

Handling Complaints in Health and Social Care: International Lessons for England.

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Executive Summary

This Report is presented by Evidence Consulting of Copenhagen, Denmark, at the request of the National Audit Office (NAO) to support their work with the Department of Health, in consultation with the Health Services and the Local Government Ombudsmen, to improve complaints handling about health and social care services in England. This is intended to inform plans to introduce a single comprehensive system for handling complaints by 2009.

The report draws lessons from experience of complaints systems in health and social care in Northern Ireland, Scotland and Wales, Australia, Canada, Denmark, Germany, New Zealand and The Netherlands. These countries were selected as being likely to provide relevant lessons for England. Researchers in these countries drew on reports and interviews with respondents responsible for complaints systems. Following this summary, synopses are presented for each country describing their complaints systems in terms of the main themes described below. The report then draws lessons for England and presents a summary of typical and good practice.

In all countries surveyed complaints systems are seen as important to improve the quality and responsiveness of services and as a stimulus to system improvement. The ideal is for staff to welcome feedback and patients/clients to feel free to complain or comment based on a clear understanding of the quality of service they should expect. Staff should feel free to apologise, resolve issues quickly at a local level, restore relationships and pass on lessons so that systems are improved. Where complaints cannot be resolved informally, complainants should be supported by local and national patient/ client centred organisations through further complaints procedures, that should be independent, simple, transparent and swift, leading to appropriate redress and action on professional conduct or system failures.

Key Themes and Lessons

The key themes and lessons that emerge from the interviews were not simply descriptions of how these shared aims were interpreted in different systems but practical examples of how to address the main constraints to achieving these aims:

Organisational responsibilities: should stress local front line responsibility for complaint handling as the most crucial aspect of the system. Complaints should as far as possible be resolved informally with the care team. At local or organisational level respondents saw value in drawing together the functions of complaint support, quality improvement and patient/client advice and engagement. Complaint support staff played an important role in training front line staff in dealing with complaints.

Organizational support for local complaints teams was also often multidisciplinary, covering quality improvement, and patient/client advice as well as complaints. It was essential that complaint appeals organisation should be seen to be independent. Their most important functions were to operate appeals processes and follow up actions resulting from complaints, particularly where they raised system wide issues.

All larger countries reviewed decentralised complaints support to regional levels. Most linked complaints and appeals to professional disciplinary action at this level.

Legislation and regulation: should provide a clear basis for patient/client and staff expectations. These may be defined as patient/client rights and standards or guidelines for health and social care providers. What is important is that they should provide sufficient clarity to ensure that providers of health and care and users should know what is reasonable, what must be improved and when complaint is justified.

Regulation should establish a clear and simple process for complaints from initiation to outcome regardless of the organizations involved in supporting the process.

Objectives: should translate the ideals and values of service providers and complaints agencies into performance measures. Good practice service providers adopt an objective of encouraging feedback from staff and users to improve their services. Most meaningful measures of performance for complaints agencies included actions resulting from complaints such as: system improvements and conduct enquiries, as well as timeliness. It was also useful to record complainants' objectives such as: explanation, apology, improvement or redress and the extent to which complainants and those complained against were satisfied by the process.

Good practice agencies also had explicit objectives of improving equity of access to complaints for vulnerable people, those with language barriers or speech problems.

Definitions: of complaints need to be broad but measurable. Including oral comments and staff improvement suggestions was helpful where local staff had an objective of increasing feedback but reporting was variable in other cases. Handling complaints alongside adverse events and complaints and improvement suggestions from staff seem very helpful since they provide a common basis for learning and improvement. While it was suggested by some respondents that imposing a view of the seriousness of complaints was counter to a user perspective, this seems essential to the efficient management of complaints. Serious complaints or clusters of common complaints can raise issues of principle that require policy review and action.

Processes: need to be simple and avoid hand offs between different agencies. In most cases local resolution (informal and formal) supported by independent review processes (assessment, review, investigation, decision and report) undertaken by a second agency seemed appropriate. Experience of independent review by lay panels was variable, while independence and local knowledge can be valuable, the authority of reviews conducted by lay panels could be questioned and so this process could extend timescales without leading to resolution.

Complaints may lead to further action – for example disciplinary action in respect of health professionals or sanction of the organisation involved. In some cases this was taken forward by the complaint support organisation itself. The commentary of an authoritative complaints agency, when made public, should be a significant sanction.

Timescales: should be as short as practical. Informal resolution and apology should be immediate where possible. Local formal resolution should be within 4-5 weeks. When moved on to a second stage, one of the greatest hurdles for patients/clients is the timescale. Thus timescales should be short but related to the complexity of the issue. Where policy issues are raised, separate longer term review may be required. However, an over emphasis on timescales can detract from outcomes such as satisfaction with resolution and the improvement actions taken.

Staffing: most directly involved in local complaints are front line care teams. The complaints process may be supported by a local complaints team. These staff are likely to work in quality improvement, patient/client advice as well as complaints support and development of patient centred services, they are seldom independent.

Both complainants and people who are the subject of complaints should have access to independent support staff or volunteers to help them in the complaints process.

Interdisciplinary advice and complaint support can be provided in large hospitals and centres but are more difficult in small practices and residential homes, which require locality advice and complaint support teams. Special arrangements are required for vulnerable groups e.g. children in care and people with mental health problems.

Specialists in complaints appeal agencies need skills in investigation and access to expertise about service standards to reinforce their objectivity and authority.

Numbers of complaints: do not reflect opinions of services. While most cases showed a gradual increase in numbers of complaints in recent years it was notable that where a positive attitude was taken numbers increased rapidly – and happily.

It is also apparent that some complaints do not reflect a realistic understanding of what patients/clients should reasonably expect. It is important to be able to close such complaints without overloading the system.

On the other hand it is also important to be able to draw conclusions from complaints occurring in different localities and different parts of the systems, where these show a common system failing or show changing patient/client expectations. And even isolated incidents of serious complaints can bring to light fundamental problems.

Attitudes of the public: show that they often find it difficult to initiate complaints. Patient/client surveys identified obstacles including: the perception that the process would be long and complex, that no action would be taken anyway and /or that there might be repercussions for their care. They most often wanted an explanation, an apology and reassurance that the same thing would not happen to others.

Patient/ client based organisations need to be available to support complainants during complaints processes and to bring a patient/client perspective to the interpretation of lessons from complaints and comments at a local and national level.

Attitudes of staff: are the most important barriers to positive approaches to complaints. Underlying staff attitudes to complaints is the fear of blame from management, professional bodies or as a result of legal proceedings. Since these are actually rational and reasonable fears they are more difficult to counter. It calls for a more supportive management culture and greater clarity as to what can reasonable be expected to be delivered to patients/clients.

With clear standards in place staff may be encouraged to suggest improvements and report adverse events before complaints arise. In one case regulations ensure such reports exempt staff from any subsequent blame. Staff training involving senior managers as well as front line staff is essential for an effective complaints system.

Apology: remains difficult for staff. It requires that apology and resolution of complaints should be separated from acceptance of liability and blame as far as is possible. While guidelines, exhortation and training may be helpful the greatest impact was achieved by providing clear legal exemption for apologies.

Redress: is emerging as a practical element of some complaints systems. No fault compensation schemes are separate from complaints systems, but small gifts and payments to recognise costs and inconvenience offer a way of recognising problems and recovering confidence, particularly when accompanied by explanation and apology. One complaints team accompany a personal apology and explanation with flowers to thank the complainant for helping them improve the system.

Monitoring: should occur at local and national levels and should involve real examples rather than just statistics. Monitoring too often focuses on timescales, to the exclusion of other outcomes. While timeliness is important, it is only one factor, the satisfaction of complainants and those complained against and actions following complaints, including system improvements and discipline, should also be monitored.

Specific mechanisms such as preparing a national annual report on complaints and quality improvement were helpful. It appeared to be very useful to draw together lessons from complaints, staff improvement suggestions and adverse events reports.

Learning: from complaints should occur at local and national level. Best practice at local level saw complaints support staff working closely with quality improvements teams. Where national complaint support agencies do not have a broad remit they need strong links to quality improvement and standard setting agencies.

At national level there were interesting examples of published databases and case studies of complaints. Case studies were sometimes expressed as challenges to the services to think about how they would avoid such a problem. One interesting development was the publication of lessons of principle on a web site. Where appropriate action had been taken these were anonymous case studies, but where individual or corporate blame was flagrant naming and shaming was used.

Improvement suggestions: were proposed by all respondents to increase the responsiveness and accessibility of complaints systems and their efficiency and timeliness. Comments included calls for a positive approach to complaints, increased transparency, to keep complainants informed of progress and personalised responses. It was suggested that when changes to the system were introduced careful consideration should be given to the resources required and in particular training and culture change. It was also noted that there are significant cultural and practical differences between health and social care in respect of complaint handling.

Given the current level of interest in this topic it would be helpful if complaints agencies and staff could share their experience, through an international conference and on-line community. This should recognise and support the skills and expertise of complaints support staff and their important contribution to the development of more responsive and more engaged health and social care services.

Country Reports

The international research team drew on previous experience to suggest countries most likely to provide lessons for health and care complaints systems in England.

The international team reviewed recent policy and research literature and performance reports, where available, mapped out the health and social care complaints systems and undertook semi structured interviews with staff responsible for complaints system policy and operations. These data are included in more comprehensive reports on each country available from the authors or the NAO.

Feedback from each country is provided in the following summary reports, organised under the themes discussed in this summary. These were checked with the respondents through an internet discussion, which also developed further the themes lessons and suggestions for applying international lessons to England.

The research team is very grateful to the many respondents who provided input to this study and have shown great patience in correcting drafts and sharing their experience and knowledge.

Northern Ireland: Integrated Health and Social Care Complaints System

Responsibilities: for complaints policy in the integrated health and social care system of Northern Ireland are overseen by the Department of Health, Social Services and Public Safety (DHSSPS). The main agencies involved in responding to complaints are the Health and Social Care Service (HSC) providers, which include Health and Social Services (HSS) Boards, HSC Trusts, Family Practitioner Services and regulated services. The four regional HSS Boards (that commission services) operate complaints review and four Health and Social Care Councils provide independent support and advice on complaints to the public. The Northern Ireland Commissioner for Complaints (the Ombudsman) acts as the final arbitrator. Regulatory and service improvement agencies that draw out and apply lessons from complaints include the Regulation and Quality Improvement Authority, Mental Health Commission and the Social Care Council.

