyd-Hart review") Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

[23] Healthwatch England. Annual report 2012-2013 (October 2013), at 17. Available at: http://www.healthwatch.co.uk/sites/default/files/full-report-2012-13_0.pdf

[24] Clwyd-Hart review at 22, 26.

[25] The Clwyd-Hart review recommended that, where appropriate, Healthwatch England be provided with additional staff and funding to research complaints issues and assist the CQC in preparing a report on complaints by providing information on the views and experiences of patients. Clwyd-Hart review at 40- 41.

[26] The Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013) (hereafter, "Francis report"), at 3.139, 3.149, recommendation 119. Available at: http://www.midstaffspublicinquiry.com/report

Local Healthwatch could work to gather feedback on complaints in different regions. If the complaints systems are not serving consumers properly, Local Healthwatch can then use their powers to inspect and get answers to help fix the problem.

We will be supporting local Healthwatch to improve low performing complaint systems and develop good practice in specified communities. Right now, there is a lack of understanding across the system of what good practise in complaints handling means. We hope to harness the power of innovation in Local Healthwatch to see what works and what doesn't, and how to best support different communities. This will result in co-designed practical solutions to improve local complaint systems.

We have proposed that local Healthwatch should be given a seat on CCG committees. We are not convinced that current commissioning practices promote continual improvement health services, particularly in regard to complaints systems. Involving Local Healthwatch in decisions affecting care and quality at a local level gives CCG committees and Quality Surveillance Groups valuable insight about complaints and people's experiences in the system, and helps to improve care.

The Clwyd-Hart report supported this recommendation, noting the importance of involving Local Healthwatch in the development and monitoring of complaints systems in all hospitals.[27]

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[27] Clwyd-Hart review at 37.