Feeding back? Learning from complaints handling in health and social care

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL | HC 853 Session 2007-2008 | 10 October 2008

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National Audit Office

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Ordered by the
House of Commons
to be printed on 6 October 2008

LONDON: The Stationery Office
£14.35

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This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

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1 October 2008

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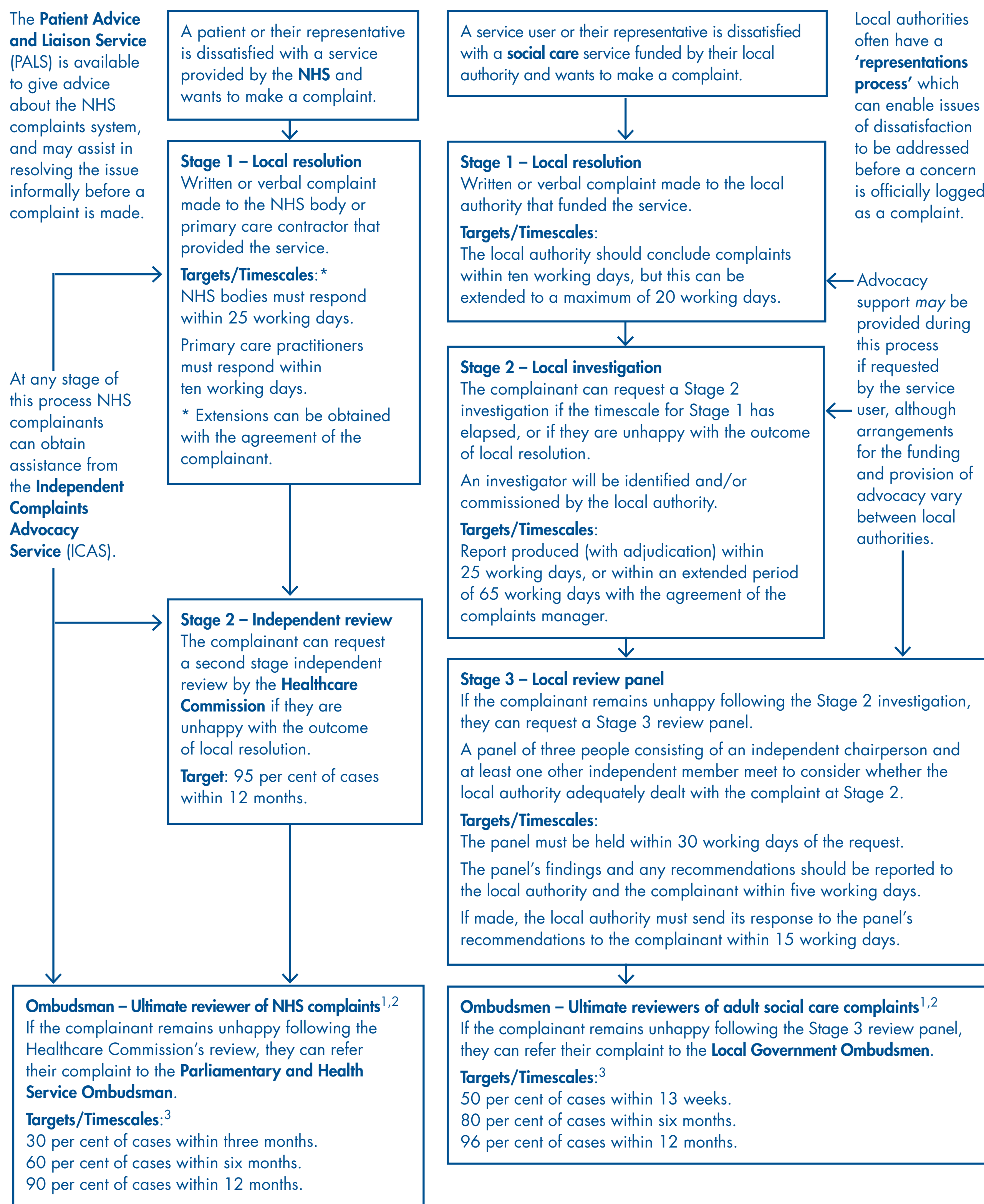
SUMMARY

1 There are currently two separate statutory processes for handling complaints about health and social care services **(Figure 1)**. The two systems have separate accountability processes, with NHS organisations accountable to the Department of Health (the Department) and social care services accountable through their local authority, to elected members. Responsibility for setting standards, priorities and policies for adult social care, however, rests with the Department. There are differences in the numbers of stages and timescales involved, and in the arrangements for advocacy support and independent investigation. The Health Service Ombudsman is responsible for the ultimate review and decision on NHS complaints and the Local Government Ombudsmen for social care complaints. There are also differences in the scale, extent and costs of complaints handling **(Figure 2 on page 6)**.

2 Following independent national reviews of NHS complaints handling in 1994 and 2001, the Department introduced changes in 1996 and 2004. The latter included the introduction of an independent review role for the Healthcare Commission (in addition to its role as the health service regulator). For social care the system has evolved incrementally, with the Department carrying out national consultations in 2000 and 2004, culminating in reform of adult social care complaints handling in 2006 but without its regulator, the Commission for Social Care Inspection, having a role in complaints handling.

1 The two separate statutory processes for handling complaints about NHS and adult social care services



NOTES

1 The Regulatory Reform Order (2007) enables the Parliamentary and Health Service Ombudsman (PHSO) and the Local Government Ombudsmen (LGO) to work jointly on cases which cross the boundaries between their respective jurisdictions and to investigate and report on complaints jointly.

2 Complaints can be fast tracked to the PHSO and the LGO in certain circumstances.

3 The different performance measures for the PHSO and LGO reflect differences in their definitions of what constitutes an 'enquiry' and an 'investigation' and the different processes involved.

2 The extent and costs of NHS and adult social care complaints handling

National Health Service

- The NHS in England provides care free at the point of delivery for 50.7 million people and over 1.5 million patients and their families are in contact with NHS services every day.
- In 2006-07, the Department spent £65.5 billion on NHS services. Care was provided by 171 acute trusts, 152 primary care trusts (PCTs), 58 mental health trusts, 12 ambulance trusts, and three care trusts. Chief executives are accountable through the Department of Health to Parliament. PCTs also commissioned services from 8,235 GP practices.
- In the last three years, 88 per cent of adults in England have had contact with the NHS. Thirteen per cent were in some way dissatisfied with their experience.

In 2006-07

- The estimated cost of handling and review of NHS complaints was £89 million (excluding the Health Service Ombudsman).

The NHS

- Received 133,400 written complaints. Of these, 32 per cent (42,600) related to primary care services.
- Employed 880 whole time equivalent staff to handle complaints (an average of two per NHS trust).
- Concluded around 94 per cent of complaints locally, taking on average 23 working days.
- Spent an estimated £68 million on local resolution at an average cost of £640 per case.

The Healthcare Commission

- Accepted 7,696 complaints for independent review.
- Received £9.8 million in funding for complaints handling and concluded 9,932 cases at an average cost of £987 per case closed, taking an average of 171 working days.

The Health Service Ombudsman

- Accepted for review 862 complaints that had not been resolved by the NHS or the Healthcare Commission.
- Reported on 1,139 cases.

Advocacy support for complainants

- The Department spent £10.7 million providing a national statutory advocacy support service for complainants.

Adult Social Care

- Following assessment of their needs, 1.75 million adults received one or more directly provided or commissioned social care services from their local authority in 2006-07.
- In 2006-07, 150 local authorities spent £15.1 billion on adult social care services. Social care services include support from social workers, personal services such as meals on wheels, and residential care. Local authorities are accountable for services to locally elected councillors.
- In the last three years, six per cent of adults in England have had contact with social care services. Fourteen per cent were in some way dissatisfied with their experience.

In 2006-07

- The estimated cost of handling and investigation of social care complaints was £13 million (excluding the Local Government Ombudsmen).

Local authorities

- Received an estimated 17,100 complaints about adult social care services.
- Employed around 290 whole time equivalent staff to handle such complaints (an average of two per local authority).
- Concluded around 95 per cent of complaints at the first local stage, taking on average 17 working days.
- Spent an estimated £9.7 million on the first local stage at an average cost of £570 per case.
- Carried out Stage 2 investigations of 900 complaints at an estimated cost of £1.4 million, taking an average of 63 working days to conclude a case. The estimated cost of a Stage 2 investigation is £1,960.
- Held 200 Stage 3 review panels at an estimated cost of £0.2 million, or £900 per complaint.

The Local Government Ombudsmen

- Received 795 complaints relating to adult social care services that had not been resolved by local authorities.

Advocacy support for complainants

- There is no statutory or national provision of advocacy, although guidance issued in 2006 does encourage local authorities to provide it on request. Local authorities spent an estimated £1.3 million on advocacy support for complainants.

Source: National Audit Office; Department of Health; Healthcare Commission; Health Service Ombudsman; Local Government Ombudsmen

3 Despite changes to the NHS complaints system, independent evaluations and inquiries such as the Health Service Ombudsman's 2005 report *Making things better?* and the Healthcare Commission's 2007 report *Spotlight on Complaints* indicated that problems remained. These included a lack of understanding about the NHS complaints process; confusion about how to complain; difficulty in navigating the complaints system; and people feeling intimidated and that their complaint would not be taken seriously.

4 The January 2006 White Paper *Our health, our care, our say* set out the Department's commitment to make it easier for people to complain about their experiences of using health and social care services, improve the quality of responses received and improve services as a result. The Department proposed a new 'comprehensive, single complaints system across health and social care by 2009' focussed on resolving complaints locally with a more personal, and comprehensive approach to handling complaints, including complaints that cover both health and social care. This proposal is an important part of the Government's intention to bring the planning and management of health and social care services more closely together.

5 The Department also confirmed its intention to merge the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission from April 2009, to form the Care Quality Commission, and later announced that this new health and social care regulator would not have a role in the review of individual complaints but would examine the standard of complaints handling and the implementation of learning from complaints. Independent review will continue to be provided by the relevant Ombudsmen.

6 The Department commissioned some small scale research in 2005 and issued a consultation document, *Making Experiences Count*, in June 2007 which recognised failings in the existing complaints systems and made proposals for how a single system might work in practice. There has, however, been no detailed evaluation of the effectiveness of the existing systems. We therefore undertook an independent evaluation of existing performance, capability, capacity and costs of complaints handling in both health and adult social care (methodology at Appendix 1). This report identifies the strengths and weaknesses of the current systems and the issues that will need to be addressed if the Department's ambition for a single comprehensive NHS and social care complaints system is to be realised.

Findings

On access and confidence in the systems

7 **Where people are dissatisfied, there is a low propensity for them to go on to make a formal complaint.** Our survey of people who had used NHS and social care services in the past three years found that around 14 per cent were in some way dissatisfied with their experience. Of these, only five per cent of people who were dissatisfied about the NHS went on to make a formal complaint compared to one third who made a formal complaint about adult social care services. The main reason people did not complain formally was that they did not feel anything would be done as a result.

8 **Once people have decided to make a complaint, navigating the complaints systems is not straightforward, particularly for health service users.** Over two thirds of those making a complaint were not offered any help in navigating the complaints process and a fifth said their experience was difficult. An April 2007 report by the Picker Institute on accessing information about health and social care found a lack of effective signposting and, that whilst there was no shortage of information, service users were often left to dig it out themselves and might not know what they needed to know. The Healthcare Commission has identified at least seven possible routes for complaints about health services.

9 **Only a small proportion of NHS complainants are aware of, or receive national advocacy support, and in social care advocacy depends on local arrangements.** In April 2006, the Department awarded nine, five year contracts to three providers for a statutory national Independent Complaints Advocacy Service (ICAS) (costing £10.7 million in 2006-07) to assist individuals to make a complaint against the NHS. Despite efforts to publicise the service, awareness is low (84 per cent of dissatisfied NHS service users who did not complain were unaware of the service). A total of 25,600 people contacted ICAS in 2006-07. Of these 7,600 (5.7 per cent of NHS complaints) received direct support, such as a home visit or assistance at a meeting, with the rest receiving some form of telephone support or advice. ICAS providers also carry out other activities such as outreach surgeries to raise awareness and provision of self help information through websites. Local authorities make their own arrangements for provision of advocacy services, so the support offered to complainants varies across the country.

On organisational culture and attitude to complaints

10 In 2007, the Health Service Ombudsman's annual report concluded that there is still a long way to go before complaints handling is taken as seriously as it should be across the NHS. The Healthcare Commission found that few trusts capture and report data on complaints in a systematic way. Just under half of the trusts we interviewed analysed trends and patterns of complaints alongside information from incidents and claims to evaluate risks to quality and safety. Whilst chief executives of NHS trusts have a statutory responsibility to sign off responses to all written complaints, the degree of engagement with this task is variable, as is the engagement of trust boards, with the focus on numbers rather than outcomes.

11 The culture and attitudes of the organisation are often a barrier to responsive complaints handling. The approaches to complaints handling in health and in social care are different. These differences include the legislation, eligibility for services and accountability arrangements. Nevertheless, in both sectors a defensive response to a complaint is often a barrier to handling it effectively.

12 Support provided to staff who are the subject of a complaint is variable. Training in complaints handling for front-line staff varies from mandatory training in a quarter of local authorities and NHS trusts, to ad hoc sessions. Staff may, however, have access to support in other ways such as counselling, and through professional bodies and unions.

13 Neither health nor social care organisations know the cost of complaints handling. Less than one third of trusts and local authorities were able to provide information on costs. Neither the Department nor local organisations are well placed, therefore, to assess the cost implications of the new arrangements, for example NHS trusts' need for independent clinical input following the removal of the Healthcare Commission's independent review role.

On the time taken to respond to a complaint and the adequacy of the response

14 Pursuing a complaint requires a personal investment of considerable time, determination and resilience on the part of the complainant. At the local resolution stage three quarters of complaints are concluded within 20-25 working days. For those that progress to the second, independent stage in respect of NHS complaints, the Healthcare Commission took on average 171 working days to respond, and social care an average of 63 working days. For those who take their complaint to the respective Ombudsmen, the need for a fair and proportionate review means that it inevitably takes longer to reach a final outcome. There are no data on how many people withdraw from the process despite being dissatisfied with the response they have received.

15 Most local authorities and two thirds of NHS organisations seek to identify complainants' expectations at an early stage providing the opportunity to identify complaints which could be resolved quickly. Whilst direct early contact with the complainant is one of the most important factors in resolving complaints satisfactorily, one third of trusts deal with complaints without assessing the expectations of the complainants. In some cases, a simple acknowledgement, apology or promise to improve the service may be all that is required. Of 10,950 reviews completed by the Healthcare Commission in its first two years, a fifth simply wanted an apology or recognition of the event.

16 Only 59 per cent of respondents to our survey felt that their complaint had been received in an open and constructive manner. Which? research on hospital complaints found that whilst most people who had made a formal complaint were pleased they had done so, only 27 per cent were happy with the way their concerns were dealt with. The Healthcare Commission's 2008 report *Spotlight on Complaints* found that procedures at the local level were not satisfactory in around half of the cases that it reviewed and that letters on the outcome were often of poor quality.

On the effectiveness of the systems for complainants dissatisfied with the initial response

17 The Department and the Healthcare Commission significantly underestimated the demand for independent review by the Healthcare Commission, leading to considerable difficulties in fulfilling this function in the first two years. The Healthcare Commission assumed its responsibility for independent review in July 2004. From the outset, it received more than double the numbers expected and a backlog quickly built up which continued to grow until May 2006. There were also delays in establishing a cohort of clinical experts to provide advice on cases.

18 A report on feedback from complainants and NHS complaints managers on the handling of cases closed by the Healthcare Commission between July 2005 and July 2006 identified concerns over timeliness and quality of responses. This was the time when the backlog was at its highest. The 2007 report, which the Healthcare Commission instigated, found that complainants believed they had received a poor service as the Commission was initially very slow at reviewing complaints and complaints managers felt that the quality and consistency of reviews was variable. Nevertheless, two thirds of complaints managers who had received recommendations from the Healthcare Commission said they found them very or fairly useful.

19 The Healthcare Commission took two years to meet its target to close 95 per cent of cases within 12 months but since June 2006, its performance has steadily improved. In May 2006, the number of open cases reached a peak of 5,384, with 835 over 12 months old. By March 2008, the number of open cases had reduced to 1,474, of which only six were over 12 months old. One reason for the improvement was an increase in complaints handling staff from 24 in July 2004 to an average of 160 since July 2006. The Healthcare Commission also increased clinical advice input and improved its processes in the light of experience. Although it continues to receive around 700 complaints a month, for cases received since June 2006 it has consistently met its target to close 95 per cent within 12 months. Ninety five per cent of cases now take less than seven months to conclude.

20 Local authorities struggle to meet the required 25 working day response time for second stage investigations. Between October 2006 and March 2007 local authorities responded to less than a quarter of stage two complaints within 25 working days. The timescale can, however, be extended to 65 working days and local authorities responded to 81 per cent of complaints within this extended timescale. The main barriers to meeting the timescales were setting up interviews with staff and the complexity of the complaint.

21 The Local Government Ombudsmen and the Health Service Ombudsman are an essential part of the independent investigation of complaints handling. In 2006-07, the Health Service Ombudsman accepted 862 new cases for investigation. Fifty two per cent of complaints (excluding those about continuing care) were fully or partly upheld in favour of the complainant. The Local Government Ombudsmen received 795 complaints on adult social care. The complaints received by the respective Ombudsmen vary greatly in character and complexity and can raise issues of difficulty and importance, such as continuing care funding. In the more straightforward cases, a decision will take less than six months; where matters are complex it will necessarily take longer.