Legislation: The complaints system was redefined in 1996 and is currently under review with major changes expected in April 2008. The concept of the citizen's rights underpins the work of the NI Ombudsman's office. The right to complain and the right to refer to the Ombudsman are protected by legislation which specifies the right to advocacy support. The new proposals refer to the Northern Ireland Act 1998, section 75, which stresses equality of opportunity.

Objectives: for the current system include: ease of access, rapid process, resolution and learning. The new proposals have been developed around four key principles:

- Openness and accessibility – flexible options for pursuing a complaint and effective support for those wishing to do so.
- Fairness and independence – emphasising early resolution in order to minimise strain and distress for all.
- Responsiveness – providing an appropriate and proportionate response.
- Learning and development – ensuring complaints are viewed as a positive opportunity to learn and improve services.

Definitions: of complaints are broadly 'expressions of dissatisfaction' whether as complaints, comments or suggestions. There is no definition of a "formal complaint", but in practice it is usually accepted as one expressed in writing to the Complaints Officer (either written by the complainant or the officer on their behalf). There is some inconsistency in approach across the HSC in recording and learning from oral complaints. There is no classification of complaints but the current review is looking at a root-cause analysis approach, which could be used for more complex complaints and a grading system that could progress less complicated cases.

Processes: for complaints currently involve 3 stages, with separate procedures for children in care. Complainants have a right to independent advocacy at any stage and may be supported by their HSS Council.

- 1st stage: Local resolution within HCS providers
- 2nd stage: Independent Review. If complainant is not satisfied with local resolution, they have the right to an independent review, carried out by the local HSS Board. The Board's Convenor provides complainants with an independent and informed view on whether any more can be done to resolve their complaint.
- 3rd stage: Referral to an Ombudsman. If the complainant is not satisfied, they may take the matter to the NI Ombudsman or seek judicial review.

Timescales: are similar to England. For local resolution: acknowledgment of complaint within 2 working days and a full response within 20 working days.

Application for Independent Review – 28 days following response to local resolution; acknowledgement at the Independent Review stage within 2 working days, decision whether to set up a panel within 20 days, appointment of panel members 20 working days, draft report of panel 50 working days, final report of panel a further 10 days and response to complainant by Trust 20 working days after receipt of panel report. For Family Practitioners' complaints, acknowledgment should be given within 3 days and completion should be notified within 10 days.

Numbers of Complaints: to HPSS Trusts (not including Ambulance), dealt with and resolved (stages 1 & 2) in 2006/07 was 6,193 for a population of 1.7 million. GP and Dentist complaints were on average 600 for the same year. The Northern Ireland Ombudsman Office dealt with 24 interviews, 163 telephone calls and 88 written complaints relevant to Health and Personal Social Services during 2006/07. In addition to 88 written complaints received during this year, 58 cases were brought forward from 2005/06 – giving a caseload of 146 complaints. Action was concluded on 119 cases within 12 months (with 15% within 0-3 months).

Staffing: overall levels of staffing and costs associated with complaints are not known. Currently the larger HSC organisations have a Complaints Manager, HSC Trusts may have a Trust Complaints and Patient Liaison Department, employing a Complaint Manager/ Patient Liaison Officer. Handling complaints and enquiries may not be their only role, they may have other responsibilities.

Attitudes of the public: were shown by the Public Attitude survey (2004) that revealed only a third of respondents (32%) thought the health and social services were effective or very effective in resolving complaints; almost one fifth (18%) considered them not very effective or not effective at all; over a third (38%) had no knowledge of the complaints system. Participants in the survey expressed dissatisfaction with the complaints process; many indicated that they would not bother – it was seen as a 'lot of hassle'. Many other reasons were given for not complaining including: lack of knowledge on how to complain and burdensome procedures. As part of the review the DHSSPS and HSC will be considering how to raise awareness and publicise complaints procedures. It is hoped that improvements will include enhanced support services such as advocacy, more choice and new approaches such as electronic submission of complaints.

Attitudes of staff: are being addressed. The review recognises the fundamental need for awareness raising and training to support a culture shift to acceptance that complaints are beneficial and essential to good clinical and social care governance.

Apology: is encouraged both in the current procedure and in the review. People are not keen to apologise, however, because of fear of litigation or admission of liability. The new system will encourage people to offer apology and acknowledge sympathy.

Redress: is not included in current or proposed complaints procedures. If there is an indication that the complainant will seek legal action and damages, the complaints procedure will be suspended. The NI Ombudsman may recommend redress but current legislation does not require public authorities to comply. When other authorities ignore such recommendations the aggrieved person can seek damages in the County Court; however, this does not apply to General Health Service Providers. The Ombudsman has suggested legislative changes to ensure compliance.

Monitoring and standard setting by the DHSSPS covers: response times, the number of complaints received, the percentage responded and number of requests for independent review. Locally, target response times are used to assess effectiveness. Boards and Trusts have monitoring arrangements for complaints

handling and consider any lessons that can be learnt. Trusts may also use Complaints Review Groups, with 2 Directors and a user, to review complaints and actions. Patient / client satisfaction with complaint resolution is not measured effectively. Other bodies which include complaints handling in their standards, monitoring and regime include the Regulation and Quality Improvement Authority which introduced safety, quality and standards to assess clinical and social care governance, including response to complaints. Control assurance standards are used to support an organisational wide risk management including complaints handling. New Nursing and Residential Home Standards are coming out soon, both of which will include standards for handling complaints.

Learning: from complaints is patchy. In some Trusts the Complaints Manager sits within the Quality Improvement Team, creating clear links with quality improvement. Currently there is little monitoring of the follow up to ensure local lessons are learned. There are regional complaint networks which share local lessons, but there is no consistency at local and regional level. There will be greater emphasis on local regional and national learning and quality improvement in the new procedures. Organisations will be assessed on handling complaints, on quality issues, effectiveness of local procedures, and the use of information for raising standards. A number of complaints have moved to the Coroner's Court, and then become public enquiries. These provide examples of sharing learning at a national level, but it is hoped that new procedures can share lessons at an earlier stage.

Improvements: The "*Complaints in the HPSS*" consultation ended in March 2007. These proposals were developed in conjunction with representatives from organisations within and beyond the HPSS, staff and user interest groups. These revised procedures aim to provide a unified and streamlined complaints procedure which will apply equally to all HPSS organisations. It is designed to provide a simple, consistent approach for staff handling complaints and for complainants across all health and personal social services. The new proposals seek to raise the standard of complaints handling by removing barriers to access, strengthening local resolution, clarifying roles and responsibilities and emphasising the importance of learning and improvement. In addition they aim to improve support services by encouraging conciliation and advocacy and ensuring that appropriate training is provided. The new proposals seek to remove the current independent review arrangements and therefore provide an opportunity for complainants to take complaints to the Ombudsman at an earlier stage in the process.

Suggestions: to improve complaints handling systems include:

- Improved communication on progress of complaints during local resolution.
- Independent support such as advocacy.
- Improved reporting and monitoring of complaints from FPS.
- Continued involvement of lay persons.
- Greater learning and sharing of ideas on complaints regionally and nationally.
- Clearer standards and guidelines.
- Training to improve staff confidence, knowledge and attitudes to complaints.
- Listening to what each complainant wants: apology, explanation or remedy.

Scotland: Health and Social Care Complaints Procedures

Responsibilities: for current policy on complaints concerning health are led by the Scottish Government Health Directorate. The main agencies involved in operating the procedures are healthcare providers and NHS Boards. The Scottish Health Council (SHC) and its local offices have an oversight role. The Scottish Public Service Ombudsman (SPSO) considers complaints that have not been resolved within the NHS and social care. Other bodies acting upon and learning from complaints include NHS Quality Improvement Scotland (parent body of SHC) and professional bodies such as the General Medical Council and Nursing Medical Council. The NHS Complaints Personnel Association Scotland (NCPAS) is used widely to channel consultations and debate about matters relating to complaints management; it has been involved in joint initiatives with other public sector colleagues.

Local Authorities and the Care Commission are responsible for complaints systems in the social care services they provide or fund. The Scottish Social Services Council operates complaints procedures concerning professional conduct. The SPSO provides an appeal process, which may be regarded as a fourth stage before judicial review. The ADSW Complaints Sub-Committee advises on complaints procedures. NCPAS and the Association of Directors of Social Work (ADSW) Complaints Sub-Committee, hold joint events and local forum meetings of complaints staff are encouraged.

Legislation and regulation: The NHS Scotland Act 1978 clarifies the rights of health complainants. Right of access to the Ombudsman, is set out in the SPSO Act 2002. A review of the health complaints system in 2002 brought a major revision to the system in 2005, reducing the process from three to two stages.

Rights of social care complainants were defined in the Social Work (Scotland) Act 1968; following which guidance regulations were established and were last updated in 1996 setting out what may be described as a four stage process. Local variations on this form the basis for complaint handling by Local Authorities.

A cross public service review of complaints handling was undertaken in 2007, as part of the Crerar Review. It indicates that the current systems are over complex; it suggests a single standardised system with most responsibility taken by the local agency, supported by a single agency, most probably the SPSO, with restrictions on the right to appeal to reduce inappropriate complaints and speed up the system.

Objectives: The values that guide the current health complaints system are timing, simplicity, easiness and speed of operation and demonstrable fairness to both staff and the public. The focus is on local resolution; complaints should if possible be resolved when they occur locally, rather than being passed to other bodies. The aim should be to get answers at the highest level within the organisation quickly. Similar aims are expressed in the Crerar report. Values in social care include transparency, suitable redress and an emphasis on informal resolution.

Definitions: Complaints are broadly defined to include oral comments expressing dissatisfaction. However, local practice in recording such comments varies widely within and between health and social care organisations. Referrals to the SPSO must be made in writing unless there are special circumstances that prevent this.

Processes: for handling complaints are different for health (H) and social care (S):

- H** Two stages: local resolution, informal and formal followed by referral to SPSO, which may result in a report to the Scottish Parliament. The local resolution process varies between different types of NHS organisation.
- S** Complaints processes for social care may involve four or five stages: 1) Informal local resolution, 1a) Formal local response, 2) Further review at a more senior

level within the local authority and 3) Independent Review by a Complaints Review Committee and 4) Referral to the SPSO. Local practice varies widely.