On learning lessons from complaints to improve complaints handling and improve services

22 Social care complaints managers have a well established support network but neither the NHS nor social care have any formal means of capturing cross-organisational learning. In social care, the National Complaints Managers Group provides a strong support network for sharing learning but these lessons are not captured in any formal way. In September 2006, the Department established a joint 'Voices for Improvement Action Network' (VIAN) to foster closer working relationships across health and social care and to improve management of, and leadership for, those working on complaints locally. Levels of activity are currently variable, with some parts of the country holding active VIAN groups and others where VIAN has not been heard of. There is also a lack of methods for capturing learning, such as toolkits, an interactive website, or a good practice database.

23 There is scope to make better use of complaints data to improve services locally. Over 90 per cent of local authorities and NHS trusts stated that they had a clearly defined system in place for learning from complaints. The Healthcare Commission found, however, that although complaints data may lead to one-off changes to service delivery these are not necessarily shared across trusts or health economies. Our survey found that only one third of complainants considered that the organisations they had complained about had demonstrated that lessons had been learned as a result of their complaint. The Healthcare Commission also found that in many cases trusts had genuinely learned from complaints but did not tell the complainant. NHS and social care complaints managers told us that they could do better in monitoring and implementing recommendations from complaints.

Conclusion on value for money

24 An effective complaints function is important in keeping people's faith and trust in services and is an essential building block of a high performing organisation. It can also provide the organisation with assurance about the safety and quality of service provision. A good complaints system needs to be accessible, responsive and demonstrate that lessons are being learned. The Department recognised in its June 2007 consultation document, *Making Experiences Count*, that this was not yet the case in the NHS. Our findings confirm this view. There is, in particular, confusion as to how to access and navigate the complaints system; a lack of public confidence in the system; concern over the time taken to respond to complaints; a failure to find a sustainable and effective independent resolution stage; and limited sharing of lessons within and across NHS bodies.

25 In adult social care, people who are dissatisfied with services are more likely to know how to complain and consequently go on to complain. However, the social care complaints system has a number of shortcomings. These include: few complainants receiving advocacy services; limited evidence that lessons have been learned and services improved as a result of complaints; and a lack of monitoring of satisfaction with handling and outcomes. There is also a need for a stronger voice for those who receive services in their own homes or in registered care homes.

26 Overall, data on the costs of complaints handling are poor. The main evidence of efficiencies is that health and social care processes conclude around 95 per cent of complaints in an average of 23 and 17 days respectively; but our evaluation suggests that the current systems do not meet the criteria for an effective complaints system of being accessible, responsive, and demonstrating that lessons are being learned.

Recommendations

27 Following the consultation on *Making Experiences Count*, which was conducted in parallel to our evaluation, the Department initiated a number of activities to facilitate a smooth transition to the new complaints handling arrangements (Part 4 refers). The intention is that organisations will be free to determine local 'fit for purpose' arrangements within the framework described in *Making Experiences Count* and that the Department will subsequently produce good practice guidance prior to wider implementation in April 2009. We have identified specific issues that we believe the Department will need to address if its reforms are to be effective. We have also identified the key features that we believe are needed for effective local complaints handling.

Issues for the Department of Health

a *The infrastructures for the two complaints systems have different legislative frameworks, accountability arrangements, numbers of stages and approaches to independent review.* **The Department** needs to promote awareness of how these differences will be addressed in the new system, including the responsibilities and accountabilities of local leadership and the support services on offer, and explain the new complaints arrangements to the public, service users, carers and providers of health and social care services.

b *Potential demand is understated by the current volume of complaints in health and social care.* **The Department** should model the potential demand for complaints handling under the new system and its impact on the capacity of local organisations to meet this demand, including the need for advocacy support, using information from its early adopter sites. It should also clarify the costs of the new system that it intends to meet nationally and those that it expects local organisations to meet.

c *The removal of the Healthcare Commission's independent review stage requires NHS trusts to improve the capability and capacity of their complaints handling functions.* **The Department** needs to evaluate the early adopter pilots to identify and share specific examples of good practice so that trusts are able to determine the most appropriate, fit for purpose means of investigating individual complaints.

d *There are variations in the approach to the investigation of social care complaints locally, with a mix of internal and external investigators and a lack of standards for investigations or investigators.* **The Department** needs to work with VIAN and the new regulator to put in place minimum standards that should apply to investigations across health and social care. For example: on skills and training of complaints managers; quality of clinical advice; and safeguards to prevent long delays creeping into the system.

e *There is currently limited dissemination of lessons on how services have been improved as a result of learning from complaints.* **The Department** needs to develop a mechanism for capturing and disseminating lessons for service improvements as a result of complaints at the local level, and for identifying general patterns across all complaints. It should consider whether similar arrangements to those introduced to address concerns over lack of learning from patient safety incidents, which involved the establishment of the National Patient Safety Agency, could be introduced for complaints to improve quality and safety of services.

f *The Department's existing core standard on complaints handling requires NHS organisations to act on concerns and make improvements in service delivery as a result of complaints.* As suggested by the Healthcare Commission and the Health Service Ombudsman, **the Department** should strengthen this standard by making it a requirement for registration with the new Care Quality Commission that health and adult social care providers can show evidence of consistently acting on complaints.

g *Networks of complaints managers can provide valuable support in improving complaints handling. The Department's attempt to establish a joint network (VIAN) in 2006 has not generated the intended commitment, cooperation and learning.* **The Department** should re-invigorate the existing VIAN infrastructure to underpin the single comprehensive complaints system so that a clear framework is in place which will support and encourage the ongoing development of learning between complaints managers locally, regionally, and nationally.

h *The removal of the Healthcare Commission complaints function will leave a legacy of cases which will need to be concluded.* **The Department** is in discussion with the Health Service Ombudsman and the Healthcare Commission on how to handle the likely handover workload which will remain and should identify how these cases will be dealt with without undue delay. It should communicate clearly the transitional arrangements to trusts, local authorities and, crucially, the public to reduce the risk of confusion in moving to the new system.

Key features of effective local complaints handling

i Establish an open and constructive complaints handling culture with commitment and leadership from senior management. They should communicate to staff the importance of complaints as a key indicator of service users' experience and the expectation that complaints should be handled in a timely and responsive manner. The culture and attitude of the organisation can be a barrier to good complaints handling. Staff who are the subject of a complaint should also be provided with appropriate support.

ii Equip complaints managers with the requisite skills and training based on standards and guidelines agreed by VIAN. Complaints managers should also be given the authority and clout to deal with complaints effectively. Visible, senior management support will help ensure that complaints are handled effectively.

iii Provide all front-line staff with the skills and confidence to respond to concerns and complaints in an open and constructive manner, including training in customer service and complaints handling. Focussing on the early and prompt response to concerns can avoid, to an extent, escalation into a formal complaint.

iv Provide clarity to service users about how to make a complaint and how, in general, their complaint will be handled. This should include explanation of the different avenues such as email, telephone, letter, and informal approaches to resolving complaints, guidance about the availability of advocacy support, and clarity about the route to be followed in the event that the complaint crosses the boundaries of health and social care.

v Establish and document complainants' expectations at the outset and track any changes in expectations to increase the opportunity to resolve complaints quickly. Provide information to each complainant about how long it is likely to take to handle their complaint; what they might expect by way of communication during the investigation and on conclusion; what remedies are open to them; and what to do should they remain dissatisfied with the outcome.

vi Have a tracking system which captures details about the time taken to respond, costs incurred, issues and themes, evidence of action taken and, if relevant, changes to services as a result of complaints. Use this information to provide feedback to staff and service users on the organisation's performance and the outcomes secured in order to reinforce a constructive culture in complaints handling. Likewise, have regular reports to the board using both qualitative and quantitative information on the outcomes of significant complaints, details of changes made and complainant satisfaction surveys.

vii Develop comprehensive approaches to obtaining feedback from complainants about the way complaints have been handled and their satisfaction with outcomes. This feedback should be used to identify the strengths and weaknesses of local resolution from the users' perspective.

viii Publicise the implementation of recommendations, service changes and improvements arising from complaints. Making the outcomes known can promote public confidence in the value of complaining and reassure service users that it can make a difference.

ix Assess and monitor the number, type, severity and outcome of complaints received by providers of commissioned services. Commissioners of services should monitor whether providers encourage feedback from service users and how they address concerns.

x Benchmark performance on complaints handling both within and between similar organisations. Benchmarking can provide organisations with assurance on performance, including whether they are deploying the right capacity on complaints handling and the quality of the resources used, and whether they are receiving more or less complaints than might be expected. As a starting point, organisations should build on the information we have provided in our individual feedback reports.

PART ONE

Effective arrangements for handling complaints are important for service users and service providers

1.1 In 2006-07, the NHS spent £65.5 billion on healthcare services and local authorities spent £15.1 billion on adult social care services. Over 1.5 million people and their families come into contact with NHS services every day and, in 2006-07, local authorities provided one or more social care services to 1.75 million adults.

1.2 In its survey of hospital inpatients, the Healthcare Commission found that 90 per cent of patients rated their care as 'excellent' or 'very good' and, in a survey of those using primary care, 74 per cent said the main reason for visiting their GP or health centre had been dealt with to their satisfaction.[1] For social care, the Commission for Social Care Inspection found that between 68 and 84 per cent of adults received a social care service that met their needs.[2]

1.3 Despite these high levels of reported satisfaction, things can and do go wrong and it is important that people have effective ways of complaining when they do. Successive governments have stressed that modern public service organisations need to be proactive in resolving complaints. Indeed, NHS bodies and local authorities have a statutory duty to ensure that arrangements are in place for handling of complaints about the health and social care services they provide and/or commission.

1.4 In addition to providing a means by which individuals can seek an admission of fault, an apology or resolution for things that have gone wrong, complaints can also provide the management of an organisation with a valuable source of information about the quality of service provision. For example, complaints may provide early warning of poor or deteriorating services, systematic errors, or problems with specific processes or areas of operation. Where organisations react to early warnings they can minimise the time and cost of resolving these difficulties and minimise the risk of damaging the reputation of the organisation.[3]

What is a complaint?

A complaint can be defined as 'an expression of dissatisfaction, disquiet or discontent about the actions, decisions or apparent failings of service provision which requires a response.'

1.5 England is not alone in having formal arrangements for handling complaints about health and social care. Such systems are common to most other developed countries, but differ in the ways in which they have developed and in the extent of local and national responsibility for complaints handling. A report on the systems in other countries prepared on our behalf by Evidence Consulting is available at www.nao.org.uk. Complaints systems in Scotland, Wales and Northern Ireland are summarised in Appendix 2.

There are different procedures for handling complaints about NHS services and adult social care services

1.6 The current procedures for handling complaints about NHS and adult social care services differ in many ways. These differences include the number of stages and timescales; the ways investigations are carried out; the extent of independent consideration; the support provided to complainants; and accountability arrangements. The procedures are also funded differently, with costs falling locally or nationally depending on the arrangements in place. For example, the independent review of NHS complaints by the Healthcare Commission is funded nationally, whereas the costs of second stage investigation for adult social care complaints are borne locally (Figure 1). **Figure 3 overleaf** shows the key developments in relation to NHS and social care complaints with major reform of the NHS complaints system in 1996 and 2004, and for adult social care complaints in 2006.

3 Key changes in NHS and adult social care complaints handling

Year	Change
1991	The statutory complaints procedure for adult social care services was introduced, consisting of three local stages (managed by the local authority), with the Local Government Ombudsman as ultimate reviewer.
1994	*Being Heard*, a report by a committee led by Professor Alan Wilson, identified deficiencies with the NHS complaints procedures; including a lack of knowledge about how to complain and a lack of satisfactory responses. The Committee recommended a common local system for handling complaints across the NHS.
1996	A common system for dealing with NHS complaints is introduced. The procedure has three stages: local resolution, independent review (carried out by lay panels appointed by the local NHS), and referral to the Health Service Ombudsman.
2000	*Listening to People: A consultation on improving social services complaints procedures* seeks views on proposals to amend the arrangements for handling social care complaints.
2001	The Department of Health's independent evaluation of the 1996 NHS complaints procedure found that: ■ 75 per cent of those requesting an independent review did not find the process sufficiently independent, whilst 77 per cent thought it took too long to deal with their complaint. ■ both complainants and staff felt that there was no systematic way of ensuring that lessons were learned from their experiences of services, and of the complaints procedure, or for making improvements to service provision as a result.
2003	The Department of Health sets out proposals for reforming the procedures for second stage review of NHS complaints, including making the Healthcare Commission responsible for independent review.
2004	The Healthcare Commission became responsible for the independent review of complaints about the NHS. The Department's aim was to provide independence, speedier resolution, and a direct link to quality improvement.
2004	The Department consulted on changes to the complaints procedure for adult social care services. The proposals included making the Commission for Social Care Inspection (CSCI) responsible for the second stage independent review of complaints after concerns about the membership, independence and decision-making of social services complaints review panels were highlighted in the Department's 2000 consultation exercise, *Listening to People*. This independent scrutiny role, which had been taken on by the Healthcare Commission in respect of NHS complaints, was never taken on by CSCI.
2005	The March 2005 budget included the announcement that CSCI, the Healthcare Commission, and the Mental Health Act Commission would be merged. The independent review role envisaged for CSCI is shelved.
2006	The White Paper *Our health, our care, our say* announced the Department's intention to introduce a comprehensive single complaints system across NHS and social care by 2009.
2006	Amendments to health and social care complaints legislation imposed a duty on NHS bodies and local authorities to cooperate when complaints relate to both NHS and social care services.
2006	Following a period of consensus building led by complaints managers, the Local Authority Social Services Complaints (England) Regulations 2006 come into force, replacing the 1991 procedure. Three local stages were retained but the regulations introduced: a new time limit for making complaints; a requirement for local authorities to appoint a complaints manager; and revised guidelines on the constitution and running of review panels. The Regulations also included powers to fast track some complaints through Early Referral to the Local Government Ombudsmen after Stage 2 investigation.
2006	The Department launched the Voices for Improvement Action Network (VIAN) to provide a forum for health and social care complaints managers to exchange experience about national developments and develop joint approaches.
2007	*Making Experiences Count: A new approach to responding to complaints* sets out the Department's proposals for a single, comprehensive system across NHS and social care. The proposals include removing the Healthcare Commission's independent review role.
2007	The introduction of the Regulatory Reform Order (2007) which enables the Parliamentary and Health Service Ombudsman and the Local Government Ombudsmen to work jointly on cases which cross the boundaries between their jurisdictions.
2008	The Department publishes its response to *Making Experiences Count*.

Procedures for making a complaint about NHS services

1.7 When people make complaints about NHS services (examples in **Figure 4**) their complaint is handled by the NHS trust (acute trust, primary care trust, mental health trust or ambulance trust) or the independent contractor (GP, dentist) they are complaining about. Foundation trusts have the freedom to establish their own systems for handling complaints at the local resolution stage, although in practice most follow the NHS procedures. Some areas of complaint, however, fall outside the NHS complaints procedure **(Figure 5)**.

4 Examples of NHS complaints

Example 1

Mrs C suffers from multiple sclerosis and is severely disabled, bed bound, and unable to speak. She requires several prescribed medicines. The local GP practice changed its system for repeat prescriptions which meant that they could only be requested in person or by post. Mrs C's husband asked for his wife to be treated as an exception. The practice refused and both Mr and Mrs C were later removed from the practice list due to a breakdown in the relationship with their GP and a refusal to change prescription habits. Mr C complained to the practice that the removal was unjustified and that no warning had been given. The complaint went to the Ombudsman but was not upheld.

Example 2

Mr J had been a patient of his dentist for fifteen years and had regularly attended check-ups with him twice a year. Following the retirement of his dentist, Mr J attended a consultation with a new dentist who informed him that he was concerned about the condition of his gums. Mr J was subsequently diagnosed with chronic gum disease and advised that prompt action was required to help rectify the problem. Mr J complained that his former dentist had failed to diagnose a chronic gum infection during numerous consultations. As the dentist had retired, Mr J's complaint was made directly to the PCT. The complaint progressed to the Ombudsman as the dentist did not respond to the PCT's or the Healthcare Commission's requests for information.

Example 3

Mrs H's mother was admitted to hospital through A&E, suffering pleurisy and pneumonia. She received chest x-rays which revealed abnormalities in her lungs. It came to light that the abnormalities could have been identified at a hospital visit seven months earlier. By the time the error was noticed it was too late for treatment. Mrs H was told that her mother had lung cancer and she later died. Mrs H submitted a complaint about the delay in diagnosing the condition that led to her mother's death. Having been dissatisfied with the trust's response, Mrs H referred her complaint to the Healthcare Commission, which found that the trust had dealt with the complaint appropriately and had taken action to make changes to its procedure. It therefore recommended that the trust supply Mrs H with documents demonstrating the action they had taken as a result of her complaint.

Source: Healthcare Commission; Health Service Ombudsman.

1.8 In 2006, the Chief Medical Officer's report *Good doctors, safer patients* highlighted that the distinction between complaints about services and complaints about doctors is not readily understood by patients and the public and that this has led to ongoing concern that the current processes for complaining about the NHS are fragmented, overly complex and lack transparency for the user.[4] The Department's July 2006 White Paper, *The regulation of the non-medical healthcare professions*, suggested that a single source of advice would help complainants navigate the system.[5]

Procedures for making a complaint about adult social care services

1.9 When people make complaints about social care services funded by local authorities, the local authority or contracted service provider will handle their complaint; people can also complain to the local authority about the assessment of need that was made (examples in **Figure 6 overleaf**). Some areas of complaint, however, fall outside the adult social care complaints procedure. For example, complaints about the conduct of social care workers are handled by the General Social Care Council, the social care workforce regulator.[6]

5 Examples of areas of complaint which fall outside the NHS complaints procedure

Fitness to practise complaints

Complaints about the fitness to practise of health professionals are not considered under the NHS complaints procedure and are handled by professional regulators. For example, doctors in the UK are regulated by the General Medical Council (GMC). If a member of the public raises a complaint about fitness to practise, they become a witness in the case, rather than a complainant: the case is then a matter between the registrant and the professional regulator. In 2006-07, around 900 fitness to practise hearings were held across the eight main health regulatory bodies.

Clinical negligence

If an individual is injured as a result of an error by an NHS healthcare professional, they may be entitled to financial compensation. However, financial compensation is not normally available through the NHS complaints process, and individuals stating that they intend to take legal action cannot use the NHS complaints procedure.

The proposed NHS Redress Scheme, which will cover lower financial value clinical negligence cases, is intended to provide an alternative to litigation for less severe cases and remove the risks and costs of litigation from the patient. The scheme also aims to address delays in the current clinical negligence system and help reduce the general burden of litigation costs for the NHS.

1.10 The only place for people funding their own social care to complain is to the provider itself. Should they be dissatisfied with the consideration of their complaint, they have no recourse to any statutory procedure or the Ombudsman. They are also unable to have their complaint reviewed by the Commission for Social Care Inspection as it has no statutory duties or powers to investigate individual complaints. Although such people can choose a different service provider, they are often the frailest and most vulnerable members of society so this is not always straightforward or possible. In July 2008, the Department announced its intention to deal with the issue of independent resolution of complaints by people who arrange and fund their own adult social care services. It proposes to extend the remit of the Local Government Ombudsmen to enable them to investigate complaints by self funders.

6 Examples of adult social care complaints

Example 1

Mr P complained to the local authority on behalf of his adult son who has mental health problems. His complaint concerned the fact that there had been a delay in receiving a response to their request for an increase in direct payments. Mr P felt that as his son had been taken swimming and had benefited from it, then this activity should be covered by a direct payment. He did not accept that an assessment of need was first required. Mr P complained about the funding panel process and the poor communication from the panel. The local authority found flaws in the funding panel process and Mr P was offered a new assessment.

Example 2

Mrs A, who lived some distance away from her parents, complained to the local authority that they had not received a good quality home care service and that this had led to them entering into residential care before they should have needed it. The home care service was commissioned from an independent provider. Mrs A complained that the carers did not perform allotted tasks and did not attend on time. She also complained that a carer had called to find her father hurt and bleeding but had left without calling for assistance. Following local investigation, Mrs A's complaint was not upheld because the home care package was found to be adequate and was regularly reviewed. The provider had also acted swiftly by dismissing the carer who left her father without calling for assistance.

Example 3

Mrs B's son, who has learning disabilities, had returned home when his residential home had been closed for refurbishment. Mrs B was concerned that the stress of caring for him on her own was causing her own health to suffer. She had found an alternative placement which she felt would suit his needs but the local authority considered it to be unsuitable. Mrs B complained about the conclusions of the local authority's assessment. Following an investigation which raised concerns about the accuracy of the assessment, Mrs B's son was reassessed and placed in the home his mother had chosen.

Source: Local authority annual reports

National reviews have highlighted failings in the local arrangements for handling NHS complaints, whilst research and analysis into social care complaints handling is lacking

1.11 In March 2005, a report by the Health Service Ombudsman on the reform of the NHS complaints procedure highlighted that public confidence in the system was low and there was a risk that a bad start to the new system would create a further loss in public confidence which would be difficult to overcome.[7] Indeed, a growing body of evidence has identified problems with different aspects of the NHS procedure **(Figure 7)**.

1.12 There is a limited body of research about the social care complaints system. The reviews that have been carried out have focussed primarily on the handling of complaints in care homes. The problems identified include: older people and their relatives fearing repercussions if they complain; low awareness of complaints procedures and where to direct complaints; and a lack of support in making complaints.[18, 22, 23]

The Department has announced plans to introduce a single complaints system across health and social care by 2009

1.13 In its January 2006 White Paper *Our health, our care, our say* the Department announced its intention to develop a comprehensive single complaints system across health and social care by 2009.[24] The Department's proposals for the system and what they aim to achieve were announced in June 2007 **(Figure 8)**.[18]

1.14 People increasingly moving between health and social care services was one of the main drivers behind the decision to introduce a single complaints system; although in reality numbers of cross-cutting complaints are small, on average three per NHS trust and local authority. Many of those who receive both services are elderly, frail or suffer from long term, disabling conditions and it is not always clear to them which organisation is responsible for the services they receive. The Health Service Ombudsman has found that only at the conclusion of some cases was it clear that the complaint had been addressed through the wrong route or addressed incompletely.[7]

7 Overview of findings identified in published research into NHS complaints

Various strands of published research into NHS complaints have identified the following:

- **Ignorance about the NHS complaints process, with a perception that it is lengthy and bureaucratic**. The nature of people's experiences with the NHS had to be either very good or very bad to prompt formal praise or criticism,[8] and the greatest barrier to formal complaints was patients' lack of a benchmark by which to judge their experience.[9]
- **Confusion about how to make a complaint,**[10] **especially when people are dealing with more than one NHS body at the same time**,[11] and difficulty in securing a satisfactory outcome[12] when complaints concern failures of communication or service delivery.[7]
- **Difficulty in navigating the complaints systems** due to the wide range of bodies to which a complainant might reasonably address their concerns,[13] and public confusion regarding the dividing lines between primary and secondary care, and health and social care.[14]
- **People feeling intimidated by the NHS and thinking that their complaint would not be taken seriously**.[15] Patients felt uncomfortable about complaining direct to their individual provider and were concerned that it could have serious consequences for their ongoing relationship. Complaints relating to GPs are a challenging area as primary care trusts have limited powers to investigate them in the absence of cooperation from individual doctors.[4]
- **The lack of a systematic way to learn lessons from complaints, both in terms of service provision and complaints handling**,[16] and under-exploitation of information from complaints as a learning resource and means to identify failures in service delivery.[17,18]
- **The lack of systems for monitoring and learning from complaints**. Board reports on complaints concentrate on discussing numbers and statistics rather than the content or seriousness of complaints,[19,20] and although complaints data may lead to one-off changes to service delivery, these are not necessarily shared across trusts or health economies.[21]

1.15 In April 2009, the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission are expected to merge to form the Care Quality Commission. It will not have a role in the review of complaints but will examine the standard of complaints handling and the implementation of learning from complaints.[18]

8 What the Department of Health's proposals are intended to achieve

The Department intends its proposals to achieve:

- an increase in people's confidence that their complaints will be taken seriously and that services will improve as a result of their experiences;
- a flexible approach to resolving complaints, which includes effective support;
- a simple, consistent, unified approach across health and social care;
- a culture within organisations of openness and fairness when dealing with complaints;
- an approach which is fair to people using and delivering services;
- an emphasis on early and effective resolution; and
- a greater emphasis on excellent local leadership and accountability that supports the resolution of complaints.

The Department considers the best way to achieve this in practice is to:

- focus everyone's efforts on sorting things out quickly, at a local level;
- make advocacy a right for anyone who might need support to make their views heard;
- make it the responsibility of the most senior managers in organisations to ensure that complaints are dealt with properly and that the learning from those complaints is used to improve services;
- make sure that complaints professionals have the skills, experience and support that they need in order to work in this new way;
- give the regulator the task of making sure that all providers of NHS or social care services, whether in the public or independent sector, have effective complaints arrangements in place that meet people's needs and make services better; and
- uphold the current role of the Ombudsmen.

Source: Department of Health. Making Experiences Count: A new approach to responding to complaints.

The Department has made no evaluation of existing capability and capacity in complaints handling

1.16 Whilst various reviews have been conducted into different aspects of the NHS and social care complaints procedures and the Department commissioned some small scale research in 2005[25] to understand barriers to the provision of feedback on health and social care services, there has been no detailed evaluation of how the arrangements work in practice and little is known about existing capability and capacity in complaints handling. This report is therefore the first detailed, independent evaluation to identify the capability, capacity and effectiveness of arrangements for handling health and social care complaints.

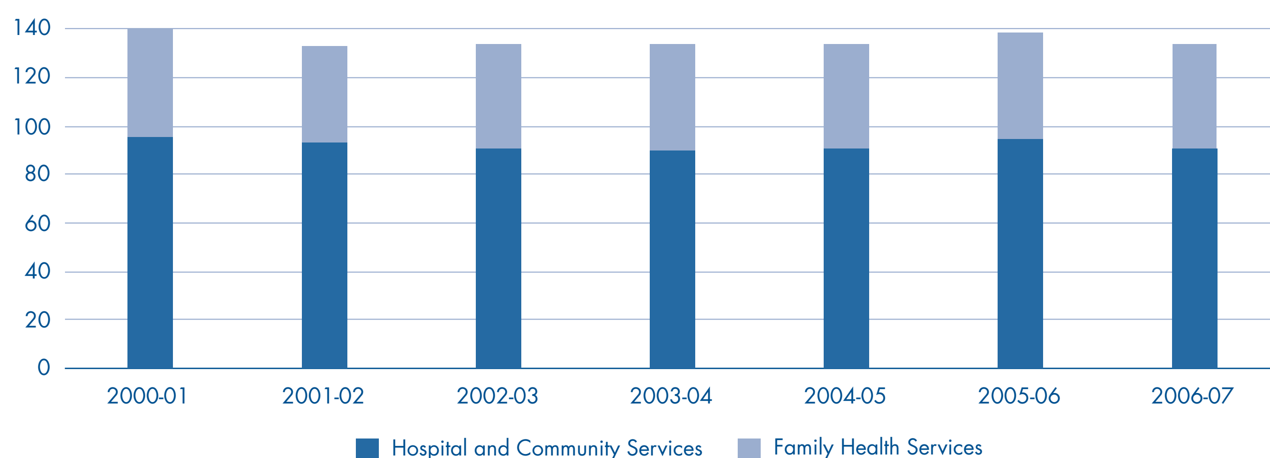
The extent and cost of NHS and adult social care complaints handling

1.17 In 2006-07, the NHS received 133,400 complaints.[26] The level of complaints received by the NHS has changed little over the last seven years **(Figure 9)**.

1.18 There are very limited data on the costs of the complaints handling function. Less than a third of trusts provided information on direct costs and the figures that were provided are likely to be an underestimate as the amount spent by front line service teams investigating complaints could not be identified. We estimate, based on an extrapolation of the data that were provided, that the cost of handling NHS complaints in 2006-07 was £89 million, including the costs of the national advocacy service and independent review by the Healthcare Commission but excluding the Health Service Ombudsman (Figure 1).

1.19 Information on the volume of complaints received by adult social care services is not collected nationally. As a result, there is no ongoing data collection and our census, which collected complaints information from 87 per cent of local authorities, is the only source of data. From an extrapolation of the data provided, we estimate that local authorities received 17,100 complaints about adult social care services in 2006-07. Data on the costs of handling adult social care complaints are also very limited, with only a third of respondents able to provide information on direct costs. We estimate, based on an extrapolation of the data provided, that the cost of handling adult social care complaints in 2006-07 was £13 million, excluding the Local Government Ombudsmen (Figure 1).

9 The NHS has received between 130,000 and 140,000 complaints in each of the last seven years



Source: Information Centre for Health and Social Care.

NOTE

1 Foundation trusts are no longer required to submit data on complaints to the Information Centre. Some foundation trusts still choose to respond but, from our census data, we estimate that around 2,000 complaints are not included in the Information Centre's 2006-07 data. A further 981 complaints received by NHS Direct during 2006-07 are also not included in the total.

1.20 At the local level, NHS trusts spent an average of £640 per complaint taking an average of 23 working days to respond. The Healthcare Commission spent an average of £987 per complaint, taking an average of 171 working days to complete its review. For adult social care complaints, local authorities spent an average of £570 per complaint at the first local stage, taking an average of 17 working days to respond. At Stage 2, local authorities spent an average of £1,960 per complaint, taking an average of 63 working days. Local authorities handled 200 complaints at Stage 3, at an average cost of £900 per complaint (see Figure 1). These figures are likely to be an underestimate as the amount spent by front-line service teams investigating complaints could not be identified.

1.21 The remainder of this report examines the effectiveness of the current NHS (Part 2) and adult social care (Part 3) complaints systems against the following criteria:

- the ease of access to systems for those wishing to make a complaint, and people's confidence in the systems;
- whether the organisational culture and attitude of staff is constructive towards complaints;
- whether complainants receive a response in a reasonable time which addresses their concerns;
- the effectiveness of the systems in place for those complainants who are dissatisfied with the initial response; and
- the extent to which lessons are learned from complaints to improve complaints handling and improve services.

1.22 Through assessing the strengths and weaknesses of the current systems, we identify in Part 4 the challenges that will need to be managed in developing a comprehensive NHS and social care complaints system.

PART TWO

The effectiveness of complaints handling in the NHS

2.1 There has been a statutory requirement for NHS hospitals to have a complaints system since 1985. The Department of Health intended that the current NHS complaints procedure, introduced in July 2004, would be open and easy to access, fair and independent, responsive and would improve services as a result of learning from complaints. It covers acute, mental health, ambulance, and primary care trusts, and independent contractors such as GPs and dentists. Foundation trusts, however, have the freedom to establish their own systems for handling complaints at the local resolution stage. NHS care is provided free at the point of need and the complaints system applies to all NHS service users or someone acting on their behalf.

2.2 The key change in 2004 was to give the Healthcare Commission responsibility for the second stage, independent review of NHS complaints. The Healthcare Commission, in its role as regulator of NHS trusts, also assesses trusts' performance in complaints handling through a self assessment against the Department's *Standards for Better Health*, one of which relates to complaints handling.[27]

2.3 Our examination of the NHS complaints procedure draws on the findings from our census of NHS trusts; our visits to 18 NHS trusts; and an omnibus survey. It also draws on interviews with and reviews and data reported by other organisations such as the Health Service Ombudsman, the Healthcare Commission and the Department of Health (our methodology is set out in Appendix 1).

On access and confidence in the system

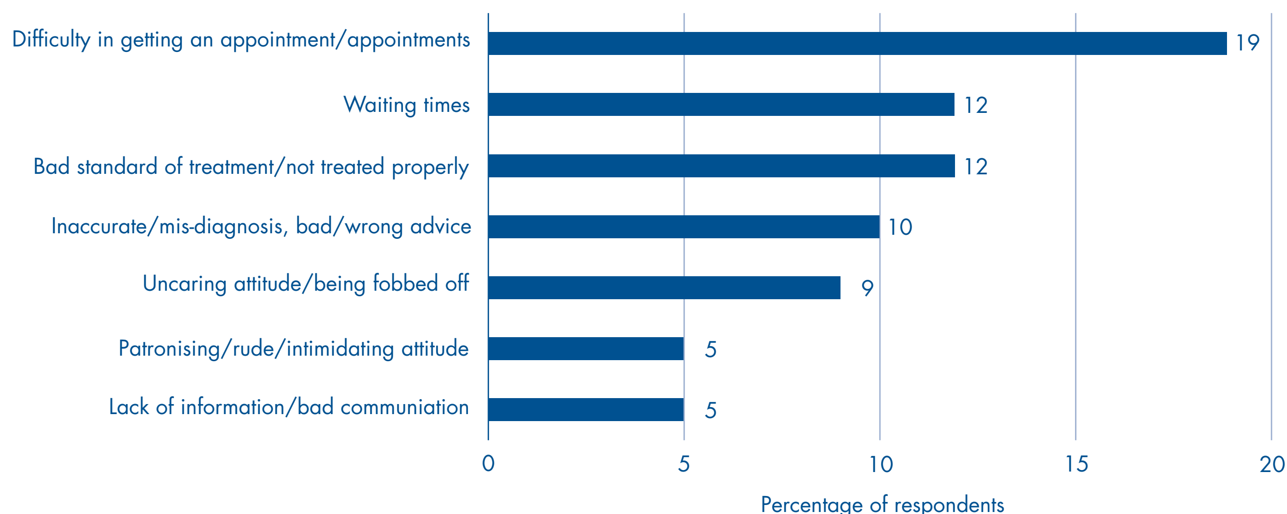
Ninety five per cent of people dissatisfied with their experience of the NHS do not make a formal complaint

2.4 Our survey found that 88 per cent of adults in England have had some contact with healthcare service providers in the last three years. Of those who had contact, 87 per cent were satisfied with their experience, whilst 13 per cent had in some way been dissatisfied. Respondents were most frequently dissatisfied with their GP (35 per cent), hospital doctor (17 per cent), or dentist (11 per cent). The most common reasons for dissatisfaction are shown in **Figure 10**.

2.5 Only five per cent of people who had been dissatisfied with NHS services made a formal complaint. Sixteen per cent made an informal complaint to which they did not expect a written response, but 79 per cent did not complain at all. Most commonly, people did not complain because they lacked confidence in the system **(Figure 11)**: 32 per cent who did not complain formally stated that they thought nothing would be done as a result of their complaint, whilst six per cent did not feel their complaint would be looked at with sufficient independence or fairness. These reasons were also cited in responses to our web forum **(Figure 12)**.