Timescales:

- H** Local resolution for NHS complaints should normally be completed within 20 wkg days of receipt for hospital and community complaints and 10 wkg days of receipt for Family Health Service complaints, - if investigations take longer, complainants should be informed of reasons for delay after the initial period and every attempt made to complete within the next 20 or 10 working days. If referred to them, SPSO will instigate its own process for consideration and possible investigation.
- S** Regulations regarding social care complaints set a timescale for formal response of 28 days from the initial receipt of the complaint, but some Local Authorities set up their own standards, e.g. within 15 working days. Stage 3 – the Independent Review Committee must meet and report within 56 days of the referral to it. The local authority then has another 42 days to respond to the recommendations.

Numbers of complaints:

- H** Hospital and Community Services complaints rose to 7,347 in 2006/7, with 2,984 about Family Health Services and 914 others. The number of health complaints that reached the SPSO doubled with the system's change in 2005: from 235 in 2004/05 to 497 in 2006/07. The funding for the SPSO services was increased by £270,000 to take account of this and the need for quicker response.
- S** Social care complaints are recorded in local authority annual reports on complaints, but no national report is available and there is no common definition of informal complaints. The number of local authority complaints that reached the SPSO was approximately the same over the last 3 years, 1017 in 2006/07.

Staffing:

- H** There are no overall staffing figures or costs available. Boards and Hospitals have a least one complaint manager or officer; Health Boards should have a senior member of the management team focussed on complaints, often the Director of Nursing. Family Health Service Practitioners should have someone identified as a Complaint officer – this could be the Practice Manager or a lead GP. Their qualifications, responsibilities and titles vary, some have clinical or nursing background, others not. There is no national training, but improved software, communication and complaints training have been discussed by NCPAS and its members with a hope to providing some consistent national material.
- S** The overall level of staffing and costs is unknown. There are Lead Complaints Officers in Local Authorities, but few staff are dedicated solely to complaints.

Attitudes of the public: were studied in a small research project jointly commissioned by SHC and SPSO. It was found that while participants were generally comfortable with current complaints processes, they identified five types of barriers: a lack of knowledge about how to complain, a lack of ability to complain, a concern about repercussions, a fear of appearing to 'nag', and scepticism about whether anything would happen as a result. The consensus was that complaints should be made to the service involved in the first instance and only if the complaint was seen to be very serious should complainants go directly to an external body. When a single complaints phone line dealing with all public services was suggested, the perceived problems outweighed the perceived benefits. It was said that 90-95% of complaints were looking for an apology and an assurance that they were listened to.

Attitudes of staff: are important in enabling people to complain and ensuring that people know that if they make a complaint, staff won't take it personally and it won't

affect their care. For example, there is a barrier between the nurse and the nurse station, it takes courage to complain, nurses must have a presence near the bed and ask people about their concerns. This requires management leadership and support.

Apology: is encouraged, SPSO issued guidance to both the NHS and Local Authorities. There is still confusion between apology and admission of liability. A key objective is to create a culture of learning from mistakes and putting things right.

In respect of social care services some Local Authorities track the number of complaints upheld or partially upheld having an apology as part of redress or part of the response offered. In one case it was reported that the vast majority are given an apology and customer care training given to frontline staff encourages this.

Redress: A very low number of complaints become claims. If someone is pursuing a complaint to a solicitor, the complaint procedure is suspended. There is no no-fault compensation as such, but if someone has been financially disadvantaged the Health Board will compensate at a local level. The Ombudsman may recommend redress, i.e. explanation, apology, re-imburement of costs and changes to working practices.

Monitoring and Learning: In health at a local level, some Community Health Care Partnerships have Quality Improvement Teams who review complaints data from their areas; board chief executive and the chairman review the outcomes of every complaint monthly and quarterly to ensure that lessons are learned. NHS Boards receive regular complaints reports – either direct or via their Healthcare Governance Committees. Quality issues relevant to complaints may be included in some Board annual reports. All complaints that reach the SPSO are examined by the NHS Head of Patient Focus; if it is a system-wide issue, they copy it to all Boards. The Chief Executive of NHS in Scotland submits an annual report to the Minister. At SPSO level, a fairly crude measure of effectiveness is the rate of 'premature' complaints which reach the office, complaints that should have been dealt with at the previous stages. At a national level, there are good links between the SPSO and NHS Quality Improvement Scotland (QIS); there are many instances where messages coming out from SPSO investigations have been picked up and are reflected in QIS guidance.

In social care the Lead Complaints Officers usually sit within Quality Improvement Teams, i.e. Performance and Information Team; they report orally and in writing to senior managers and the Directors of Community Health and Social Care Partnerships or Community Social Care Partnerships. Tangible outcomes as results of complaints are recorded and actioned. Complaints data are used to promote customer satisfaction in some Local Authorities. Sharing local lessons at regional or national level is through the ADSW Complaint sub-group, where complaints issues are discussed at their meetings four times per year.

Improvement suggestions: In health a review of complaints handling is due in 2008. It is felt the process works well, being simple, clear and fair. Time for culture change, clarification of liability issues, linked to leadership and training is needed. More resources and clarification of 'complaints handlers' roles are also needed.

In social care (and formerly health) the Independent Review process had strengths but also disadvantages in time and complexity. A unified system supported by SPSO and/or a new Complaints Authority could allow variations between health and social care in local resolution, perhaps with review committees bringing independent and expert views, within a common overall approach. Changes need careful management to avoid losing skills and experience, whatever the nature of the revised system. Careful management is needed where complaints split between health and social care to ensure a coordinated response and clearer information to the complainant.

Wales: Towards Citizen Centred Health and Social Care Complaints Systems

Organisational responsibilities: are established by the Welsh Assembly Government. In health the focus is on trying to resolve complaints at local level by NHS trusts or primary care practitioners/local health boards. People unhappy about the handling of their complaint locally can apply for an independent review. At any stage after the local attempt, they can ask the Public Services Ombudsman for Wales (PSOW) to look into their case. Community Health Councils in Wales provide an independent advocacy service for people wishing to make a complaint. Citizens' Advice Cymru and One Voice Wales also provide support. Learning lessons from complaints forms an important part of organisations' clinical governance regimes; complaints handling is also monitored through Healthcare Inspectorate Wales.

For social care, Local Authority social services departments operate local complaints systems in accordance with national guidance and regulations. The Independent Complaints Secretariat, on behalf of the Welsh Assembly Government, supports the independent panel stage with appeals to the PSOW. Lessons and issues might be taken up by the Social Services Improvement Agency, part of the Welsh Local Government Association; the Social Services Inspectorate in Wales or the Association of Directors of Social Services.

The Office of Public Services Ombudsman in Wales (PSOW) was set up in 2006. It replaced four agencies to create a 'one-stop shop' for complaint appeals.

Legislation and regulation: relate to broader citizen rights, such as Data Protection Act 1998, the Government's Code of Openness in the NHS, Freedom of Information Act 2000, Race Relations Amendment Act 2000, Human Rights Act 1998.

In health the 1996 complaints guidance, was replaced in April 2003 and a new set of Directions issued to NHS Trusts and Local Health Boards. New regulations for handling social services complaints were introduced in 2006.

Objectives: should be seen in the context of the Assembly Government's aims of developing citizen centred integrated local services and their core principles of customer service: access, personal experience, responsiveness, language options and redress. Objectives for health complaints handling are to: ensure as many complaints as possible are resolved locally, make the process faster and more independent, support for people who may wish to complain and for those complained against and ensure lessons are learnt. Fifteen principles have been identified for the new social care complaints system.

In 2007 the PSOW put forward the following guidelines for good complaints handling to Local Authorities, relevant to both health and social care; they should be:

- comprehensive, covering all services provided by or on behalf of the authority
- clearly defined, with easily understood and straightforward to use procedures
- quick but sufficiently thorough
- fair and objective
- sensitive to the special needs and circumstances of the complainant
- ensures effective communication with the customer
- decisive and capable of putting things right where necessary
- effectively managed and regularly analysed to spot lessons for improvement.

Definitions: The recent Social Services complaints guidance notes that '*As a rule of thumb, a complaint is a complaint when the person making it says it is*'. There is a distinction between local resolution (stage 1) and formal consideration (stage 2), but all stages should be managed systemically. In health, a complaint is '*an expression of concern about NHS treatment or service, verbal or written, which requires a response*'; currently a review team is considering definitions of a complaint in health.

Processes and timescales: differ between health and social care:

- H** This may be described as a three stage process involving three agencies:
- 1- Local resolution, may include informal and formal sub stages – 20 days
 - 2 - Independent review by lay person, 1 month, or panel - 6 months
 - 3 - Referral to the PSOW - can follow stages 1 or 2 - 20 days.
- S** This may be described as a four stage process involving three agencies:
- 1 - Local resolution, 10 days which may be extended to further 10 days
 - 2 - Formal consideration usually by an independent person - 25 days
 - 3 - Independent panel review involving a lay person and expert – 40 days
 - 4 - Referral to the PSOW – can follow stages 2 or 3 - 20 days.

Staffing:

- H** Overall levels of staffing and costs are being examined as part of the current complaints system review. Usually there are Trust Complaints Managers/Officers, their numbers depending on the size and locality. Some Trusts have taken an integrated approach to concerns, complaints, comments, diverse incidents and claims for clinical negligence.
- S** There is 1 Complaint Officer in each LA area; dealing with complaints handling and relevant procedures i.e. training, information, reports. It is estimated that supporting stage 3 costs about £100,000- £120,000 per year nationally.

Numbers of complaints:

- H** In 2006/2007, there were 6,346 complaints. 62% of complaints about hospital and community services were concluded within the 4 week target. Only 182 hospital and community services complaints requested independent review in 2006/07. The PSOW received 191 NHS complaints in 2006/07.
- S** There are no national complaints data for stages 1 and 2, but 28 complaints were handled at stage 3 (the Independent Panel) and 124 social services complaints reached the PSOW in 2006/07. (Wales has a population of 3 million.)

Attitudes of the public: The PSOW undertook a customer satisfaction survey, which showed that those whose complaints had been upheld tended to have a markedly more favourable view of all aspects of the service than those whose complaints had not. He thinks that only a tiny proportion of all users of NHS or social services who are dissatisfied with an aspect of the service received will ever make a complaint. This may be because they are satisfied, or dissatisfied but do not know how to complain or think that making a complaint won't serve any useful purpose.