2.6 Although nine out of ten NHS patients are diagnosed and treated entirely within primary care, only 32 per cent of all NHS complaints received in 2006-07 were about primary care.[11, 26] Our survey found that one in ten people are reluctant to complain about a service provider with whom they may have an ongoing relationship, for example their GP. Six per cent did not wish to damage the relationship with their service provider and a further four per cent did not want to be perceived as a troublemaker.

10 Common reasons for dissatisfaction with NHS services



Source: Omnibus survey carried out on behalf of the National Audit Office

11 Propensity of dissatisfied service users to complain

Formal complaint made
Informal complaint made
Lacked confidence in the system
Could not access the system
Worried about affecting relationship with provider
Other reasons for not complaining

Source: Omnibus survey carried out on behalf of the National Audit Office

12 Service users' reasons for choosing not to complain

"No one listens so why bother"

"Feel that it would not make any difference"

"I did not want to be seen as a troublemaker and be treated differently"

"Didn't want to make a fuss"

"I felt the staff on the ward would become more hostile"

"My parent requires further treatment and I did not want the complaints to have an adverse effect"

Source: National Audit Office web forum

2.7 Amongst complainants responding to our survey, only 34 per cent stated that the organisation they complained about demonstrated that lessons had been learned as a result of their complaint. However, 77 per cent of trusts responding to our census reported that they publicise changes made as a result of complaints, and three quarters said that they routinely inform complainants of changes made following their complaint. In its April 2008 *Spotlight on Complaints* report, the Healthcare Commission found that in many cases trusts had genuinely learned from complaints but did not tell the complainant.[28]

Sixty per cent of people do not know where to seek help about making complaints

2.8 National surveys have found 60 per cent of service users do not know where to seek help about making complaints[29] and only 18 per cent of users recalled being given information about how they could complain.[30] Our survey found that the second most common reason for dissatisfied users not complaining was their inability to access the system. Five per cent of respondents did not know who to complain to and 14 per cent felt their complaint was not serious enough.

2.9 From 1974 to 2003 Community Health Councils (CHCs) had a statutory duty to represent the interests of the public in the health service. This included providing support to patients who had experienced problems or who had made a complaint. In July 2000, the Department announced that CHCs would be abolished, and two new services were established to take on these functions:

- Patient Advice and Liaison Services (PALS); and
- the Independent Complaints Advocacy Service (ICAS).

2.10 Patient Advice and Liaison Services (PALS)[a] are often the first port of call for people wishing to make a complaint as PALS play a role in handling queries about services and can facilitate access to the complaints system. In a national evaluation commissioned by the Department of Health, a range of stakeholders reported that PALS had had a positive impact on user experiences of the complaints system and the ability of trusts to respond appropriately to concerns and complaints.[31] Although 99 per cent of trusts have a PALS in place, our omnibus survey found that just 13 per cent of those who made a complaint (formal or informal) were advised that PALS could assist them.

2.11 The national evaluation of PALS found that the visibility and accessibility of PALS is enormously variable and, where this was less than optimal, it was a significant barrier to effective working.[31] Our census also found that PALS staffing levels varied from those relying entirely on volunteers or NHS staff working on a rotational basis, to a mental health trust with eight dedicated PALS staff operating across several sites.

2.12 Complainants also seek help from other organisations which are not part of the NHS. For example, the Patients Association helpline provides advice about the complaints process and how to make a complaint, and Action against Medical Accidents also receives enquiries from the public concerning NHS complaints.[32]

In 2006-07, the Department spent £10.7 million on advocacy support but awareness and take up is low with considerable variation in different parts of the country

2.13 In 2003, the Department launched a statutory national Independent Complaints Advocacy Service (ICAS) to provide support to service users who choose to make a formal complaint about the NHS. The current ICAS contracts were launched in April 2006 and run for five years at a total cost of £56.9 million. This service is provided by three different providers across the nine Government Office regions. The annual cost of running this service in 2006-07 was £10.7 million.

2.14 The current ICAS contracts saw the Department introduce two service delivery models: direct advocacy and remote advocacy. Direct advocacy focusses on the provision of one-to-one support to those with the most complex needs (for example, individuals with learning difficulties or mental health problems). Remote advocacy seeks to empower clients who want and are able to raise their own concerns. In such cases support is provided via telephone or written correspondence, or by referral to self help information. One of the key aims of ICAS is to provide support to the most disadvantaged and vulnerable users of NHS services. The contracts therefore require that no more than 75 per cent of resources should be focussed on remote advocacy.

2.15 During 2006-07, ICAS provided direct advocacy for 7,578 complainants which represents 5.7 per cent of all NHS complaints. We found variation in use of ICAS across the nine Government Office regions ranging from four per cent of all NHS complaints in London to eight per cent in the North West. The Department has not set a target for overall use of ICAS but believes there is further capacity to increase take up in some areas. Although the complexity of individual cases varies, our analysis of new cases compared with advocate staffing numbers indicates that there are wide variations in caseloads across the service, ranging from 99 new cases per advocate in the North West to 35 per advocate in the West Midlands. The Department told us that variations in caseload in 2006-07 may have arisen as a result of this being the transition year to the new contracts, so teams in some regions had shortfalls in staffing.

2.16 In 2006-07, ICAS also had 17,944 client contacts (13 per cent of NHS complaints) which provide an indication of the number of people that received remote advocacy. ICAS also carries out other activity not captured by these data. For example, ICAS advocates run outreach surgeries where they engage with community groups to raise awareness of the service and each of the providers have websites from which self help information packs can be downloaded.

2.17 Our omnibus survey found that public awareness of ICAS is low, with 84 per cent of dissatisfied service users (who did not complain) unaware of the service. Our survey also found that overall 69 per cent of those that had made a complaint (formal or informal) about health services were not advised of any support services that could help them in making their complaint. Just six per cent were directed towards ICAS.

a PALS provide a wide range of advice and information for patients, for example, on health related matters and support to patients, families and carers.

2.18 The Department collects data on the use of ICAS according to age, ethnicity and disability **(Figure 13)**. We sought to compare the ICAS ethnicity data with ethnicity data collected by the Department for all NHS complaints in 2006-07 to see if the ICAS client base reflected the overall NHS complaints population. This comparison was not possible, however, because ethnicity was unknown for around 54 per cent of cases as some complainants were reluctant to disclose this information. It was also not possible for us to carry out a similar analysis by age or disability as this information is not collected for all NHS complaints. As a result, whilst the data collected by the Department provide an indication of who is using ICAS, they cannot be used to measure the service's success in reaching individuals from specific groups.

On organisational culture and attitude to complaints

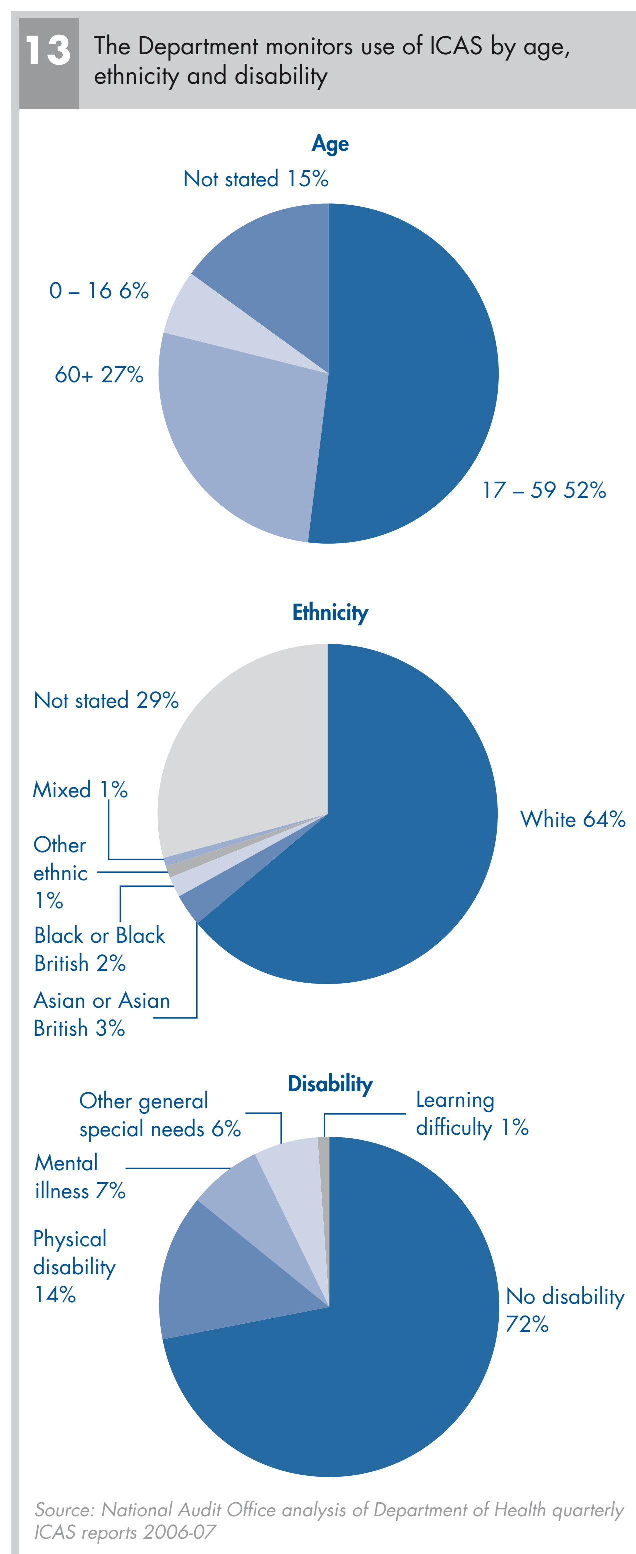
Complaints are not always received in an open and constructive manner

2.19 Our survey found that 59 per cent of people who made a formal complaint considered that it had been received in an open and constructive manner. Over a third (36 per cent), however, considered that their complaint had not been received in an open and constructive manner and five per cent did not know. One fifth of complainants found their experience of complaining difficult. When asked what one thing would have led to their complaint being handled better, respondents made a number of suggestions including offering an apology or acknowledging the problem (seven per cent), and being listened to (five per cent). No single response, however, stood out clearly from the others.

2.20 In its first *Spotlight on Complaints* report, the Healthcare Commission stated that one of the frequent problems in the way that complaints are handled locally is the failure to apologise, even when shortcomings have been identified.[33] It also reported that obtaining an apology was cited as the desired outcome for ten per cent of complainants amongst 10,950 completed independent reviews. Trusts frequently told the Healthcare Commission that they had not apologised for fear of admitting legal liability. The medical defence organisations and the NHS Litigation Authority, however, have consistently made it clear that apologies can be given to try to resolve matters without admitting liability.[28]

2.21 Another common outcome sought by complainants who have taken their complaint to independent review is the desire to obtain recognition of the event being complained about (nine per cent). The most commonly sought outcome, however, was a better explanation (33 per cent).[33]

13 The Department monitors use of ICAS by age, ethnicity and disability



Source: National Audit Office analysis of Department of Health quarterly ICAS reports 2006-07

Leadership from the chief executive sets the tone for complaints handling in trusts

2.22 We examined through our census the extent to which the culture within NHS trusts was open and fair in relation to the handling of complaints and the majority of complaints managers (56 per cent) and chief executives (51 per cent) consider that overall there is an open and fair culture of complaints handling within their trust. A significant proportion of complaints managers (40 per cent) and chief executives (46 per cent), however, felt that pockets existed where there was a tendency towards a blaming and closed culture. This was confirmed in our interviews with complaints managers and chief executives, who recognised that the attitude of operational staff towards complaints could sometimes be defensive.

2.23 We found that the culture in terms of complaints handling is dependent on the leadership provided by the chief executive, who sets the tone within the trust. The relationship between the chief executive and the complaints manager and the level of interest the chief executive takes in complaints adds to the clout a complaints manager has when dealing with trust staff. Chief executives also demonstrated their commitment to complaints by locating their complaints manager close to their own office. In our interviews with trusts we found examples of chief executives that are highly committed to the importance of complaints **(Figure 14)**.

14 Examples of chief executives committed to the importance of complaints

"I really do believe that it's the accountable officer that is pivotal in all of this; if I'm not interested in complaints then nobody else will be"

"I don't just sign the complaint; I read every single line of every complaint in this organisation"

"Complaints are a learning opportunity and it provides a role model for the organisation that the chief executive's interested in the process and interested in the outcome"

"We don't hide from complaints……we welcome them"

Source: National Audit Office interviews with NHS trusts

2.24 The NHS (Complaints) Regulations 2004 require trusts to prepare a quarterly report for consideration by their board. These reports are required to specify the number of complaints received; identify the subject matter of the complaints; and summarise how they were handled, including the outcome of the investigations. The regulations also require trusts to have a board member responsible for ensuring that action is taken in the light of the outcome of any complaints investigations. We found that complaints are on trust board agendas either monthly or quarterly for 87 per cent of trusts, and 23 per cent of complaints managers reported directly to the board. Although most boards are considering complaints in some context, the existence of complaints on the board agenda does not in itself demonstrate the importance placed on the quality of complaints handling and the implementation of lessons learned. For example, the Healthcare Commission's investigation into the outbreaks of *clostridium difficile* at Maidstone and Tunbridge Wells found that complaints reports to the board concentrated primarily on statistical analysis rather than the nature of the complaints.[20]

The day to day responsibility for handling complaints lies with complaints managers

2.25 The complaints manager is the lynchpin of the complaints process and has a wide range of responsibilities in terms of administration and handling of complaints, providing help and advice to people wishing to make a complaint, and supporting staff involved in handling complaints. The relationship with the chief executive on complaints handling does, however, vary. Just 12 per cent of chief executives maintained regular dialogue with complaints managers as a way of ensuring action had been taken on complaints, and just five per cent reported that serious complaints were escalated to senior management as a way of ensuring action was taken.

2.26 We found that complaints managers rarely held senior positions within the trust with nearly half sitting three levels or more below the chief executive. Just over half (53 per cent) of complaints managers have a salary between £26,000 and £35,000 (broadly equivalent to Agenda for Change salary band 7) and nearly a quarter earn between £36,000 and £45,000 (broadly equivalent to Agenda for Change salary band 8a). Reporting lines for complaints managers were diverse with 35 per cent reporting into the governance, quality or risk structure and one in five reporting to the clinical, medical or nursing lead.

2.27 The role of complaints manager can often involve dealing with complainants as well as staff of all levels within the trust. Complaints managers therefore require a range of skills and adequate support for them to perform their role effectively. Although there is no standard training given for the role and no formalised skill set exists, complaints managers we interviewed agreed that they required specific skills in order to perform their role. Our census found that complaints managers have undertaken a variety of different types of training, including root cause analysis (11 per cent) and risk management (eight per cent). Eleven per cent of complaints managers had undertaken the *Managing complaints for service improvement* course run by the Institute of Healthcare Management. Ten per cent reported having received no training in complaints handling.

2.28 The arrangements for training front-line teams vary from training that the organisation has deemed mandatory to less formal ad hoc sessions. For 87 per cent of trusts, complaints training for front-line staff was covered as part of their induction. However, five per cent had no formal training and only a quarter of trusts provided a compulsory module on complaints handling. Training front-line staff is important if trusts are to deal with complaints effectively, especially as the availability and capacity of staff was highlighted by our census as one of the main barriers to responding to complaints in a timely manner. The Healthcare Commission has also identified that trusts need to support and train staff in responding better to complaints as soon as they arise and encourage less defensive responses.[33]

2.29 NHS staff who are the subject of a complaint are commonly supported by their line manager and the complaints manager. Support is also provided in other ways, for example by counselling, having access to mentors, allowing representatives to support staff in meetings and encouraging staff to seek support from their professional body or union.

"When I give complaints training I ask everyone 'who's responsible for dealing with complaints in this trust?' and some of them try to pin it on me, but I just say 'no, we're all responsible because you can pick up a complaint wherever you are'."

Source: National Audit Office interviews with NHS trusts

On the time taken to respond to a complaint and the adequacy of the response

The majority of NHS complaints are concluded at the first stage of the complaints process but quality and complainant satisfaction are not routinely measured

2.30 The 133,400 formal complaints in 2006-07 were made by NHS service users or someone acting on their behalf, either orally or in writing (including email). Complaints should initially be made to the organisation or practitioner providing the service. The first, local stage 'aims to resolve complaints quickly and as close to the source of the complaint as possible'[34] and involves the trust investigating the complaint and communicating its findings to the complainant. The Department expects primary care practitioners to respond to complaints within ten working days and chief executives of NHS organisations to respond within 25 working days, though the latter deadline can be extended with the complainant's agreement.

2.31 Ninety four per cent of complaints received by NHS trusts do not progress beyond the first stage. Although this suggests that local resolution is working effectively, it does not measure the quality of responses nor complainant satisfaction with the process. Few of the trusts we interviewed measured quality of responses and the vast majority had no formal quality assurance process. Review by the complaints manager and chief executive was the main way of assuring quality of responses.