Attitudes of staff, apology and redress: PSOW Guidance notes that the local complaint systems need to define what authority staff have, and what they should do if they think they have not got enough authority to deal with a complaint. They should be able to make an apology on behalf of the authority and offer appropriate redress, including but not limited to financial redress.

Monitoring:

- H** Performance is measured with time targets for local resolution of complaints, but these maybe too rigid for complex complaints. It may be also measured by numbers of complaints referred to other stages within the process.
- Individual Trusts may send out a short questionnaire, a complaint satisfaction survey, to all parties at the end of the Local Resolution stage, which can be a measure of patient satisfaction.
- Follow up of selective individual complaints Action Plans may be achieved by the Trust Complaint Team to see if it addresses all the issues brought up by this complaint, doing a number of quality checks; if the Plan is brought to the Trusts Operational Risk Management Group, they will consider the issues raised by that

complaint and decide if they agree on the Actions, to bring about changes and service improvement and avoid reoccurrence.

S PSOW Guidance advises Local Authorities that a good performance indicator would be the proportion of complaints received which were resolved to the customer's satisfaction. It also advises that the senior officer with lead responsibility for the complaints system should be able to:

- set standards for the system,
- ensure the system is understood and properly implemented by all staff,
- challenge staff who are not complying with the system,
- get improvements made,
- say if the system is not adequately resourced.

Feedback is obtained by sending a form to those who went through the process, to measure satisfaction and record any concerns or suggestions. This may be followed up by discussions with customers to resolve specific issues.

The performance indicators in the business plans indicate numbers of complaints being resolved at stage 1 with the relevant timescales. In the quarterly reports, there are comments regarding anything outside timescales or particular issues.

Local follow up is achieved by monitoring the recommended actions for the resolution of particular complaints. Councillors and leading officers receive regular reports through a formal process of reporting. Reports analyse complaints by, for example, number, subject and outcome. Trends can be identified together with lessons of general importance. The action that councillors and leading officers take on these reports has an important influence on the way staff and the public regard the complaints system.

Learning:

H NHS Trust and Local Health Boards receive monthly or quarterly anonymised reports on complaints and any emerging trends, which are discussed in the public part of the Board Meetings. Trusts report annually to the NHS Complaints policy team at the Welsh Assembly Government on complaints received, lessons learned and actions taken. Trusts and Local Health Boards publish annual reports on complaints handling, which are sent to the Welsh Assembly and Community Health Councils. Lessons are also shared at regional or national level through the Welsh Complaints Managers Networks and the Welsh Risks Managers Networks. Healthcare Inspectorate Wales monitors overall complaints handling.

S Each authority creates its own mechanisms. Complaints Officers may sit within teams which deal with quality assurance issues; they report to their heads of their departments, who in turn report to chief executives. Targets for complaints improvements are incorporated into local quality improvement targets and business plans. At national level the All Wales Complaints Officers Group, which meets at least quarterly, shares local lessons.

Improvement suggestions:

- Suggestions regarding independent review were mixed:
 - In health it was suggested that it increased timescales and could result in impractical suggestions that may not be acted upon.
 - In social care it was reported that it was well regarded and useful.
 - In both cases the ability to bypass it may lead to a decline in use but this has not yet proved to be the case in health.
- Realistic complainant expectations should be established and recorded.
- Combining complaint and regulation functions was seen as unhelpful.

Australia : State level complaints systems in health and social care

Organisational responsibilities: for health and social care complaints depend upon the agency responsible for each element of the service. Aspects of Medicare supported health services and care for elderly people are Federal (National Government) responsibilities, other aspects are State (and Territory) responsibilities and a high proportion of health and care are insured and provided by the private sector. For this reason there are many different organisations with parallel responsibilities for complaints and quality of care at Federal and State levels. To pick out some examples: for aged care, funded at Federal level there is an National Aged Care Commissioner and a National Aged Care Investigation Scheme, for health and community services, primarily funded and delivered by the States there are State Health or Health and Community Services Complaints Commissioners, for private health insurance, subsidised by the Federal rebates there is a Private Health Insurance Ombudsman. All States and Territories have advocacy bodies that assist people in making complaints and an Ombudsman usually handling complaints for other care services. National policy and practice in complaints is advised by the Australian Commission on Safety and Quality in Health Care.

Legislation and regulation: varies between States, however they generally copy legislation as it is changed by the leading State. Federal government funding support for State health and care services is regulated by the Australian Health Care Agreement (AHCA). This, inter alia requires States to maintain complaints bodies independent of public hospitals with powers to investigate and resolve complaints and recommend system improvements. The roles and functions of these complaints bodies are set out in State legislation. AHCA also requires a Public Hospitals Complaints Charter setting out how complaints can be lodged. The role and functions of the Private Health Insurance Ombudsman (a Federal agency covering 44% of Australians) are set out in the Private Health Insurance Act 2007.

Objectives: are defined by each complaints agency. For example, the Health Quality and Complaints Commission of Queensland (HQCC) established in 2006, list their values as: respect, integrity, independence, learning and responsiveness. HQCC is also developing a charter of patient rights including: service provision of an appropriate standard, respect and engagement, provision of timely and accurate information, informed decision making, consent and support, personal information, confidentiality, and access to records, effective complaints processes and involvement of family, friends, carers, and advocates.

Definitions: of complaints again vary, the NSW Health Care Complaints Commission (HCCC), accepts complaints about health care practitioners or organisations in writing, via the mail, e-mail or fax using the on-line complaint form on the Commission's website. Interpreter services are also provided in 20 community languages. As in all States it is suggested that providers are contacted first to try to resolve the complaint there. This precludes informal comments or expressions of dissatisfaction to providers. In NSW the HCCC has Resolution Officers located in the 8 Area Health Services as the public face for serious complaints. A state wide data system enables complaints to be severity classified, logged and tracked and tools are provided to help staff deal with complaints.

Processes: are variable but generally described as 2 stage processes with 5 steps:

- Resolution within the practitioner or provider organisation informal/ formal.
- Referral to Complaints Agency:
 - Assessment - some agencies use formal severity assessment criteria.
 - Investigation and resolution with the provider, or if not further review.

- Further action which may include investigation, commentary or referral to another agency such as registration board or prosecution service or if it is a system wide issue it may result in a report to the State Minister of Health.

Some complaints agencies also prosecute in serious cases.

Timescales: typical timescales are shown in the following examples:

- HQCC - Queensland
 - Informal local resolution unspecified
 - Initial assessment 10 days maximum
 - Investigation and resolution with provider 30 days maximum
 - Further assessment and investigation leading to action 90 days max
- HCCC – New South Wales
 - Overall timetable 60 days to assess, investigate and decide
 - Response to all parties within 14 days of decision.
 - Investigation and resolution 90 days (over 60%, 98.7% within a year)

Staffing and Numbers of Complaints:

- HQCC – Queensland 2006/7 population 4.1 million
 - Staff 79
 - Budget £3.95
 - Complaints episodes 5,067
- HCCC – New South Wales 2006/7 population 6.8 million
 - staff 77
 - Budget £4.25 million
 - Complaints finalised 3,164, inquiries received 7,927

Attitudes of the public and staff: have been influenced by vigorous public debate. For example, NSW HCCC has evolved and changed its values from consumer advocacy to a more independent focus on accountability and disciplinary action. This change was brought about partly due to criticism, particularly from clinicians that the Commission was too biased towards consumers, and needed to take a more independent stance in handling consumer complaints. This criticism, together with the Commission's failure to deal with major complaints brought out in the media, and poor complaints handling practices, came to the fore during 2003, during which time the then NSW Health Care Complaints Commissioner was sacked. The decision not to name members of the medical profession involved in the complaints highlighted in the media was considered a major reason for the Commissioner's sacking.

Apology: To recover their confidence in the health system, complainants need an acknowledgement of their complaint, and an explanation of what happened and an apology where appropriate. Apology is encouraged by "Open Disclosure Standards" where it is appropriate but there are still cultural barriers to overcome within health professional groups. In NSW under the Civil Liability Act 2002, apologies can be made without it constituting an express or implied admission of fault or liability by the person in connection with the incident. The apology is not admissible as evidence in any subsequent civil proceeding. Similar legislation has been enacted federally and in all States and Territories of Australia.

In both NSW and Queensland the Premier of the State has apologised publicly (and probably privately) to people whose relative died through faults in the health system.

Redress: through no fault compensation is not a part of the complaints system, but major changes in medical negligence legislation since 2002 have significantly changed the medical negligence environment. These include: overhaul of health care and civil liability laws, insurance coverage for doctors for public work in the public hospital system and capping of compensation payments.

Monitoring: State Complaints agencies report to State Parliaments on their performance. For example HQCC, Queensland has set targets for 2007/08 for a number of performance measures including:

- Number of enquiries and complaints closed and investigations finalised
- Number of standards released or reviewed
- Percentage of HQCC recommendations accepted by agency (80%)
- Percentage of health service providers reporting against standards (50%)
- Percentage of complaints assessed within 90 days (75%)
- Percentage of investigations finalised within 12 months (95%).

The implementation of recommendations made to health care organisations is monitored by HCCC NSW. There are three monthly meetings with NSW Director-General of Health which work well. The NSWHCCC can also report to the Minister if recommendations fail to be implemented, and then in turn the NSWHCCC can report to Parliament if implementation of recommendation is still outstanding.

Learning: from complaints is recognised as important. In NSW a Clinical Excellence Commission (CEC) has been in operation since 2004 as part of the NSW Patient Safety and Clinical Quality Program. The CEC is a board governed statutory health corporation with a CEO reporting directly to the NSW Minister for Health. The mission of the CEC is to build confidence in healthcare through making it demonstrably better and safer for patients and a more rewarding workplace. The CEC has established a system of recording adverse events in hospitals The CEC is focused on making system-wide improvements. In some cases such improvements may come about as a result of complaints received by the NSWHCCC.

Queensland is unique in Australia in having a health complaints commission with responsibility for establishing standards for measuring and monitoring the quality of health services. Thus lessons from complaints can be directly applied in practice.

At Federal level the Office of Aged Care Quality and Compliance manages the Aged Care Complaints Investigation Scheme, and also sets standards and issues compliance notices (Notices of Required Action).

Bi-annual meetings are held with Health Care Complaints Commissioners from all States and Territories in Australia, the Aged Care Commissioner and the New Zealand Health and Disability Commissioner attending. Information is shared about lessons learned at these forums.

Improvement suggestions: put forward by respondents included:

- Personal letters are important for the satisfaction of complainants.
- Complainants need to be kept informed of the progress of their complaint.
- The key to responsiveness is timeliness, it is important to improve timescales.
- A client management system can flag the expectations of complainants e.g. explanation, apology, system changes - and so improve responsiveness.
- The Code of Health Rights and Responsibilities will make it easier to judge complaints against reasonable expectations and to provide explanations.
- A "positive action" process is needed, to move away from an adversarial approach and accept complaints as constructive inputs. This implies front line professional staff should encourage and support feedback from patients and clients to improve services.

Canada: Coordinating learning from complaints, adverse events and redress.

Organisational responsibilities: are determined by the 10 Provincial and 3 Territorial Ministries of Health and their Regional Health Authorities (RHAs). Coordination and support for shared learning from complaints, adverse events and redress is provided by the Canadian Patient Safety Institute (CPSI) at national level.

Complaints about health professionals' conduct are handled through self-regulating Professional Colleges, usually about 20 in each province, They are required to establish "Inquiry, Complaints and Reports" and "Internal Review" committees. Health Quality Councils, Commissioners or Managers at provincial or local level may also be involved in complaints with a view to improving systems performance but will refer specific complaints concerning professional conduct to Professional Colleges.

Complaints against an RHA may be appealed to a Public Health Appeals Board.

Resolution of complaints about social service providers is supported by local Service Resolution Managers. Complaints about assisted living are handled by the Office of the Assisted Living Registrar. Complaints about mental health services are supported by a special Mental Health Patient Advocate Office. Local mediation in such cases may be followed by formal external review and /or court action.

Ombudsman services throughout Canada have the power to review a RHA's handling of patient complaints and the fairness of the decisions they reach, though this is not an appeal of the final decision.

All complainants may be accompanied by a Patient Advocate during investigation and resolution. The system is moving towards a similar pattern across Provinces e.g.:

- Alberta has a Patients Concerns/Complaints Resolution Framework to provide practical assistance and direction to RHAs and professionals and to facilitate a consistent approach throughout the province and across and between health regions, providers and regulated health professionals.
- Québec has devoted considerable effort to support dissatisfied users by establishing Complaint Assistance and Support Centers (CAAPs) in each Region of Québec providing help lines and information services. The Québec Ombudsman's jurisdiction now covers virtually all health and social services, from hospitals and foster families to youth centres and rehabilitation and residential homes.

Legislation and regulations: relate to the *Health Professions Act* (HPA) amended (2007), which is omnibus legislation for all health professions. The HPA must be enacted by the individual professional colleges, by introducing Regulations, Bylaws and Codes of Ethics in the college register, to which there is open access. Local bylaw approval processes in these cases are often delayed. There are current reviews e.g. in British Columbia to ensure that all self-regulated professions are subject to the same law (HPA). A recent (5 Dec 2007) bill in Alberta brought amendments to the HPA including giving the Minister power to direct a health regulatory body to change a code of conduct or bylaw or standard of practice. The College of Physician and Surgeons saw this as an attenuation of self-regulation and vigorously protested.

A bill enacted in 2006 extended the remit of the Québec Ombudsman's office to taken on the duties of the Health and Social Services Ombudsman.

Objectives: The majority of complaint review systems and ombudsman services in health and care have two objectives: to respect the rights of users and to improve the quality of services. This has resulted in different conceptions of complaints. Users, counselors and ombudsmen are primarily concerned with respect for users' rights. Quality commissioners are more directly concerned with improving services.

Their responses to complaints are limited by institutional norms, limitations on their investigative powers and their authority over the institution's employees.

Definitions: Complaints must be filed in writing. The issues raised by complainants range from access to records to sexual misconduct. The majority of complaints concern the competence of clinical care. Communication problems are a common element in most complaints

A variety of Canadian stakeholders work collaboratively, through the Canadian Patient Safety Institute to produce national guidelines on disclosure to patients and families. The guidelines stipulate that disclosure and discussion of potential consequences should be initiated within one to two days following discovery of potential harm.

Processes and timescales: HPA sets out a minimum set of requirements including: the independent make up and administration of investigative and adjudicative bodies (with mandatory lay members), rights of appeal, the proper notice of a proceeding and the right to be heard, and that the process must not be overly complex, so that complainants can understand how the process works.

Institutions are encouraged to offer early mediation as an alternative non-judicial dispute resolution procedure that encourages communication between parties and holds health care providers and organizations to account. The drawback is that settlements are often isolated responses to specific issues and can miss system problems at the institutional level and in collaboration between professionals.

The Office of Assisted Living Registrar will be able to address complaints about assisted living: health and safety concerns and standards violation, and unregistered residences. Complaints about Children and Youth Services will be dealt with by a Professional Services/ Resolution Manager who must review and report the results within 30 working days.

In cases relating to professional conduct an investigation will be initiated when the Registrar of a college receives information from a member of the public or a source, such as the Coroner's Office, the police, a hospital chief of staff or another health-care professional, providing reasonable and probable grounds. Under the HPA, an inquiry committee is responsible for investigating such complaints, and has powers to dismiss the complaint or order that a disciplinary committee be convened. Committees must reach a decision within 120 days.

In cases that cross professional and organizational boundaries a collaborative approach must be taken to avoid duplications and to co-ordinate information to the complainant about progress in keeping with the *Health Information Act*.

Staffing, numbers of complaints, compensation claims and adverse events:

A major professional college registrar's office will be staffed by 4-5 full time equivalents for complaints management. Administration costs will be covered by college members' annual subscriptions.

Canada has a tort system in case of personal injury. It probably only tangentially affects the quality of health, given the presence of liability insurance with Canadian government funding professional and hospital liability insurance. A minimal cover of £500,000 is required, Health Insurance Reciprocal of Canada (HIROC) who insure more than 85%, paid over £150 m compensation in 2006 from a population of 33 m.

A major campaign, 'Safer Health-Now!', with a focus on preventable adverse events and open disclosure, will make 'avoidability' and therefore eligibility for compensation transparent to providers and complainants alike with the potential to compensate greater numbers of injured patients.

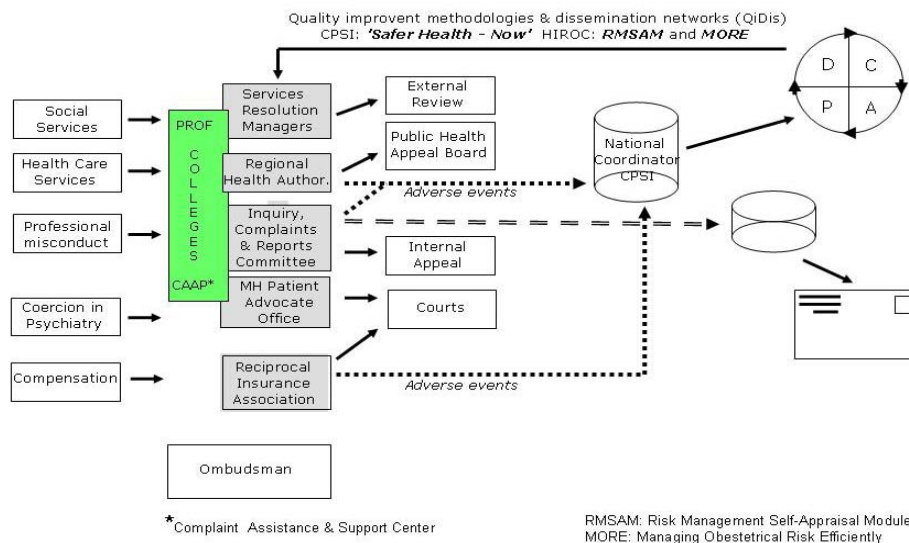
Attitudes of the public: surveyed in Alberta in 2004, showed that 62% of complainants were dissatisfied with how their complaints were handled.

Attitude of staff: is focussed on professional standards and education. There is a need for greater emphasis on organizational issues particularly where the case involves different professionals and organisational units.

Apology: is part of the alternative mediation regime that is encouraged by HPA.

Monitoring and further action: More than 70% of complaints concern physicians and surgeons, only about 10% relate to nursing. More than 50% of complaints concern hospital care. About 60% are dealt with by Registrars who find about 20% of cases valid. About 15% lead to Committee reviews, which uphold about 5% of cases. Only about 1-3% of complaints rise to the level of disciplinary action.

Learning: should improve concerns/complaints resolution practices as well as improve links between concerns/complaints management, patient safety and quality improvement. Learning is supported by campaign teams in 'Safer Health – Now' coordinated by the CPSI. HIROC also supports learning through computer based learning programs for Risk Management Self Appraisal Modules and Managing Obstetrical Risk Efficiently. These steps provide the basis for a Deming approach: Plan, Do, Check Act, to complaints, adverse events and compensation knowledge.



Improvement suggestions: organizations should:

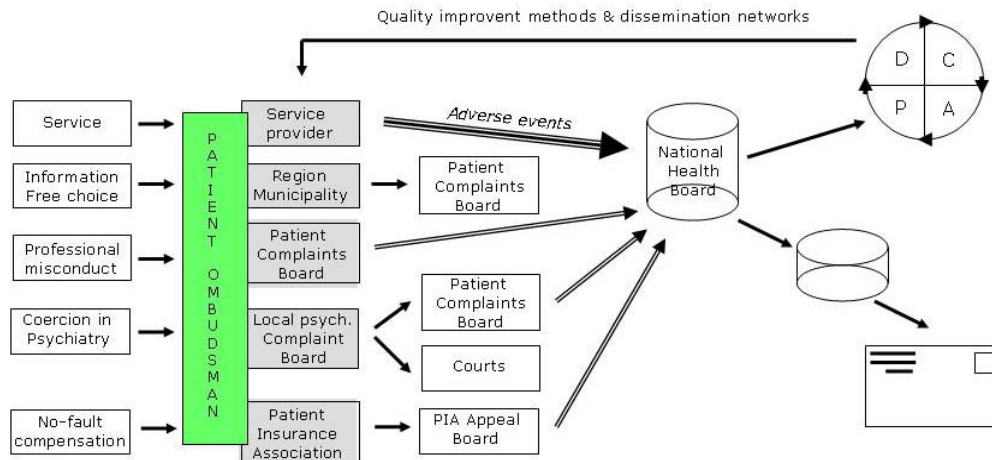
- meet timely targets for concerns/complaints resolution,
- provide explanations for the outcomes of concern/complaint resolution,
- ensure that they act in accordance with other professional legislation (e.g., the *Health Facilities Review Committee Act*) – 'enterprise perspective',
- support peer group discussion of complaints resolution data to encourage sharing, learning and identification of quality improvement opportunities,
- review and report on the operations and effectiveness of the concerns/complaints resolution process against documented performance targets.