2.32 There has been no comprehensive analysis of the quality of responses to complaints received by the NHS. However, the Healthcare Commission's review of the 10,000 complaints it received between August 2006 and July 2007 reported that letters that confirmed the outcome of a complaint were often of poor quality, with the emphasis more on the process of the investigation rather than the outcome for the patient. It also reported that procedures for handling complaints were not satisfactory in around half of the cases it reviewed and that 26 per cent of complaints were referred back to trusts for further work on the basis that they had not made every effort to achieve a successful local resolution.[28]

2.33 When we asked trusts how they monitor complainants' satisfaction, a quarter of trusts stated that they do not routinely do so. Eighty per cent of trusts did not carry out a satisfaction survey of complainants in 2006-07. For those that did, on average 59 per cent of respondents were satisfied with the resolution of their complaint. This means that that whilst six per cent of complainants choose to refer their complaint to the Healthcare Commission, a larger proportion remain dissatisfied following local resolution but do not take their complaint further.

Trusts respond to three quarters of complaints within the 25 working day target

2.34 The main way in which performance in complaints handling is measured is against time targets for responding. In 2006-07, 76 per cent of complaints were responded to within the target timescale (25 working days from September 2006, 20 working days prior to that). Performance against this target varies by trust and the average response time is 23 working days. Eighty per cent of trusts average 25 days or under, with averages ranging from seven days to 58 days **(Figure 15)**. **Figure 16** shows the main barriers to responding to complaints within the timescale.

2.35 Complaints managers we interviewed said that timescales helped when chasing operational staff for responses and managing the expectations of complainants. They emphasised, however, that the quality of the final response was more important than meeting the target. Our omnibus survey found that around a third (36 per cent) of people were not kept up to date on the progress of their complaint. In contrast, only 11 per cent of trusts reported they did not update complainants on progress with their complaint.

Around two thirds of trusts consulted complainants at an early stage to assess expectations

2.36 Seventy per cent of trusts consulted complainants in the early stages of the complaints process to establish the reasons for their complaint and 62 per cent of trusts consulted complainants to establish the kind of resolution they were seeking. Around a third of trusts therefore dealt with complaints without assessing the expectations of complainants. Complaints managers interviewed told us that face to face meetings were one of the most effective ways to resolve complaints to the satisfaction of the complainant. The scale of complaints received by trusts, however, often precluded such meetings, with acute trusts for example receiving an average of 393 complaints in 2006-07.

> "Staff are very good at meeting with complainants at any meetings I've been involved in. It's quite amazing how much better you can resolve those issues, rather than keep writing."
>
> *Source: National Audit Office interviews with NHS trusts*

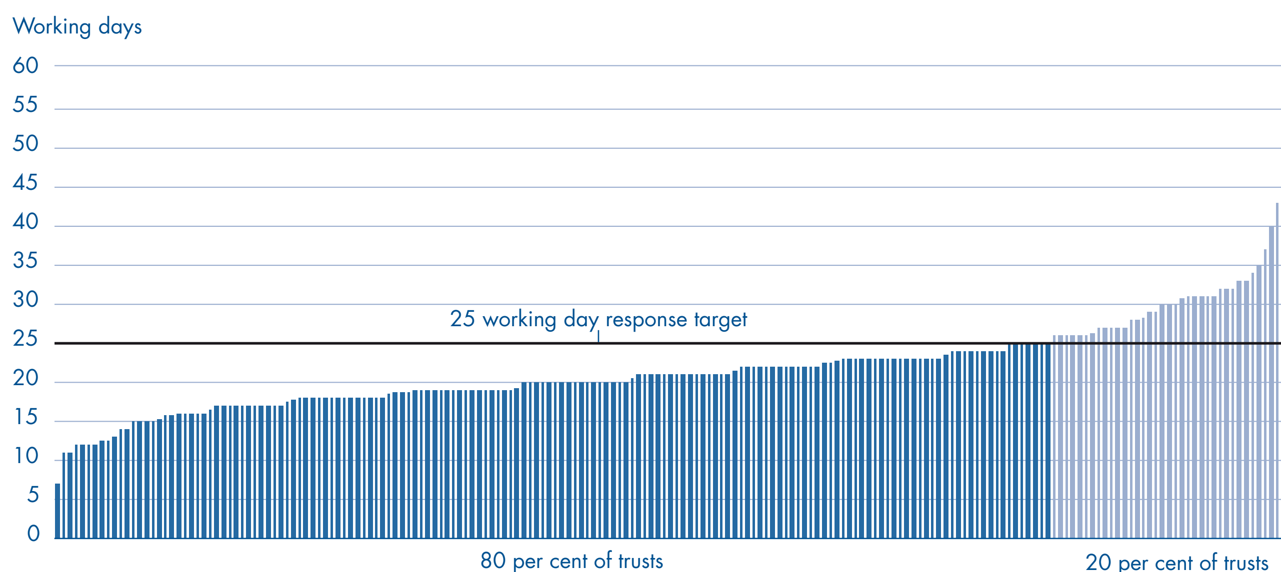
On the effectiveness of the systems for complainants dissatisfied with the initial response

The Department and the Healthcare Commission underestimated the demand for independent reviews

2.37 Prior to giving statutory responsibility for independent review to the Healthcare Commission in 2004, the Department did not prepare a detailed business case. In discussion with the Healthcare Commission it estimated that between 3,500 and 5,000 requests for independent review would be made each year. During its first year of operation, the Healthcare Commission received 8,495 requests, 361 of which were received prior to the new complaints legislation coming into force on 30 July 2004.

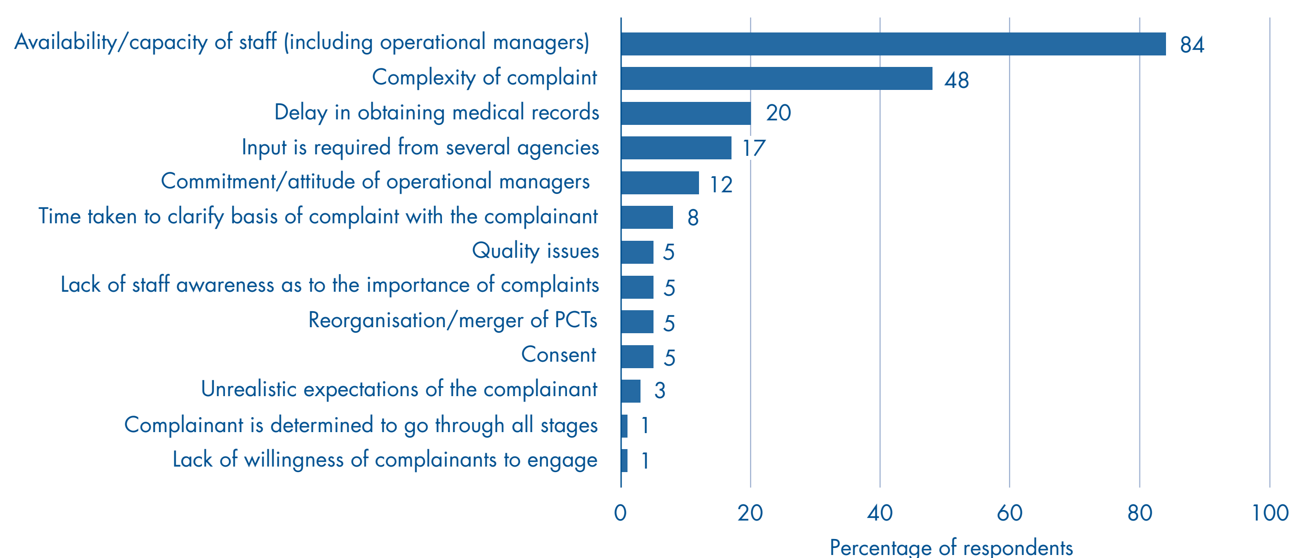
2.38 Based on the suggested level of complaints, the Healthcare Commission initially expected a monthly volume of between 290 and 420, but the average volume of incoming cases in the first four full months of operation was 700. The Healthcare Commission did not have sufficient staff or independent clinical input to deal with this number of complaints and, from the outset, a backlog developed and continued to grow until the number of open cases reached a peak of 5,384 in May 2006, of which 835 had been open for more than 12 months. The Healthcare Commission increased its complaints handling staffing levels from 24 in July 2004 to 122 in June 2006, at which point the backlog began to decrease **(Figure 17 on page 28)**. Since July 2006, the Healthcare Commission has employed an average of 160 complaints handling staff and by the end of March 2008 the number of open cases had been reduced to 1,474. Towards the end of 2006, the Healthcare Commission also introduced a performance improvement plan which included the establishment of a specialist team to procure independent clinical advice.

15 Eighty per cent of trusts respond to complaints within an average of 25 working days



Source: National Audit Office census of NHS trusts

16 Main barriers to responding to complaints within the timescale



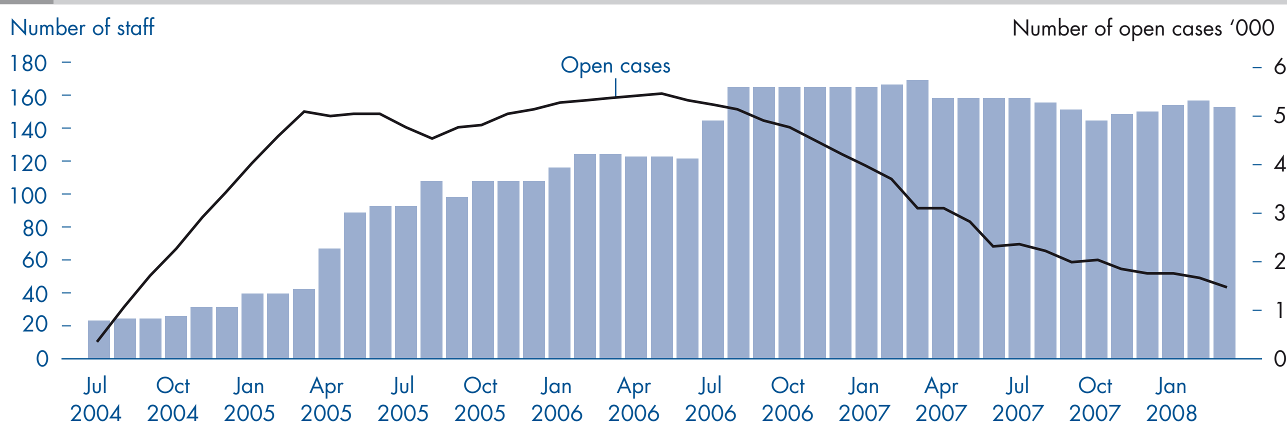
Source: National Audit Office census of NHS trusts

It took the Healthcare Commission two years to meet its internal target to close 95 per cent of cases within 12 months, but its performance has steadily improved since then

2.39 Upon taking up its role in July 2004, the Healthcare Commission set itself a service level agreement target to close 95 per cent of cases within 12 months. It took two years before the 12 month target was met **(Figure 18)**. Although the Healthcare Commission has continued to receive around 700 cases a month, it has consistently met its target since then.

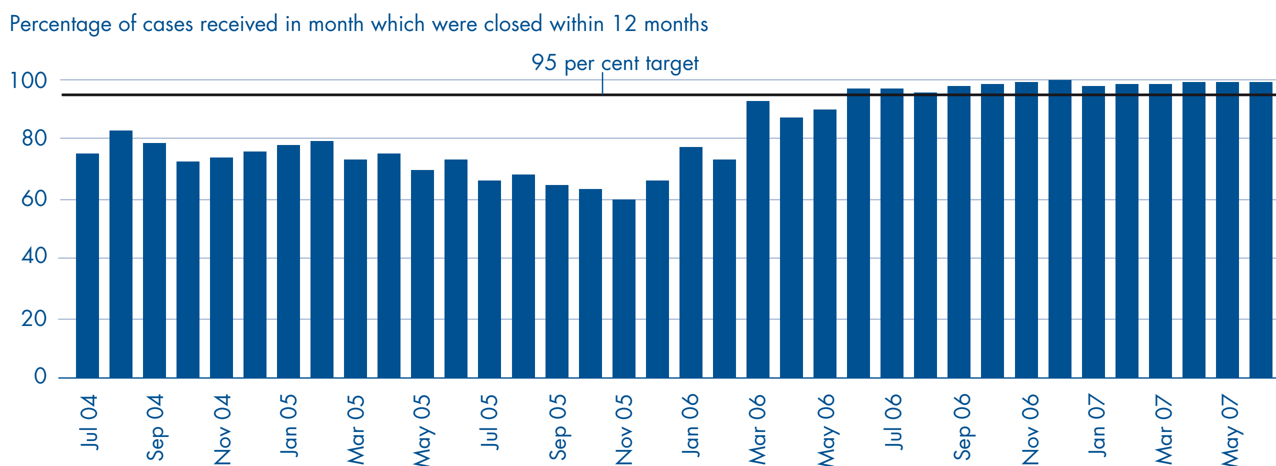
2.40 The Healthcare Commission has also made improvements in reducing the average age of open cases from a peak of over seven months in January 2007 to around two and a half months in March 2008. The proportion of cases that had been open for six months or longer was also reduced from a peak of 58 per cent of all open cases in August 2006 (2,880 cases) to 12 per cent of all open cases in March 2008 (171 cases). The number of cases that had been open for 12 months or longer was reduced from a peak of 1,083 in November 2006, to just six in March 2008. Ninety five per cent of cases now take less than seven months to conclude.

17 The backlog of cases continued to grow until sufficient levels of staff were in place



Source: Healthcare Commission

18 The Healthcare Commission's performance against its Service Level Agreement target



Source: Healthcare Commission

A survey undertaken on behalf of the Healthcare Commission at the time of the worst backlog found that independent reviews were not meeting the expectations of over half of complainants

2.41 In April 2007, the Healthcare Commission published a report it had commissioned from BMRB based on a survey of 1,504 complainants whose cases were closed between July 2005 and July 2006, and interviews with 93 NHS complaints managers.[35] The survey, whose population consisted of complainants whose cases had been reviewed when the Commission had a large backlog of cases (paragraph 2.38), found that only 26 per cent of complainants thought the complaints review function was independent.

2.42 Half of complainants (52 per cent) said that the service did not meet their expectations; the main reason cited being that the process was too slow. Sixty one per cent were very or fairly dissatisfied with the process overall. Satisfaction was, however, strongly related to outcome, with those who had a favourable outcome being more satisfied. In more recent feedback to the Healthcare Commission, from complainants whose cases were closed when the backlog had begun to fall (between August 2006 and July 2007), the number who thought their case had been handled independently had increased to 63 per cent.[28]

Complaints managers were concerned about the time taken by the Healthcare Commission to respond to complaints and the quality and consistency of reviews, although many found its recommendations useful

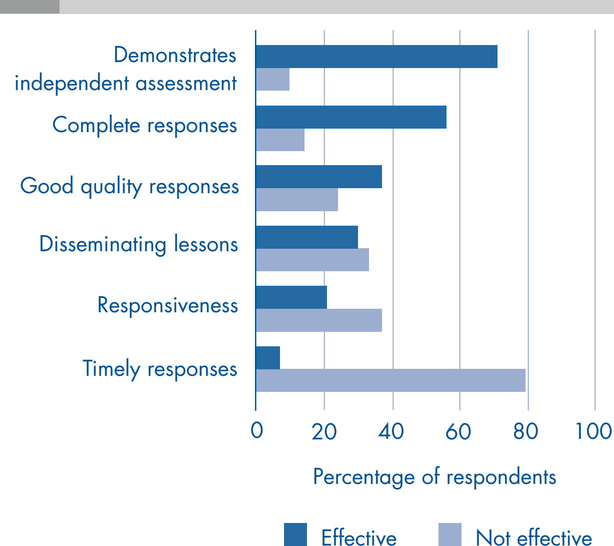
2.43 In our census we asked complaints managers for their assessment of the effectiveness of the Healthcare Commission's role in terms of timeliness, thoroughness and independence. The Healthcare Commission scored most highly on independence but complaints managers were less positive about its timeliness **(Figure 19)**. BMRB's research also found that the quality of responses and consistency of reviews was variable, with a quarter of complaints managers rating the Healthcare Commission as not effective in producing responses of a good quality and two thirds of complaints managers rating the process as inconsistent. Nevertheless, two thirds of complaints managers who had received recommendations from the Healthcare Commission had found them to be very or fairly useful.[35]

In 2006-07, the Healthcare Commission received 7,696 requests for independent review and took an average of 171 days to close a case

2.44 In 2006-07, the Healthcare Commission received 7,696 requests for independent review and its complaints review function cost £9.8 million. During this period it closed around 10,000 cases of which around 15 per cent were upheld or partially upheld in favour of the complainant.[36]

2.45 We undertook an independent assessment of the Healthcare Commission's performance in terms of the time taken to close a case by examining a random sample of 130 cases drawn from cases closed during 2006-07. Our analysis found it took on average 171 working days to close a case, with the highest being 648 working days and the lowest six working days.

19 Complaints managers' perception of the effectiveness of second stage independent review by the Healthcare Commission



Source: National Audit Office census of NHS trusts

The Healthcare Commission's complaints role has delivered benefits

2.46 The Healthcare Commission has published three reports which between them describe the findings of an audit of complaints handling in 42 trusts and provide an overview of the handling of the 26,000 cases it received and reviewed between July 2004 and July 2007.[21, 28, 33] By publishing these reports the Healthcare Commission has contributed to national learning on the effective handling of complaints by highlighting best practice; identifying gaps in practice; and making recommendations on how complaints handling can be improved **(Figure 20)**.