Denmark: Systematic learning from complaints, adverse events and redress

Organisational responsibilities: Complaints regarding health care are supported by local Patient Assistance and Support Offices (PASOs) which help patient contact with service providers: the 5 Regions responsible for hospital and outpatient care and 98 Municipalities responsible for local preventative health services (serving a population of some 5.4 million people). Complaints not resolved by local Complaints Boards for physical and mental health may be passed to the national Patient Complaints Board. PASOs also help patients with no-fault compensation administered by the Patient Insurance Association and Appeals Board. Disciplinary action and systems improvements are taken up by the National Health Board.

Responsibilities for social care complaints are less clear due to the recent reorganisation of Municipalities and the pending reorganisation of complaints handling in 2008, which may affect both health and social care. Complainants may seek assistance in filing a claim from members of the senior citizens' council or the senior citizen groups. Complaints are then reviewed by Complaints Councils including Patient and Social Complaints Councils and a national Social Appeals Board.

In future the first tier of support for health and social care complainants may be supported by a Patient Ombudsman Service as shown below.



Complaints handling integrated with central and local learning systems

All complaints will in future be addressed to the new Patient Ombudsman's Office which will then decide the course of further action. It will be responsible for achieving a short average time to resolve complaints. Under the new law complaints can be raised about violations in the entire system, including complaints about violations of new information rights, free choice of provider and other matters. In addition users and staff will be able to report on adverse events in both health and social care. Learning systems and networks will be put in place to ensure that complaints and other evidence is systematically captured, analyzed, acted upon and evaluated.

Legislation and regulation: A new act came into force in 2007 consolidating and codifying patient rights. No fault compensation, introduced in 1992 was extended in 2004 to cover private hospitals, GPs, private specialist medical clinics, nurses, chiropractors etc. The duty to report adverse events in health was subject to legislation in 2003. A bill will be introduced in 2008, as part of a public sector quality reform, introducing further reforms to complaints handling, and organizational measures to improve learning from complaints. Adverse events reporting will be extended to primary care and social care.

Objectives: are to ensure that the silos of information in the Patient Complaints Board (discipline), The Patient Insurance Association (compensation), and the adverse events reporting system are transformed into a quality improvement and learning system with organizational structures for rapid dissemination.

Definitions: Complaints must be filed with the PASO or the Municipality Department for Health and Social Affairs or the institution providing care. A service user, their representative or heir can file a complaint.

User complaints can be subdivided in complaints about service levels (~50% of complaints covering access and waiting times, food, accommodation etc), professional misconduct, no-fault compensation for medical injuries, coercion in psychiatry and other elements of services e.g. transport.

Adverse events may be reported by both patients and staff. There is a separate system for dealing with complaints about dentists.

Processes and timescales: Service level complaints are handled within the health or social care provider organization unless they raise issues of principle. The PASO provide a help line and information services on the complaints review mechanisms as well as assistance with complaints. These services are free and confidential.

For professional conduct complaints Patient Advisors in PASOs facilitate arbitration between the professional and the complainant. If not satisfied they may file a complaint with the Patient Complaints Board.

The Board assesses the case to decide whether to proceed, contacts the professional within 6 weeks, and may investigate. The target is to reach a decision within 12 months; current average time is 13.8 months. A Patient Complaints Board decision to close a complaint is final, it cannot be appealed.

Claims for no fault compensation handled by the Patient Insurance Association take up to 2 years because information is required on the patient's final condition.

In Social Care the estimated time for completion of decisions by the Complaints Councils is approximately 17 days plus the Municipalities processing of claims of about 22 days adding to a total of 40 days.

Staffing, numbers of complaints, compensation claims and adverse events: The Patient Complaints Board made decisions in 2.305 cases in 2006 of which 57% were about hospitals and 15% about GPs. Physicians accounted for 86% of complaints, and nurses 3%. Of the total cases decided, 1.648 ended with no need for further action, in 567 cases the professional was criticized, and in two instances the matter was sent to the prosecutions office. Productivity per staff member was 124 decisions/year in 2006. The goal for 2007 is 145. In 72 decisions, where the board decided to issue severe or repeated criticism, title and names of the professionals were published on the Board's website. In 2 cases decisions were passed to the Prosecutor's Office for legal action against professionals involved.

Applications for medical injury compensation in 2006 amounted to 4.848. 1.310 people were granted compensation of £38 million. Administrative costs were £7.2 m.

In 2004, 6,000 adverse events reports were made, resulting in 137 specific proposals for change. These are often the result of 'root cause analysis' reviews. It is estimated that 50% of adverse events are medication errors.

In social care there were 807 complaints in 2003, 3.5 case per Complaints Council.

Attitudes of the public and staff: Positive use of information from complaints, no-fault compensation and adverse events is seen as beneficial to the public and professionals and has an economic rationale for the health system, as adverse event

add 7 days to hospital stays. For these reasons the various health care professional bodies have been supportive of the creation of the Patient Complaints Board (for discipline), the Patient Insurance Association (for compensation), and the adverse events reporting system.

Apology is supported by local arbitration between professionals and service users.

Redress: is supported by the no fault medical injuries compensation scheme and a similar scheme which provides compensation for injury caused by pharmaceuticals.

Monitoring and further action: The Patient Complaints Board is charged with the core task of disseminating the Board's important decisions of principle. Every year the Patient Complaints Board distributes around 250 such cases. Their website gives access to a database comprising more than 2,000 such decisions of principle. One of their goals is to publish 200 anonymous decisions of principle a year. In addition there are targets set for the average time to reach decisions and the number of complaints handled per staff member. Where the board decided to issue severe or repeated criticism the title and names of the professionals are published on the Board's website, information is passed to the National Health Board to consider disciplinary action, and cases may be passed on for prosecution.

Learning: will be enhanced by drawing together data from the complaints handling system, data on disciplinary action in relation to health professionals, data on compensation cases and data from the adverse events reporting system. This will turn these information silos into sources of knowledge for health care quality improvement.

This step will be matched by organizational structures for the dissemination of good practice. The current quality reform will establish organizational structure and formalised networks to ensure that lessons are disseminated fast and effectively. The Danish Institute for Quality and Accreditation in Healthcare will establish such networks for regions, hospitals, and GPs, which will ensure that complaints and other incidents are systematically captured, analyzed and acted upon with follow up to evaluate the effectiveness of actions taken.

A similar scheme for capturing information on and responding to complaints, compensation claims (which may also apply to injuries caused by social care services), professional conduct inquiries and adverse events reporting is proposed for Municipality managed or funded services.

Improvement suggestions:

- It is vital to improve timeliness.
- There should be a statutory requirement to provide information concerning the status of the complaint to both the complainant and care provider.
- It is important to track complaints that are resolved informally for their contribution to system-wide improvements.
- Information to senior citizens about their social care rights should be improved and outreach programmes provided to help them complain if rights are violated.
- Complaint mechanisms should be improved in relation to the transfer of care from hospital to home or community care provided by different organisations
- Special attention should be given to complaints about care in multidisciplinary environments.
- Professional practice in diagnostic and technological procedures should be reviewed to produce guidelines and monitor compliance to meet current and future needs in the high risk diagnostic area.

Germany: Fragmented complaint handling in a complex system

Organisational responsibilities: Policies for consumer complaints in health and care are set by German Federal Government and 16 Regional State Governments (Länder). However, laws and regulations recognise the self governing nature of the German health and care system, with 292 sickness funds (including nursing and long term care funds) governed by member elected boards representing employers and employees. There are also 49 private insurers. Sickness funds and insurers may issue their own regulations or guidelines to their members within the overall legal framework. Hospitals have a great degree of autonomy in handling patients' complaints and apply their own interpretation of any guidance they receive. Health professionals are also self governing in respect of their codes of practice through regional professional associations (chambers). Groups of regional physician chambers provide independent arbitration committees. Patient and consumer groups also play a significant role in supporting complaints. All of these bodies may have complaint handling functions, many of which overlap and few of which use the same approach. It is therefore misleading to refer to a German system for complaint handling, there are many and varied systems.

Legislation and regulation: The call for greater consumer and patient orientation may be traced to the Conference of Regional Health Ministers in 1996 and the efforts of several health consumer and expert groups. This led to changes in the law in 2004 creating a new regulatory framework, which now includes:

- The establishment of the Patients' Commissioner of the German Government and support for independent consumer and patient protection and advice offices.
- Sickness funds were also given the right (but not obliged) to support member complaints. Similar regulations apply to long term nursing funds. Rehabilitation insurers are required to provide local service and advice offices often in collaboration with sickness funds.
- The establishment of complaint management units in hospitals is regulated by the Regions, by 2006 4 of the 16 Regions have enacted regulations requiring hospitals to establish complaints functions but implementation varies. They are asked to ensure complaint staff are independent from line management, but this is not necessarily followed.
- Physician Chambers support complaint handling through roles in defining and enforcing professional codes of practice dating back at least to the 19th century.
- Independent arbitration committees: groups of Chambers provide appeals and compensation arbitration services. Legislation in 2004 required patient/ consumer representation, this now happens in some cases usually without voting rights. As a last resort complaints may result in action in the civil, criminal, social and professional court systems. The latter are special courts for major professional misconduct cases they can censure professionals and fine them up to £1820.
- Consumer Offices: are funded by Federal Government, Regions and private sources; in some cases they have a health department providing legal advice on how to pursue complaints and compensation.
- Independent patient services and self help groups pilots, run by national and local patient/ consumer and self help groups are funded by sickness funds. They are organised in 22 sub regional groups.

Definitions processes and timescales, numbers of complaints and staff: vary across these different systems and even similar services vary between Regions and from one organisation to another:

- Patients' Commissioner:
 - Definitions: emails, letters, phone calls and face to face at "citizen hour"
 - Processes: responds to all inquiries, analyses and redirects complaints and represents common issues to parliament and other decision making bodies but does not handle individual cases.
 - Numbers: ~70,000 complaints in 2004/5 less now (population 83 m)
 - Staff – Commissioner is an MP plus 11 staff, 8 professional + 3 support staff.
- Sickness funds*:
 - Definitions: telephone, letters and any indication of "discontent"
 - Process: investigates cases of medical malpractice and "reads between the lines" to note areas of concern, responds within a day, reports quarterly.
- Hospital Complaints Unit*:
 - Definitions: seen as part of quality improvement, gathering information from complaints, concerns, criticism, praise and disapproval, elicited from flyers as people enter hospital, comments accepted by phone, letter or feedback forms.
 - Process: confirmation within 3 working days, investigation and report within 2 weeks, resolution and report to patient in 4 weeks, system improvement and further report to patient – mean time to resolution 13 days.
 - Numbers: positive approach leads to increase 90 in 2004 to 1000 in 2007 from 50,000 inpatients and 70,000 outpatients (73%) and staff (27%)
 - Staff: 2 part time staff but training has led to engagement by all staff.
- Physician Chambers*:
 - Definitions: usually letters of complaint about medical malpractice, or breach of code of ethics, cases may be reported in person e.g. sexual misconduct.
 - Process: confirmation letter within one week, physician contacted and asked to respond within one month, investigation concluded within ~ 2- 3 months.
 - Outcomes: 85% of cases settled by review of letters, 15% reviewed by board of 3-7 members, of these 20% go to Professional court with involvement of the legal dept. 80% closed by meeting with President of Chamber.
 - Numbers: 657 in 2006 from a population of 1.7 million
 - Staff 1 jointly qualified doctor/lawyer plus 2 experienced administrators
- Independent Physician Arbitration Committees*:
 - Definition: complaints appeal from chambers by voluntary agreement
 - Process: no standard procedures for peer review, standards are being developed, burden of proof rests with the appellant
 - Numbers: est 40,000 medical error appeals 12,000 cases proven (pop 83 m)
- Consumer offices (health affairs department)*:
 - Definition: consumers seeking help to pursue complaints and compensation, by phone (46%), personal consultation (43%) or in writing (11%)
 - Process: clients pay a fee as a contribution to costs unless unemployed, legal advice is provided on how to pursue litigation, also web site and newsletter
 - Numbers: in 2005 3,026 enquiries were made (from population of 1.7 m)
 - Staff: 6 employees working part time and 2 consultants
- Independent patient services and self help group*:
 - Definition: all forms of written and verbal complaint, focussed on improving access for disadvantaged groups.
 - Process: provides non legal advice to patients to enable them to decide how to handle complaints proceedings and whether and how to seek redress
 - Numbers: one third of enquiries concern complaints.
 - Staff: 3 general advisers in a local office – total of 70 in 12 offices nationwide.

*These are examples taken from case study interviews, as local practice varies.

Attitudes of the public: An analysis of 850 letters of inquiry submitted to the Patient's Commissioner showed that:

- 76% of inquiries related to coverage/ reimbursement by insurers
- 26% concern reimbursement of pharmaceuticals
- 51% of inquiries were in connection with chronic diseases
- 9% concerned communications of misconduct of physicians
- 14% referred to disadvantage and lack of fairness
- 20% concerned the financial burden

Another study showed that, in the majority of cases of complaint, misconduct by health professionals and excessive use of diagnostic services was the focus.

In general it seems that German patients are adopting a more demanding consumerist view of health and care services but current systems pose considerable barriers for complainants particularly for disadvantaged groups lacking skills in writing or dealing with quasi legal proceedings. For this reason a plethora of organisations provide various forms of support for complainants.

Attitudes of staff: The example of changing attitudes at one hospital show what can be achieved but this was probably more of an exception than a rule.

Apology: is one outcome of complaint procedures that is difficult to achieve.

Redress: can be achieved through the Independent Physician Arbitration Committees but only with great difficulty. Note that such committees are dominated by health professionals, they are independent only in the sense of being unrelated to the physician against whom a complaint appeal is raised. Nevertheless this route is preferred to the court system because it is free of charge whereas court proceedings can be very costly.

Monitoring: is difficult if not impossible. There is no federal or regional process for monitoring complaints other than by inviting complainants to contact the Patients' Commissioner. It is not possible to ascertain how inquiries at this level match the numbers and types of complaint in all the different complaint systems.

Learning: from complaints is clearly difficult in these circumstances. Though in some cases complaints staff do meet to share experiences, this is very often limited to meetings between staff from similar organisations. And yet the specific case study of a hospital complaint unit was amongst the most positive examples of best practice found in the 9 countries reviewed

Improvement suggestions:

- Legislation at Federal level and in some Regions provides a framework for improved patient/consumer focussed complaints systems.
- However, this has not yet been carried through in professional associations and other systems that traditionally govern health complaints.
- A more radical and sustained approach to reform the complaint system may be required as health and care users develop a more consumerist approach.
- Current systems are not easily accessible by many disadvantaged people and further steps are required to achieve greater equity of access.
- While some hospitals are developing positive approaches to complaints it is more difficult for consumers in ambulatory care to know how to complain particularly when a range of different professionals are involved. This requires a patient /consumer approach rather than the current focus on professional conduct.

New Zealand: An integrated system based on health and disability rights

Organisational responsibilities: are focussed on a central complaints handling agency, the Health and Disability Commissioner (HDC). This independent agency promotes and protects the rights of health and disability consumers, and facilitates fair, simple, speedy, and efficient resolution of complaints - together with a national network of independent advocates, under the Director of Advocacy, and an independent prosecutor, the Director of Proceedings, both located within HDC. The agency also has the objective of improving the quality of healthcare and disability services. In this respect it can make recommendations even when no complaint has been raised. Local handling of disputes will usually start within the provider organisation in one of the 21 District Health Boards that provide or fund health and disability services for the 4 million population. Customer Relations Officers at the District Health Board level provide the first point of contact for complainants, with an option to contact the local Health & Disability Consumer Advocacy Service or HDC.

Legislation and regulation: In 1974 the tort based system for compensating medical injuries was abandoned in favour of a government funded system for no fault compensation, supported by a state funded insurer, the Accident Compensation Corporation, to pay unmet patient expenses from injuries arising from medical treatment. In the 1980s, there were concerns that a no-fault system amounted to a "no accountability" system. The 1988 Cervical Cancer Inquiry Report noted a strong need for the establishment of a Commissioner as an independent complaints resolution and educational body for patients' rights. A bill was first introduced in 1990 and following health reforms in 1993, it was broadened as the Health and Disability Commissioner Act to cover disability services consumers. The first Commissioner was appointed in 1994. The rights of health and disability consumers were defined in the Code of Health and Disability Services Consumers' Rights of 1996. The Act and the Code were updated in 2004, to make their operation more flexible. An inquiry into the quality of services and level of care for disabled people and how they might be improved is currently being considered by the parliament, so further developments are expected in 2008.

Objectives: The vision of the HDC is to be champions of consumers' rights, whilst their mission is resolution, protection and learning. Their objectives are to protect and promote the rights of health and disability consumers which are:

- You should always be treated with respect.
- No one should discriminate against you, pressure you into anything, or take advantage of you.
- Services should help you live a dignified, independent life.
- You should be treated with care and skill and receive well coordinated services.
- Service providers should listen to you and give you information in a way you can understand and that makes you comfortable to ask questions if you don't.
- You should have your condition explained to you, including benefits, risks, alternatives and costs of treatment, and have any questions answered honestly.
- You can make your own decisions and are free to change your mind.
- You can have a support person with you at most times.
- All these rights apply if you are asked to take part in research or teaching.
- Your right to make a complaint about services must be taken seriously.

HDC report that one of their biggest challenges is to be responsive and timely.

Definitions: of complaints are very broad. Complaints can be received on-line, in writing or orally. HDC does not even need to receive a complaint to take action.

Processes: may involve three main stages

- Informal and/or formal local resolution within provider organisations and District Health Board for which patients/clients can request free local advocacy support.
- Referral to HDC :
 - Assessment: Complaints assessors receive complaints as part of the overall complaints resolution process. They acknowledge and record complaints, gather preliminary information, send the complaint to providers for comment and manage the complaint file. Complaints are assessed by senior staff, who recommend how to handle the complaint. The Commissioner can: take no action, take an educational approach, ask for an apology, recommend action and follow up on actions, formally refer to a provider, advocacy or formal mediation. Or:
 - Investigation: Complaints may be subject to detailed investigation. An Investigator will be appointed, who will contact all parties, gather evidence and seek expert opinion on whether expected standards were met. This information will be used to assess whether there has been a breach of right in the Code. Complainants and service providers are given the opportunity to comment. And the Commissioner makes a final decision. This may include: an apology, a change in the way things are done by an individual, changes to policies and practice.

Copies of the final opinion are sent to relevant professional groups so members can be informed. The Ministry and Minister of Health can also be asked to take steps to improve a service, particularly if a problem is revealed through the investigation or consumers need to be protected through implementation of new policies or procedures.

The Commissioner can refer complaints to other agencies such as the Medical Council of New Zealand, or statutory officers such as the Privacy Commissioner. He most often uses this power to refer matters raising competence or professional conduct issues, for review by the registration boards.

The Director of Proceedings, an independent prosecutor within the Commissioner's office, can also be asked to make a decision as to whether the provider should be taken before a tribunal for consideration of disciplinary action, disciplined or taken to court. This occurs only in only a small number of more serious cases.

Timescales:

- Responses to enquiries enabled 96% to be closed within one day.
- Written responses were closed in 87% of cases within one month.
- Complaints were closed in 96% of cases within one year.
- Just over half 54% of the investigations were finished within a year.

The complexity of the issues, and the need to seek outside expert clinical advice and to be fair to all parties, may delay the process. HDC are committed to reducing investigation times, with the aim of concluding most within a year.

Staffing, numbers of complaints and budget: HDC has a total of 52 staff (about 48 whole time equivalent), in 2006/7 they handled 7,444 enquiries, 1,289 new complaints were referred to HDC, an increase of 20% on the previous year, 89 complaint investigations were concluded and 126 cases were closed after being referred to other agencies, 19 were referred to the Director of Proceedings. The Health and Disability Commissioner has a budget of some £3 million.

Advocacy staff (26 whole time equivalent advocates and 8 support staff) working out of 26 local offices, handled 8,388 enquiries and helped complainants deal with 4,078 complaints in 2006/7. HDC both directly provides advocacy services and funds advocacy by other consumer support groups.