The Health Service Ombudsman is the ultimate reviewer of NHS complaints

2.47 If a complainant remains unhappy after local resolution and independent review they can complain to the Health Service Ombudsman, which is independent of the NHS and Government. When the Health Service Ombudsman receives a request for an independent investigation it will initially review the Healthcare Commission's response and take one of three actions:

- Not uphold the complaint against the Healthcare Commission.
- Uphold the complaint against the Healthcare Commission and refer it back so that further work can be carried out to address the failings identified.
- Uphold the complaint against the Healthcare Commission and decide to investigate the substantive complaint.

2.48 In certain circumstances complaints may be referred directly to the Health Service Ombudsman by the Healthcare Commission or the complainant. Such cases include those concerning retrospective continuing care funding or where the complainant has a terminal illness. The Health Service Ombudsman also has discretion to investigate cases that have not exhausted the complaints process, for example where the relationship has broken down to the extent that a resolution is unlikely at the earlier stages, or those cases which have both health and social care elements.

2.49 In 2006-07, the Health Service Ombudsman accepted 862 cases for review (around 0.6 per cent of all NHS complaints), 575 of which had been reviewed by the Healthcare Commission. Fifty two per cent of cases were wholly or partially upheld in favour of the complainant and all the recommendations made by the Health Service Ombudsman during 2006-07 were either accepted or are being considered by the body or practitioner complained about.[37]

2.50 The Health Service Ombudsman has published three reports, intended to help trusts and health authorities improve the handling of complaints about continuing care funding.[38, 39, 40] The Health Service Ombudsman's work identified circumstances where some people had wrongly been denied funding leading to them having to pay for care themselves. These reports have provided valuable lessons and since publication, complaints about continuing care funding are a decreasing part of the Health Service Ombudsman's workload – 352 cases in 2006-07 (31 per cent of all health cases reported), of which 85 per cent were fully or partly upheld compared with 1,097 (58 per cent of all health cases reported) in 2005-06, of which 92 per cent were fully or partly upheld.

2.51 Complaints managers rated the Health Service Ombudsman's performance highly in terms of independence, quality and completeness but least effective in terms of timeliness. The Health Service Ombudsman underperformed against its timeliness targets in 2006-07, completing 17 per cent of cases within three months against a target of 30 per cent, and 80 per cent of cases within 12 months against a target of 90 per cent.

On learning lessons from complaints to improve complaints handling and improve services

Complaints information is not always fully integrated with other business management information and data systems are under-utilised

2.52 In our census, 90 per cent of trusts reported that they learned lessons from complaints as part of an integrated risk management system. The Healthcare Commission found, however, that although complaints data may lead to one off changes to service delivery, these are not necessarily shared across trusts or health economies.[21] We found that just under half the trusts we interviewed integrated complaints information with data on litigation, patient safety incidents and contacts with PALS in any systematic way. Those trusts that did so were able to share themes and identify issues in a timelier manner. In many cases, complaints managers acknowledged that more could be done to utilise the information collected to provide a more integrated approach to risk management.

20 Main findings of the Healthcare Commission's reviews of complaints handling in the NHS

Published	Report	Main findings
January 2007	*Spotlight on Complaints. A report on second-stage complaints about the NHS in England*	Identified problems in the way that complaints are handled locally by the NHS based on complaints received and reviewed between July 2004 and July 2006: ■ failure to acknowledge that a complaint is valid; ■ failure to apologise, even where local shortcomings are identified; ■ responses which do not explain what steps have been taken to prevent the recurrence of an event which has given rise to a complaint; ■ responses which contain technical or medical terms, which the complainant may not understand; ■ failure to involve staff directly concerned in the complaint in the local investigation; and ■ a lack of capacity in terms of the availability of well supported and trained complaints investigators and clinical advisers to provide robust local investigations.
October 2007	*Is Anyone Listening? A report on complaints handling in the NHS*	This audit of complaints handling in 42 trusts found that: ■ complaints handling differs across the country and processes are applied inconsistently within trusts and across the NHS; ■ there is little evidence of trusts using complaints data to inform their decision-making when commissioning services, particularly the services of independent contractors; ■ trusts use many tools to capture and report complaints data but few trusts do it in a systematic way; ■ the NHS needs to do more to make the complaints system accessible; and ■ trusts emphasise procedures rather than outcomes.
April 2008	*Spotlight on Complaints. A report on second-stage complaints about the NHS in England*	Identified problems in the way that complaints are handled locally by the NHS based on complaints received and reviewed between August 2006 and July 2007: ■ procedures for handling complaints were not satisfactory in around half of the cases reviewed; ■ many trusts did not use the full range of options available to them to resolve complaints; ■ letters that confirmed the outcome of a complaint were often of poor quality, emphasising the process of the investigation rather than the outcome for the patient; ■ many letters did not use empathetic language when it was needed and did not explain complex medical terms; ■ many trusts did not test their responses to complaints against existing national guidance to support their statements that care was of a suitable quality; and ■ in many cases trusts had genuinely learned from things that had gone wrong and had taken remedial action, but did not tell the complainant.

Source: Healthcare Commission reports

PCTs find monitoring complaints about independent contractors challenging

2.53 Whilst PCTs are responsible for ensuring that independent contractors have a complaints procedure in place, in 2006-07 nine per cent of PCTs submitted incomplete information to the Information Centre for Health and Social Care because they did not receive returns for all contractors in their area.[26] We found variations in the extent of tracking and recording of complaints about independent contractors with some PCTs not recording or tracking any complaints. Where the population and contractors are spread over a wide area, monitoring complaints was a particular challenge.

Changes in NHS configuration have led to the disintegration of networks though the Voices for Improvement Action Network has been launched

2.54 Following the change in Strategic Health Authority (SHA) leadership since July 2006, complaints networks in some areas have disintegrated and there is no formal method to disseminate relevant information and learning. Twenty eight per cent of trusts no longer share lessons learned with the SHA. Of those that do, only 40 per cent rated their trust as effective in using this method. Although some complaints managers have formed their own networks (or maintained the previous networks), these networks are patchy and more established in some regions than others.

"We used to have the SHA Complaints Network but it's gone, so I really do feel that I'm not part of anything at the moment."

"We used to have excellent meetings with the former SHA; that's fallen by the wayside."

Source: National Audit Office interviews with NHS trusts

2.55 The Department launched the Voices for Improvement Action Network (VIAN) in September 2006 with the aim of providing a facilitated local-based network for NHS and social care complaints staff. VIAN groups' objectives are to provide a forum for health and social care managers to meet, exchange experience, learn about national developments and discuss approaches which foster closer working relationships and coordination across health and social care (for instance, in delivering joined up responses to complaints which cut across health and social care). The Department also intends VIAN to improve management of, and leadership for, those working on complaints locally. Our interviews with complaints managers, however, found wide variability in awareness and activity levels of VIAN groups, ranging from regular attendance at meetings to some cases where VIAN had not even been heard of. Some experienced complaints managers did not attend as they were sceptical of the benefits for them from the networks, although they acknowledged the general benefits of such groups for people new to the complaints manager role.

"I've only been to one meeting so far but I found it quite interesting. I think it would be really helpful if it brings about a seamless service."

"We've been attending their meetings and it has been really helpful to have the social services side…I think it's linking well."

"VIAN is not moving in this area at the moment. As far as I'm aware, we haven't got an identified VIAN leader so our meeting is basically our ad hoc VIAN network."

"What was VIAN? …I had a few emails but I've had nothing else since."

Source: National Audit Office interviews with NHS trusts

The effectiveness of adult social care complaints handling

3.1 The statutory complaints procedure for adult social care was introduced in 1991. Since then the system has evolved incrementally, until the current adult social care complaints procedure came into effect in September 2006. It covers all local authorities and applies to social care service users whose care has been funded following a needs assessment. Complaints can be made by the person receiving the service, or by someone acting on their behalf.

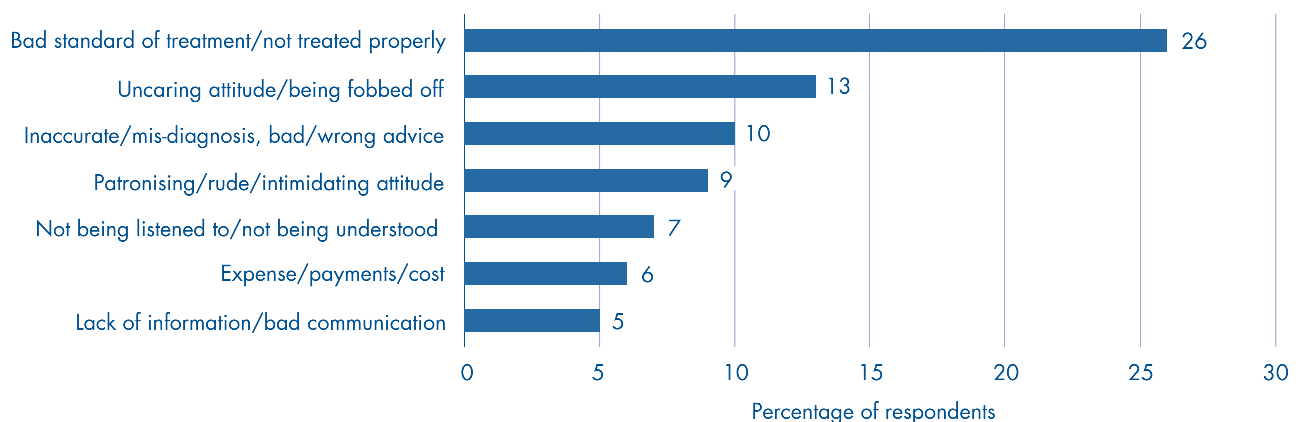
3.2 Our examination of the adult social care complaints procedure draws on the findings from our census of local authorities; our visits to 19 local authorities; and the omnibus survey we commissioned. It also draws on interviews with and reports and data presented by other organisations such as the Local Government Ombudsmen, the Commission for Social Care Inspection and the Department of Health.

On access and confidence in the system

A third of those dissatisfied with adult social care services make a formal complaint

3.3 Our survey found that six per cent of adults in England have had some contact with social care service providers in the last three years. Of those who had contact, 86 per cent were satisfied with their experience, whilst 14 per cent had in some way been dissatisfied. Respondents were most frequently dissatisfied with their social worker (29 per cent) or home help (26 per cent). The most common reasons for dissatisfaction are shown in **Figure 21**.

21 Common reasons for dissatisfaction with adult social care services



Source: Omnibus survey carried out on behalf of the National Audit Office

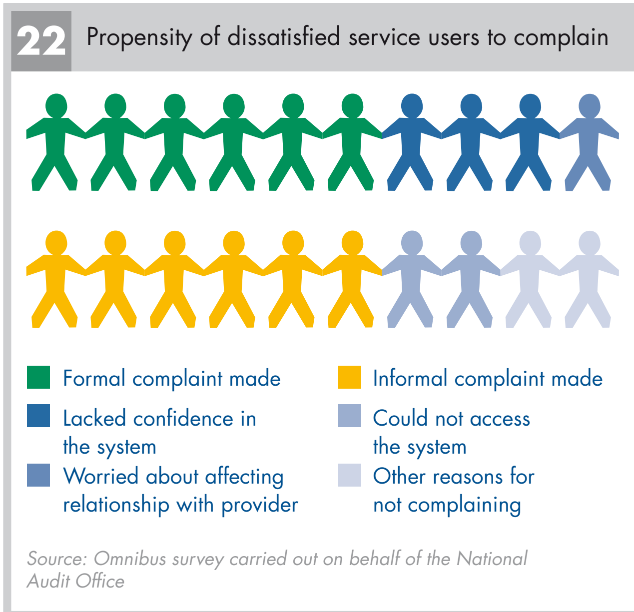
3.4 Thirty two per cent of those dissatisfied with the services they had received made a formal complaint and a further 30 per cent made an informal complaint to which they did not expect a written response. Thirty eight per cent did not complain at all **(Figure 22)**. Most commonly, people who chose not to complain did not do so because they did not feel anything would be done as a result (31 per cent).

3.5 Our survey also found that 17 per cent of people are reluctant to complain because they have an ongoing relationship with a service provider, for example their social worker. Four per cent did not wish to damage the relationship with their service provider and a further 13 per cent did not want to be perceived as a troublemaker. Help the Aged has highlighted in particular older people's perception that complaining might compromise their care.

"Older people often feel concerned about making a complaint, because they either do not want to make a fuss, or they hold the perception that their care will be compromised as a result of their complaint. This is also true of older people's relatives or friends who may feel the same way. They build relationships with carers who are providing very personal services and do not like to offend these people whom they depend upon."

Source: Help the Aged response to Department of Health consultation 'Making Experiences Count'

22 Propensity of dissatisfied service users to complain



Source: Omnibus survey carried out on behalf of the National Audit Office

3.6 The perception that nothing will be done as a result of making a complaint is consistent with our census finding that 38 per cent of adult social service departments do not publicise changes they have made as a result of complaints. Indeed, complaints managers told us it is difficult to evidence learning from complaints.

"What we have to get better at is showing people how things change as a result of complaints and how they change in a good way…being able to feed back to people and saying 'right, as a consequence of this, we've done this, this and this'– because so often we're not very good at that and I think that's an area that we've got to work on."

Source: National Audit Office interviews with local authority complaints managers

3.7 Two thirds of adult social service departments have a representations process where concerns or complaints can be dealt with without going through the formal statutory procedure. Those authorities that were able to provide data on the number of representations received reported a total of 3,800 in the six month period leading up to 31 March 2007, an average of 55 for each authority responding.

Advocacy provision is inconsistent nationally and service user take up is low

3.8 Once a service user has accessed the complaints procedure they may require assistance in making their complaint, but there is no statutory requirement for adult social service departments to provide advocacy to help complainants. Local authorities make their own arrangements for the funding and provision of advocacy and therefore the support offered to complainants varies throughout the country.

3.9 Respondents to our census reported just 300 requests for advocacy in 2006-07, an average of less than three requests per authority responding, covering just 2.4 per cent of the complaints received by those authorities. In nearly a quarter of authorities complainants were only informed about available advocacy services upon request. In our interviews, complaints managers told us that they see themselves as having an informal advocacy role in guiding the service user through the complaints procedure.

3.10 Only a third of local authorities responding to our census were able to provide information regarding expenditure on advocacy. Nearly half of these stated that they did not spend anything at all (which may be the result of reliance upon charitable organisations), and a third did not provide advocacy in response to every request. Advocacy services are often paid for using a flat fee, regardless of usage. With such low levels of take up, value for money may not always be achieved from such arrangements. Based on average expenditure amongst respondents to our census, we estimate that local authorities spent £1.3 million on advocacy support for complainants in 2006-07.

On organisational culture and attitude to complaints

Leadership and support from senior management is important for effective complaints handling

3.11 We examined through our census the extent to which the culture within local authority adult social service departments was open and fair in relation to the handling of complaints. The overall complaints culture is perceived by complaints managers (50 per cent) and directors (48 per cent) to be open and fair. Forty seven per cent of complaints managers and 52 per cent of directors acknowledge, however, that there may be some pockets with a tendency towards a more blaming and closed culture.

3.12 In our interviews complaints managers told us that support from senior management was a crucial factor in allowing them to manage complaints effectively, more so than their own level of seniority within the authority. We were also told that locating complaints managers close to senior management promoted effective working relationships and provided a clear message to staff about management ownership of complaints handling.

"If you've got your complaints team just up the corridor it makes senior management own it……If you bury your complaints team structurally and geographically then it's quite easy to deny all knowledge of them."

Source: National Audit Office interviews with local authority complaints managers

3.13 Two thirds of complaints managers report directly to senior management, with three quarters providing them with complaints information on a quarterly, or more frequent, basis. Seventy one per cent of adult social service departments had complaints on the agenda of senior management team meetings at least quarterly, though in eight per cent of authorities complaints were only on the agenda annually.

Training, skills and support for complaints managers and operational staff varies

3.14 The role of complaints manager is rarely a senior management position and is usually positioned several levels below the adult services director, who represents the first tier of the management structure. Just over half of complaints managers have a salary lying between £26,000 and £35,000, with 35 per cent earning between £36,000 and £45,000.

3.15 In our interviews, complaints managers identified a range of skills which are commonly perceived to be vital for their role. There is, however, currently no formalised skill set and the level of training received by adult social care complaints managers varies widely. The most common complaints training received was provided by the Local Government Ombudsmen which around a quarter of complaints managers had attended. Thirteen per cent of complaints managers reported having received no training in complaints handling.

3.16 The arrangements for training front-line service teams vary from mandatory training to no training at all. In 71 per cent of local authorities, complaints training is covered as part of the induction programme for general adult social care staff. A quarter of authorities have a compulsory training module for general staff, with 51 per cent offering an optional module. In eight per cent of authorities, however, there is no formal training available for general adult social care staff on how to handle complaints. Staff who are the subject of a complaint receive support from line managers and complaints managers. Support is also provided through counselling, access to mentors, and encouraging staff to seek support from their professional body, union, or colleagues.

On the time taken to respond to a complaint and the adequacy of the response

Ninety five per cent of complaints do not proceed beyond Stage 1 of the complaints process but quality and complainant satisfaction are rarely measured

3.17 Of the 17,100 formal complaints that local authorities received in 2006-07, most (95 per cent) were concluded at Stage 1. Service teams take the lead in forming a response and complaints are usually investigated by the manager of the service area in question. Just one per cent reached the third stage. The high percentage of complaints which do not proceed beyond Stage 1 may indicate effective local resolution, but there is a paucity of information to assess whether complainants have been satisfied with their response.

3.18 There is no national monitoring or analysis of complaints handling performance in adult social care and arrangements have not been made to evaluate whether the current complaints procedure is achieving the aims which were set out as the key principles for the system. This deficiency is partly a result of the way in which social care complaints handling has developed, with no national body having oversight of the complaints system and the Commission for Social Care Inspection not having had responsibility for the independent review of social care complaints.

3.19 Three quarters of adult social service departments did not conduct a satisfaction survey of complainants in 2006-07. Response rates to satisfaction surveys are low and complainants are often unable to separate satisfaction with the way in which their complaint has been handled from satisfaction with the outcome of their complaint. The lack of a systematic, comprehensive approach to seeking feedback leaves a gap in terms of being able to learn from service users' experience of how their complaint has been handled.

Local authorities respond to three quarters of Stage 1 complaints within the 20 working day target

3.20 Between 1 October 2006 and 31 March 2007, 77 per cent of Stage 1 complaints were responded to within the 20 working day timescale, with an average response time of 16 working days. Eighty one per cent of local authorities average 20 days or under, with averages ranging from two days to 47 days **(Figure 23)**. The main barriers to responding within the timescale are shown in **Figure 24**.

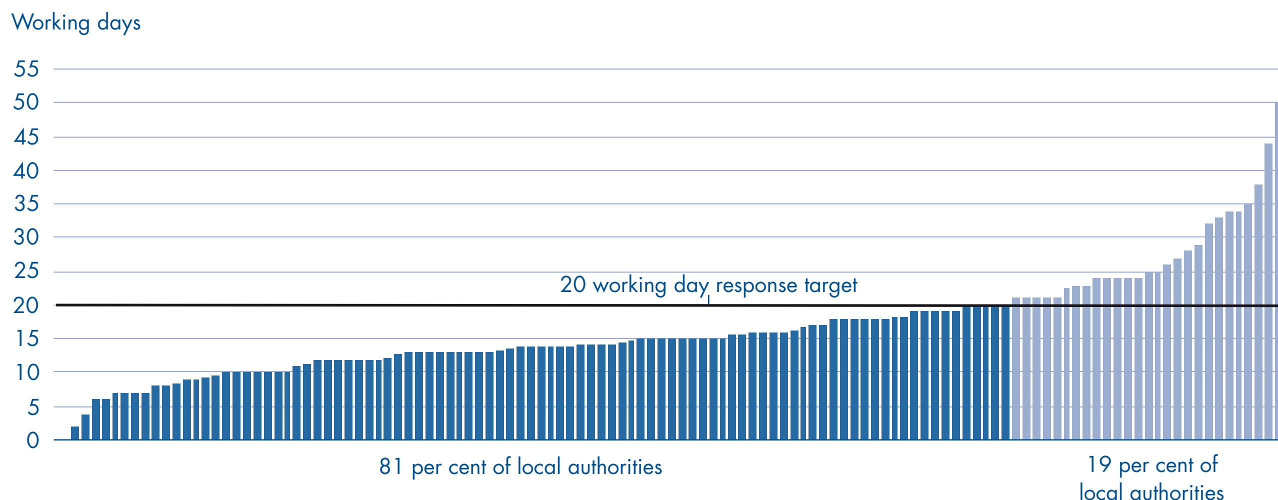
3.21 In our interviews, complaints managers told us that target timescales enable them to communicate to local authority staff the importance of the timely handling of complaints, and to give the complainant a clear picture of when they can expect to receive a response. Our omnibus survey found that 35 per cent of people were not kept up to date on the progress of their complaint.

Emphasis on local resolution and early personal contact promotes the swift resolution of complaints

3.22 Complaints managers considered that one of the most important factors in resolving complaints successfully was to have early contact with complainants, and 90 per cent of local authorities stated that they consulted complainants early in the process. Personal contact, whether face to face or by telephone, can help to clarify the terms of the complaint and the kind of resolution the complainant is seeking. It can also provide the complainant with confidence that their concerns are being addressed.

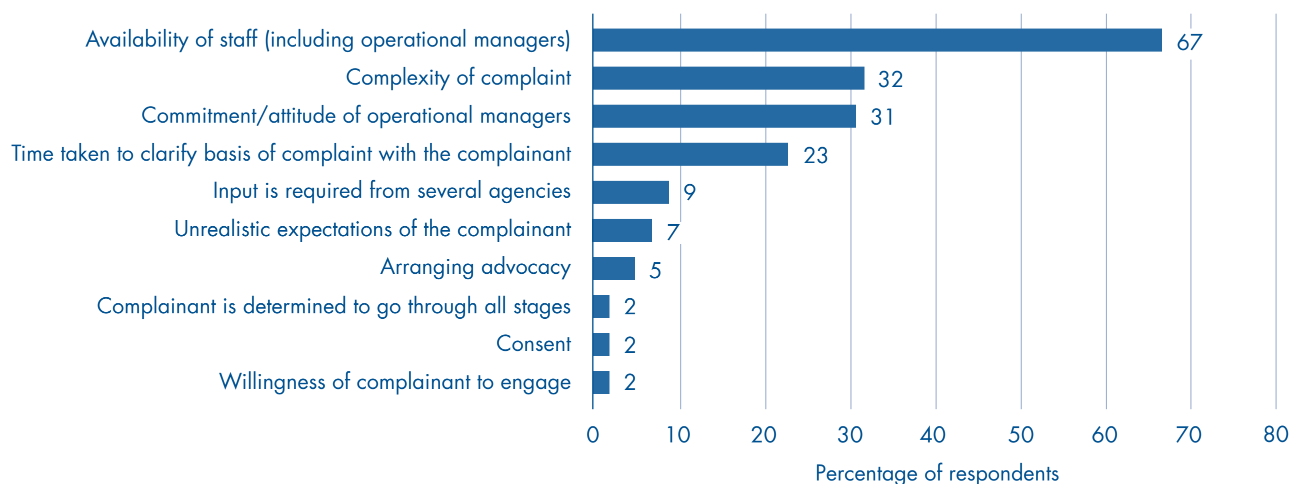
> “So you find that it works with a face to face meeting and those ones where you're likely to get the people being dissatisfied usually is where they've had a response without somebody having spoken to them.”
>
> “The main thing is about seeing people; if you see people, most complaints end from there really because they feel that someone's taking it seriously.”
>
> *Source: National Audit Office interviews with local authority complaints managers*

23 Eighty one per cent of local authorities respond to complaints within an average of 20 working days



Source: National Audit Office census of local authorities

24 Main barriers to responding to Stage 1 complaints within the timescale



Source: National Audit Office census of local authorities

3.23 Complaints managers told us that the most common reasons for complaints escalating were not addressing all of the complainant's points and a failure to apologise in the initial response. Our omnibus survey supports this, with almost a quarter of people stating that an apology or acknowledgement of the problem would have improved the handling of their complaint.

On the effectiveness of the systems for complainants dissatisfied with the initial response

The arrangements for Stage 2 investigations of adult social care complaints vary between local authorities

3.24 Complaints managers appoint investigating officers to lead the investigation of a complaint at Stage 2. The officer must not be in the direct line management of the service or person about whom the complaint is being made but may be an employee of the local authority ('internal') or wholly independent of the local authority ('external'). Use of internal and external investigators varies across the country. Fifty six per cent of local authorities use a mixture of internal and external investigators, 37 per cent use exclusively external investigators, and seven per cent use only internal investigators.

3.25 In our interviews, some complaints managers considered that using an employee of the local authority as an investigating officer at Stage 2 did not provide a sufficient level of independence for the investigation or did not provide the perception of an independent investigation for the complainant. Other complaints managers reported that even where the investigating officer is external, some complainants still do not consider them to be independent as they are commissioned and paid for by the local authority.

3.26 There is no required experience, training or qualification for Stage 2 investigators. Sixty nine per cent of local authorities provide training to investigators or will include them in training provided by the Local Government Ombudsmen. Such training may include information about report writing skills, areas relating to key legislation or details of local policy initiatives.

Local authorities struggle to meet the 25 working day target for Stage 2 complaints, but consider local review supports local ownership of action arising from complaints

3.27 Of the 17,100 Stage 1 complaints received in 2006-07, 900 (5.3 per cent) progressed to Stage 2 of the procedure. In 2006-07, Stage 2 investigations took an average of 63 working days. Between 1 October 2006 and 31 March 2007 less than a quarter of Stage 2 complaints were responded to within the 25 working day target. This can be extended up to 65 days, however, and 81 per cent were dealt with within the extended timescale. **Figure 25** shows the main barriers to responding to Stage 2 complaints within the timescale.

3.28 Complaints managers told us that it is important for local authorities to have ownership of the complaints that they receive. Where the authority generates its own action points from complaints, or commissions the investigator itself, there is an implicit acceptance of the validity of those recommendations and an improved likelihood that they will be implemented.

"…emphasis has to be about local resolution and, unless you have a fully independent complaints process, you take away the ownership of the complaint from the local authority because the local authority can sit there and say 'we're not happy with that but they've made us do it' and I think the best complaints resolutions in any negotiations is the face to face stuff between the person who has complained and the authority that's being complained about, so local resolution is the real key."

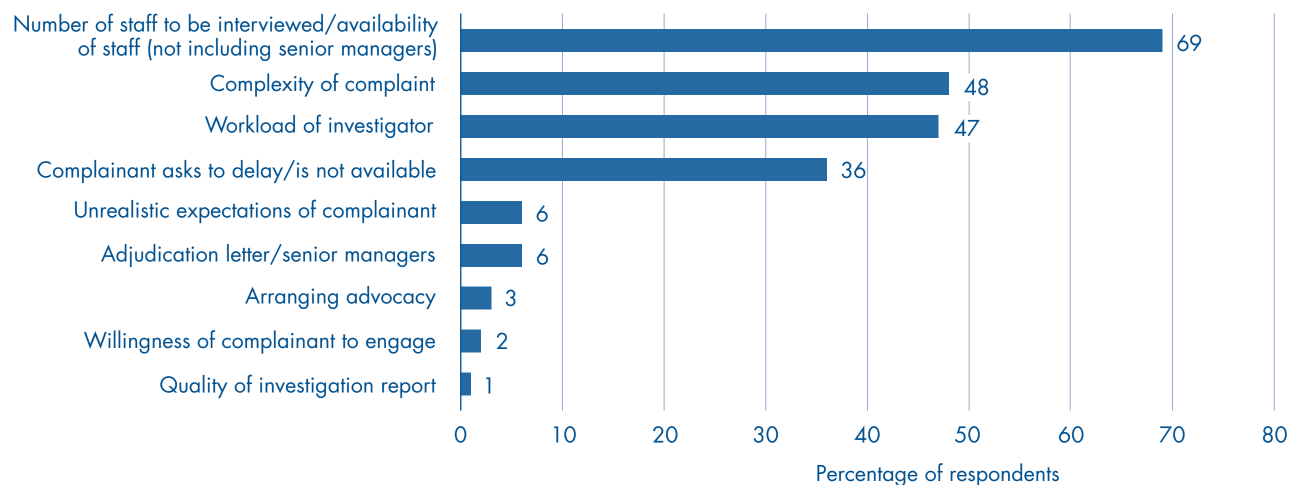
"If they're part of the investigation and they feel that that's been done in the spirit of finding a solution that's fair and workable for everybody, then I think you've got more of a chance of making it work and making a change."

Source: National Audit Office interviews with local authority complaints managers

Complaints managers have contrasting views about the usefulness of Stage 3 panel reviews and struggle to organise them within the timescale

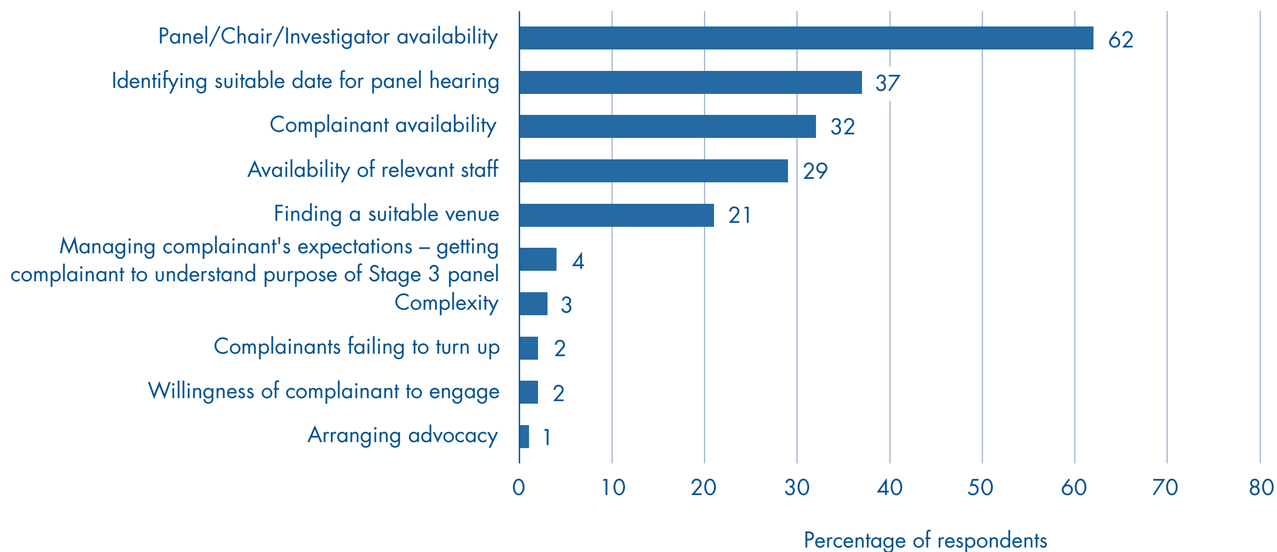
3.29 Respondents to our census reported that 200 Stage 3 review panels, which review local handling of individual complaints, were held during 2006-07. Two thirds of Stage 3 panels were held within the 30 working day timescale, with the most common barriers to timely handling reported as panellist and investigator availability **(Figure 26)**.

25 Main barriers to responding to Stage 2 complaints within the timescale



Source: National Audit Office census of local authorities

26 Main barriers to meeting Stage 3 review panel requirements within the timescale



Source: National Audit Office census of local authorities

3.30 Complaints managers had mixed views about the usefulness of Stage 3 reviews. Some told us that they are overly bureaucratic, hard to organise and that they can be intimidating, especially for more vulnerable complainants. Other complaints managers consider that the review provides an independent assessment of the way the complaint was handled and gives complainants the feeling that they have "had their day in court". There is, however, a common misconception amongst complainants that the review panel will reconsider their complaint, whereas the purpose of the panel is to evaluate whether the local authority has adequately considered the complaint in the Stage 2 investigation. When asked to state if there were any aspects of the current system they would like to see removed or revised 29 per cent of complaints managers and 28 per cent of directors answered "the Stage 3 panel review".

"…the complainant found it so traumatic and she cried the whole way through."

"People have told me they feel that they really are being heard and it's something to do with the way the panel operates; that they are centre stage, they're asked first what they want out of it, their opinion is sought by somebody who isn't the department and isn't the investigator."

Source: National Audit Office interviews with local authority complaints managers and directors

In 2006-07, the Local Government Ombudsmen obtained a remedy for over 150 complainants

3.31 The Local Government Ombudsmen (LGO) received 795 complaints on adult social care in 2006-07.[41] Of these 254 were judged to be premature, and referred back to the relevant local authority for a response and a further 59 were outside the Ombudsmen's jurisdiction. Of the complaints decided upon in 2006-07, a local settlement was agreed by the authority in question in 141 cases and the LGO reported maladministration and injustice in the handling of the complaint in ten cases.[b]

3.32 The LGO do not hold data concerning the route by which they have received complaints and so it is not possible to determine how many of the estimated 200 complaints reviewed at Stage 3 progressed to the LGO. A complainant does not have to exhaust all stages of the local authority procedure before being accepted by the LGO and in exceptional circumstances, for example where someone is particularly vulnerable or it appears that an entire administrative system has broken down, the LGO will consider becoming involved sooner.

On learning lessons from complaints to improve complaints handling and improve services

Although lessons are shared from complaints handling across local authorities, there is no systematic way of capturing and disseminating learning to improve services

3.33 Ninety two per cent of local authorities said they had a clearly defined system for learning from complaints. Complaints managers told us, however, that effectiveness in monitoring and implementing recommendations from complaints needed to be improved.

3.34 When a Stage 2 investigating officer has concluded their investigation they issue a report with recommended actions. The local authority then formulates actions to be taken in response to the recommendations, along with timescales for their implementation. There is, however, no formal means through which lessons are captured from the 95 per cent of complaints that are concluded at Stage 1, meaning opportunities to learn are being lost for the vast majority of complaints. Common to both stages is the lack of a systematic way to monitor the implementation of any recommendations made.

3.35 For contracted out services, one third of local authorities were kept informed about complaints relating to external providers directly by the providers themselves. Local authorities rely mainly on contractual arrangements to gain assurance that complaints handling processes are in place in services they commission.

3.36 Complaints managers considered that the National Complaints Managers Group (NCMG), which has been in place since the 1990s, was the most effective way of sharing lessons and learning from other organisations. Whilst complaints managers value highly the NCMG as a source of support and sharing lessons, there is currently no means (for example a database or other knowledge management tools) through which good practice and lessons in complaints handling or service improvements are captured for wider learning with local authority colleagues.

b The term local settlement is used to describe the outcome of a complaint where, during the course of the Ombudsman's consideration of the complaint, the local authority takes, or agrees to take, some action which the Ombudsman considers is a satisfactory response to the complaint and the investigation is therefore discontinued.

3.37 Until 2006, the NCMG operated a website through which examples of good practice were made available. A number of these examples were included in the Department's July 2006 guidance document, *Learning from Complaints*.[42] In September 2006, the Department of Health launched the Voices for Improvement Action Network (VIAN) to act as a local facilitated learning network for NHS and social care complaints staff (see paragraph 2.55 for more on VIAN).

3.38 Since the early 1990s, local authorities have been required to produce an annual report on complaints which, amongst other things, provides details of learning and service improvements. No assessment has been made, however, of the usefulness of these reports in identifying and sharing lessons from complaints. Our review of a random sample of around ten per cent of reports found that their quality, coverage and content varied considerably. We also found that although these should be made available to the public, one third of authorities did not publish their report on their website and 20 per cent did not publish it at all.

The Commission for Social Care Inspection has no responsibility for considering individual complaints or for examining the effectiveness of complaints handling

3.39 Unlike the Healthcare Commission, the Commission for Social Care Inspection has no responsibility for the direct consideration of individual complaints nor for providing national analysis and feedback on complaints handling. With no national body with an oversight of the adult social care complaints system, good performance is not identified and opportunities to document and spread good practice are missed. In addition, key lessons for service delivery arising from complaints made to individual authorities may not be effectively disseminated nationally and mistakes which might otherwise have been avoided may be repeated.

PART FOUR

Complaints handling going forwards

4.1 This Part of the report identifies the key activities that underpin the Department's implementation of its new proposed system, and the challenges that will need to be managed if the Department is to realise its expectations of the system. It draws on the evidence presented in Parts 1-3 of the report and on our review of complaints handling in Scotland, Wales and Northern Ireland (see Appendix 2), as well as lessons from other countries (a report is available at www.nao.org.uk).

4.2 The Department's commitment, in its January 2006 White Paper *Our health, our care, our say*, to introduce a comprehensive single complaints system across health and social care by 2009[24] was followed by a consultation (*Making Experiences Count*),[18] launched in June 2007 on how its proposal for a single system might work in practice (paragraph 1.13 and Figure 8). The four month consultation period sought views about what the new arrangements would need to include in order to be efficient, effective and fair. This consultation was carried out at the same time as our fieldwork for this report (Appendix 1). In February 2008, the Department published its formal response to the consultation aimed at clarifying and confirming the Department's aims for reforming the health and social care complaints arrangements.[43] The Department also began work on facilitating a smooth transition to the reformed complaints handling arrangements in April 2009, ranging from clarification of policy to practical front-line support and guidance.

The development of good practice guidance to inform roll-out prior to April 2009

4.3 In April 2008 the Department established an **Early Adopter programme** of 12 sites (covering 96 health and social care organisations) to: assist in developing arrangements for more effective local resolution; test how these might work in practice; and identify and resolve issues linked to transferring to the new system prior to wider implementation.[44] The programme which formally runs until the end of September 2008 leaves organisations free to determine local 'fit for purpose' arrangements within the framework described in *Making Experiences Count*. The Department plans to produce a package of good practice guidance to inform wider implementation prior to April 2009, using information gathered from the Early Adopter programme.

4.4 The Department is providing Early Adopters with **dedicated support** through a centrally led field team, including a restricted website for sharing experiences, a toolkit for complaints handling, and a helpline service providing expert advice for front-line staff. The Department held five **regional conferences** during July 2008 (attended by over 600 delegates from NHS and local authority organisations in England). It used these as an opportunity to have a local presence, share news on progress, and discuss specific areas or issues. It also allowed others to hear directly from the Early Adopters in their regions about their experience so far and for Early Adopters to begin to share good practice.

Changes in legislation and approach to health and social care regulation including the introduction of a new regulator registration requirement

4.5 Following the introduction of the new health and social care regulator, (the Care Quality Commission) on 1 April 2009 (paragraph 1.15) all providers of regulated health and adult social care services will need to register with the new Commission from April 2010. The Department has consulted on the registration requirements for safety and quality of care that providers will need to meet and expects to publish the results in the next few months. One of the proposed requirements relates to *Responding to people's comments and complaints*. The requirements will be set in secondary legislation and the new Commission will have a range of powers of enforcement where providers fail to meet the requirements.

4.6 The Department expects that the new regulator and commissioners of services will take into account the way complaints have been generally handled when assessing providers' performance. If complainants are unhappy with the way their individual complaint has been dealt with, the Health Service Ombudsman and Local Government Ombudsmen will provide an independent review of the handling of individual cases that come to them.

4.7 The Department is also consulting on the proposed NHS Constitution, published in June 2008.[45] The consultation runs until October 2008. The Constitution comprises commitments and pledges on rights for patients, the public and staff. It includes reference to the need for a system of redress that is both proportionate and has the trust of patients and the public. **Figure 27** sets out the coverage of the draft Constitution in terms of complaints and redress.

4.8 Finally, the Department is developing the principles for aspects of the general complaints framework (as described in *Making Experiences Count*) which it believes should be enshrined in secondary legislation. The framework will apply to all providers of NHS care (including foundation trusts, primary care providers, and the voluntary and independent sectors – via contracting arrangements with PCTs and local authorities) and social care arranged or managed by local authorities. The Department envisages laying amended regulations to that effect in early 2009.

Specific issues that need to be addressed to prepare for the introduction of the new system

4.9 There are five main issues that we have identified from our audit of complaints handling in health and social care organisations that we consider need attention if the new single comprehensive system is to be effective. Whilst these are relevant to both health and social care, there are differences in the challenges they present in each sector. In developing its guidance, the Department should evaluate the Early Adopter sites in relation to the issues identified below (see also our recommendations in the Summary).

- **Those wishing to make a complaint need clarity as to how to access the system, and to have confidence in it.** In particular, for NHS complaints there will still be a number of alternative routes depending on the nature of the complaint and the outcome expected and service users will need help to navigate the complaints system to enable them to choose the right route at the outset. For social care the main confusion is around eligibility of complaints from self funders. The Department will need to publicise the outcome of its proposal to extend the remit of the Local Government Ombudsmen to reduce the current

27 The draft NHS Constitution and complaints and redress

1. **You have the right** to have any complaint you make about NHS services dealt with efficiently and to have it properly investigated.
2. **You have the right** to know the outcome of any investigation into your complaint.
3. **The NHS will strive** to ensure that if you make a complaint, you receive a timely and appropriate response, that any harm you suffered is corrected where possible, and that the organisation learns lessons and puts in place necessary improvements. (pledge)
4. **The NHS will strive** to ensure that you receive appropriate support and are treated with respect and courtesy throughout the handling of any complaint you make, but the fact that you have complained will not affect your future treatment. (pledge)

Source: NHS Constitution

levels of confusion. In addition, complainants whose complaints cross the boundary of health and social care will need to be clear how to pursue their complaint and to know that the organisations concerned will take responsibility for providing one coordinated response. Advocacy arrangements differ between the NHS and social care. The proposal to make advocacy a universal right for all who require it needs to be communicated effectively to service users and there is also a need to clarify how, in practice, advocacy will be provided.

- **The culture and attitudes of organisations need to be more open and constructive towards complaints.** Chief executives and senior managers determine the culture of the organisation and need to convey to staff that complaints handling is an integral part of safety and quality and that all staff have a responsibility to respond openly and constructively to complaints. At the same time managers should be accountable for ensuring that the organisation has the resources to handle complaints and that all staff are aware of and have access to appropriate training and support where needed.
- **Complainants should receive a well informed response in a reasonable time, which addresses their concerns.** Complainants need clarity about the likely length and outcomes of the process, including progress updates, and also an opportunity to feed back their views on the way in which their complaint was handled. Responses to complaints which cross the boundary of health and social care must be properly coordinated to ensure that each aspect has been fully addressed.
- **Complainants who are dissatisfied with the initial decision on their complaint need to feel that their concerns will be investigated consistently and by people independent of the complaint.** The changes to the NHS complaints system in 2004 were largely in response to concerns about the need for independent investigation of complaints. The decision to remove the Healthcare Commission's independent review role places additional responsibility on local organisations to emphasise better resolution locally. Whilst independent review by the respective Ombudsman will remain, the impact on demand is unknown and there is therefore a need to model the potential impact this might have and the implication on resources at the local and Ombudsmen level. For example, when Scotland removed the independent review stage, there was a doubling in the volume of complaints received by the Scottish Public Services Ombudsman (Appendix 2).
- **Evidence is needed that lessons are being learned and services are improved as a result of complaints received being acted upon.** The removal of the Healthcare Commission's role in complaints handling could also undermine the scope for national learning and identification of good practice in respect of NHS Complaints. There is a need at the local level to identify and capture good practice locally and enable its dissemination across local bodies. The joint complaints managers' group VIAN has an important role to play here.

4.10 Throughout its work on reform to the health and social care complaints procedures, the Department has assessed the risks to be managed as the project moves towards implementation. It is therefore aware of, and recognises, many of the issues we have identified. It continues to work on identifying other potential risks that might arise during implementation (for example, through the Early Adopter programme, and continued stakeholder engagement), to ensure risks are mitigated and/or managed in the transition to the reformed procedures in 2009.

APPENDIX ONE

Methodology

The evidence used in this report was collected between September and December 2007. Our examination was scoped to focus on the complaints procedures for the NHS and for adult social care. It did not cover handling of complaints about NHS services provided in prisons, nor about children's social care services. There were six main aspects to our fieldwork:

- **A census of 394 NHS trusts and 150 local authority adult social service departments** carried out by the NAO. The NHS questionnaire was developed in consultation with the Information Centre for Health and Social Care Review of Central Returns (ROCR) Committee, who considered it to be useful and reasonable, in terms of the burden on NHS trusts (Gateway reference number ROCR-Lite/07/014/FT6). The Department of Health also reviewed the NHS and social services questionnaire, and the social services questionnaire was also reviewed by the Association of Directors of Adult Social Services. Questionnaires were piloted before despatch with complaints managers in NHS trusts and local authorities. The census therefore had two elements:
  - **Questionnaire to NHS trusts.** A census of NHS trust chief executives and complaints managers, including foundation trusts. Out of a total of 394 NHS trusts, 382 responses to the questionnaire were received (a 97 per cent response).
  - **Questionnaire to local authority social services departments.** A census of local authority directors of social services and complaints managers. Out of a total of 150 local authorities, 131 responses to the questionnaire were received (an 87 per cent response rate).

  In some cases, we used results from these censuses to extrapolate data to provide an estimated figure for all NHS trusts and local authorities, in particular questions about costs.

  In addition to this report we have produced individual feedback reports for each NHS trust and local authority to enable them to assess their data against other organisations in the census population.

- **Consulting users of NHS and adult social care services.** Two pieces of work informed our findings about the level of exposure to these services, the nature of dissatisfaction, peoples' propensity to complain and experience of complaining:
  - We commissioned TNS Global to carry out an omnibus survey of health and social care service users, including carers. TNS Global conducted three waves of face to face interviews. In total, 5,263 interviews were carried out. The questions were asked of adults (16+) in England. Overall 88 per cent had contact with NHS services in the last three years and six per cent had contact with social care services. Of these, 13 per cent and 14 per cent respectively were in some way dissatisfied with their experience, and our analysis focussed on these groups. Results were weighted to be nationally representative. A report covering the results of this survey is available at www.nao.org.uk.

- An online web forum of service users. The NAO designed an online web-based questionnaire accessible from the NAO website, where we invited service users to tell us about their experience of complaint handling in the NHS and adult social care. The questionnaire was promoted through contact with 26 groups representing service users (for example, the Patients Association, Help the Aged and Scope), and links were subsequently made through the websites of 13 organisations. We also commissioned Mencap to produce an easy read version of the questionnaire. A total of 229 responses were received between September and November 2007 when the questionnaire was closed down and responses analysed.

- Visits to and **semi-structured interviews** with 18 NHS trusts and 19 local authorities to gain a more in-depth understanding of complaints handling locally. In NHS trusts, we interviewed chief executives (or other board member responsible for complaints) and the complaints manager. For local authorities, we interviewed either the complaints manager or the director of social services.

- We also carried out an in-depth examination of **the performance of the Healthcare Commission in handling the independent review of NHS complaints** since July 2004. We interviewed Department of Health and Healthcare Commission officials, reviewed Healthcare Commission management and performance information, and carried out a random sample of 130 cases closed in 2006-07.

- We commissioned an independent **international review** of complaints handling in health and social care, to draw comparisons between countries and to shed light on the English experience. The researchers' selections of systems were those most likely to provide relevant lessons for England: Northern Ireland, Scotland, Wales, Australia, Canada, Denmark, Germany, New Zealand and The Netherlands.

- **Review of secondary data** available from the Department of Health, the Healthcare Commission, the Commission for Social Care Inspection, the Parliamentary and Health Service Ombudsman and the Local Government Ombudsmen.

- We also used meetings of the Department's Individual Voices for Improvement (IVI) Policy Forum to act as an **Expert Panel** which advised us on the scoping of the study and our emerging findings. The members of the Expert Panel were: Anita Harris, Programme Manager, Complaints Reform, Department of Health; Sue Heaven, Parliamentary and Health Service Ombudsman's office; Peter McMahon, Deputy Local Government Ombudsman; Gillian Johnson and James Johnstone, Healthcare Commission complaints function; Steve Carney, Commission for Social Care Inspection; Phill Sowter, Complaints Manager, London Borough of Camden; Jill Miles, South of England Advocacy Projects (SEAP); and Veronica Jackson, Association of Directors of Adult Social Services. We also kept the social care National Complaints Managers Group informed as the study progressed.

APPENDIX TWO

Complaints handling in Scotland, Wales and Northern Ireland

1 This Appendix summarises the systems in Scotland (since 2005), Wales (since 2003) and Northern Ireland (since 1996). These have developed independently of the system in England and have a minimum of two stages for health and three stages for social care. The scale of complaints also varies with NHS complaints in England nearly twelve times that in Scotland. The progression rates to the Ombudsman or equivalent range from one to four per cent with figures indicating that fewer stages mean an increased proportion of complaints reaching the Ombudsman, providing some indication of what may happen when independent Healthcare Commission review is removed in England. More details on these and other national complaints systems can be found at www.nao.org.uk.

Scotland	Wales	Northern Ireland
Policy and legislation		
Major review in 2002 and changes at the Scottish Parliament led to a new system from 1 April 2005. Directions to Health and Special Health Boards and the Agency of Complaints Procedures, NHS Scotland Act 1978 and SPSO Act 2002 clarify rights of complainants.	New guidance issued in 2003 following a two year review. From 1 April 2003 directions to NHS trusts and Local Health Boards provide the statutory framework of the complaints procedure.	Health and social care complaints procedure was developed in 1996, however following recent review new procedures are due in 2008. The Health and Personal Social Services (Northern Ireland) Order 2003 provide the current statutory framework for the complaints procedure.
Complaints procedures		
Health 1. Local resolution 2. Scottish Public Service Ombudsman (SPSO)	Health 1. Local resolution 1b. Local independent review[1] 2. Public Services Ombudsman for Wales (PSOW)	Health and social care 1. Local resolution 2. Local independent review by local Health and Social Services Board 3. Northern Ireland Commissioner for Complaints
Social care 1. Local resolution 2. Local review 3. Local independent review panel 4. Scottish Public Service Ombudsman	Social care 1. Local resolution 2. Formal consideration 3. Local independent review panel 4. Public Services Ombudsman for Wales	
Scale of complaints received at the first stage		
Health 11,200 Social care no data	Health 6,346 Social care no data	Health and social care 6,793

Scotland		Wales		Northern Ireland
Scale of complaints received at other stages (as a percentage of first stage complaints)				
Health	not applicable	Health	3 per cent → Stage 1b	No data
Social care	no data	Social care	no data	
Scale of complaints received by the Ombudsman/Commissioner (as a percentage of first stage complaints)				
4 per cent (complaints doubled when moved from three stage to two stage system in 2005 from 235 complaints reaching the Ombudsman in 2004-05 to 477 complaints reaching the Ombudsman in 2005-06).		3 per cent		1 per cent
Advocacy and support for complainants				
Support for health complainants is provided by the Independent Advice and Support Service (IASS). The service is provided by the Scottish Citizens Advice Bureau Service and is funded by local NHS Boards.		Community Health Councils provide an independent advocacy service to people wishing to make complaints about health services.		Complainants have a right to independent advocacy at any stage. This service is provided by independent Health and Social Services Councils.
Feedback and learning				
All complaints that reach the SPSO are examined by the NHS Head of Patient Focus. If a system-wide incident is identified it is brought to the attention of all NHS Boards. The SPSO also follows up implementation of its recommendations and reports monthly on the trends and issues highlighted by its investigations to feed back the learning from complaints.		All health complaints that reach the PSOW are sent to the Health Inspector Wales (the Regulator) so that it can take account of them during its inspections.		There are currently no arrangements in place for national learning from complaints.

NOTE

1 Complainants may go straight from stage 1 to stage 2 and miss this stage.

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on behalf of the Controller of Her Majesty's Stationery Office
5861310 10/08 77240

Design and Production by
NAO Marketing & Communications Team
DP Ref: 008530

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Feeding back? Learning from complaints handling in health and social care

A report by the Comptroller and Auditor General

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