Attitudes of the public and staff: HDC place a great emphasis on developing appropriate understanding of health and disability rights with consumers and local health and care staff. This is achieved by working with local health and disability networks and educational sessions. Thus advocates took part in 2,575 networking contacts within their local communities and carried out 1,665 education sessions across the country in 2006/7. They visited 98% of rest homes to raise awareness.

In addition a broad array of educational initiatives is undertaken by other HDC staff including seminars and conferences, publications and web site developments.

The Health and Disability Commissioner himself, Ron Paterson, maintains a high public profile with television, radio and other media appearances raising awareness of health and disability rights and quality improvement issues.

Raised awareness and championing of health and disability rights has led to acceptance of greater openness in dealing with complaints and other quality issues. Open disclosure is now accepted as a feature of the New Zealand system and included in the strategic plan. All District Health Boards are to implement open disclosure policies by 2010

Apology: may be achieved through advocacy or may be recommended by HDC.

Redress: as noted New Zealand has operated a no fault compensation scheme for medically induced injuries for 30 years.

Monitoring: of HDC is by comprehensive performance reports in its annual review. Under the New Zealand Public Health and Disability Act 2000, District Health Boards have a responsibility to monitor the delivery, quality and performance of services that are publicly funded. This should include monitoring complaints and complaints handling.

Learning: HDC places great emphasis on learning from the experience of complainants. From 1 November 2006, the Commissioner began naming District Health Boards and public hospitals in breach of the Code where system problems were noted. A National Quality Improvement Committee (QIC) has recently been established to lead national quality and safety initiatives. The Commissioner's Director of Advocacy has been appointed as a member of this committee.

It publishes case studies on its web site and in other publications. It also challenges District health Boards to say what measures they have in place to prevent a reoccurrence of situations leading to a breach of health and disability rights.

Improvement suggestions:

- The Code of Health and Disability Services Consumers' Rights is a key driver in promoting and protecting consumer rights
- Make it easy for people to complain (e.g. a form on a website)
- Be responsive and get back to complainants quickly.
- Keep trying to make system better by being more responsive and speeding it up.
- Provide regular updates to complainants about their files
- Have recently improved investigation processes through going out and interviewing people rather than it being a paper-based exercise
- The local advocacy service is key to resolving complaints locally, this has been particularly important for people with a disability and people in rest homes.
- Overall New Zealanders are happy with their complaint system.

The Netherlands: A central role for patients/ consumers in health and care

Organisational responsibilities: The Ministry of Health Welfare and Sport regulates health and care policy. Responsibility for funding and providing health and care services and complaints relating to them are born by the 19 independent insurance agencies and the providers of health and care services (most are not for profit private providers) and health professionals. These providers are represented by national associations. Patient/consumer organisations at local, regional and national level play a strong role in representing the views of their members.

In the mid 1990s regional patient/consumer groups started to run some 25 information and complaints helpdesks supported by a national knowledge centre established by the National Patient/Consumer Federation, the Royal College of Physicians and the National Hospital Association. Now all Dutch hospitals and large care institutions have central helpdesks, they operate their own complaints systems and also provide access to a formal complaints committee.

Complaints against professional services provided directly by government (academic hospitals, regional health authorities and certain medical experts) may be appealed to the office of the National Ombudsman. The great majority of cases concern services funded by privatised health insurers, these may be brought to the institutional and regional complaints committees and a specific arbitrage processes. Complaints may also result in cases taken to professional disciplinary boards.

Legislation and regulations: An interrelated set of new laws were enacted to underpin patient/consumer rights and complaints procedures. The cornerstone was the 1995 Act on Client Complaints in Healthcare, followed by similar acts on psychiatric care, medical treatment contracts, quality in healthcare institutes, participation in healthcare institutes, medical examination and on scientific research on people. This set of 8 laws created the basis for the Netherlands complaint handling system. Practical experience has built on this base so that political and legal emphasis on patient/consumer rights has become part of professional attitudes and the goals of health providers.

Objectives: for health and care complaints reflect a policy reform carried through in the 1990s to position patient/consumers as key stakeholders in health and care.

Definitions: Dutch health and care complaints systems can be defined in terms of 3 interrelated layers: 1 = local, 2=sector, 3 = justice

- 1a *Consumer awareness*, to understand their rights and discuss complaints informally, at an early stage, stimulated by guidance, leaflets and posters.
- 1b *Facilities for information, mediation and guidance*, including: helpdesks, advocacy services, publications, phone and internet based support.
- 1c *Formal complaints-committees of institutions and professional groups*, as required by law, they can determine a case but cannot impose sanctions.
- 2a *Disciplinary boards*, five legally based regional disciplinary boards are run by the state, others are instituted by the professional organisations.
- 2b *Arbitration boards* committees with authority to settle conflicts and determine compensation for damages.
- 2c *Ombudsman system* government ombudsman only deals with cases against the government, a healthcare insurance ombudsman service is also available.
- 3a *Civil courts* may determine compensation for material and immaterial damages due to medical or care failures.
- 3b *Criminal courts* may determine prosecutions brought by the police and state attorney of offences against human rights and illegal practices in health and care.

Processes : The 1995 Act on Act on Clients Complaints in Healthcare requires every hospital, nursing home, psychiatric institute and group practice to make its own rules for filing complaints. Self-employed professionals can use the regulations made by their professional association. The Act imposes a global framework for the regulations and the way a complaints committee has to operate. It is left to the institutions to determine their own procedures within this framework.

Basic legal requirements for complaints regulations include:

- A complaints committee, with three members including an independent chairman each hospital has such a committee, nursing homes share joint committees.
- Transparent hearings (in writing or in person) considering both sides.
- A judgment whether the complaint is valid or not, which could be accompanied by recommendations for correction and quality improvement in the system.
- The committee should bring its recommendations to the attention of the management of the institute, the complainant and the person complained about.
- Management or the person complained about must inform the complainant within a month about improvements that will be made as a result of the judgment.

Complaints procedures in hospitals do not provide an appeals procedure other than the courts or referral to arbitration, which must be agreed by both parties. However, for nursing homes there is a National Appeals Committee.

Based on these requirements guidelines have been developed by the Netherlands Patient /Consumer Federation in consultation with other bodies involved. These were set out in 2004 in the publication "Complaints Guidelines in Healthcare."

Staffing: All Dutch hospitals have a central helpdesk for patient information and guidance. They are staffed by volunteers or employees providing information, referring to written material or web links for better understanding of: diseases, treatments, lifestyles or the legal position. More than 50% of the hospitals have some sort of specific complaints staff connected to the service desk, who guide questions and complaints towards the right person within the hospital. They try to restore communications and relationships. Mediation is becoming more important in complaints management, but if required, they provide support in filing complaints.

There are also many national helpdesks providing support for complainants in specialised fields. They can be contacted via internet, telephone, mail or in person.

Psychiatric patients can get information and guidance about their position and rights from patient-stewards, employed by an independent national foundation but working within the psychiatric institutions. In case of problems and complaints they try to stimulate communication, but if necessary they help patients file formal complaints and assist them in committee-hearings.

Numbers of complaints: Surveys suggest that each of the 90 general hospitals will receive some 150 -250 complaints, 90% of which will be dealt with informally either by information exchange, restoring communications or by mediation. On average hospital complaints committees will receive about 20 formally filed complaints each year. Nursing homes typically generate 2 formal complaints a year, joint complaints committees typically handle 10-20 cases. Psychiatric institution complaints are less easy to typify, about 10-20% of complaints are about involuntary treatment. Disciplinary boards receive some 1000 complaints a year in total but only 15-20% of these will be upheld. These cases take at least 8 months, usually longer.

Attitudes of the public: Research from various Dutch sources has shown that:

- 20% of the adult population feel they had ever had reason to complain about healthcare, only 50% of these said they had discussed this with the provider.

- 50-75% of people would discuss the problem with the healthcare provider before making a formal complaint and 50% are informed about the complaint process.
- 25-40% of complainants say they would not have filed a complaint if the person responsible had shown more empathy, but
- 60% of patients who had discussed their problem with their provider concluded it had not resolved the issue.
- 90% of people making a formal complaint say they do so in order to improve the quality of services and ensure others do not encounter the same problem.
- 60-80% of complainants wish to hear some sort of explanation or admission.
- Less than 50% expect to solve their problem or receive compensation.

Attitudes of staff: One of the most important factors underlying the Dutch health and care complaint systems has been the introduction of guidelines and standards for skilful information disclosure, empathetic behaviour, respectful attitudes and openness. These have become part of the curriculum in medical and paramedical education. This has enabled staff to deal more openly with comments and complaints and thereby reduce the likelihood of formal complaints proceedings, which can be time consuming and risk polarizing attitudes of defensiveness and distrust.

Apology: Complainants report that after their complaints were upheld by a complaints committee (or through some other process), only 20% of providers have either admitted they made a mistake or offered an apology, in only 14% of cases were relationships said to be restored.

Redress: is not included within the complaints system, complainants may take cases to arbitration or pursue damages through civil courts.

Monitoring and learning: is difficult as there are no regulations systematising this, however, the National Patient/Consumer Federation, the Royal college of Physicians and the National Hospital Association draw out lessons and present a national report.

Improvement suggestions:

- Complaint systems are integral to patient/client rights and quality improvement.
- Implementation must be bottom up, with engagement through patient/consumer organisations bringing local ideas and experience to regional and national level.
- Implementation must also be top down with government and sector leadership for legislation, financing and positive attitudes at every level.
- The informal stage is the most effective and efficient point to resolve complaints. It is the core business of complaint handling, it should be legislated and funded.
- Integrated helpdesks should provide access to regional patient/consumer offices.
- Formal complaints committees should be:
 - Either clearly independent or part of the institutions' management process
 - Authoritative enough to impose sanctions, improve systems and offer redress
 - Subject to some form of appeal other than court action.
- Transparent feedback to all parties is essential.
- Arbitration boards should be used more widely they offer quick, easy settlement.
- Compensation must be fair to all parties no fault compensation may be required.

The Dutch system is a patchwork of different elements, the Government is now reviewing the system with a view to producing a more coherent system. They will look into a number of the issues listed here: more independence for complaints committees, possibilities for appeal, combining complaints and claims for compensation and more transparency in feedback following complaints.

How International lessons might apply to England

This section reflects on lessons from other countries' complaint systems for England. This is based on the personal experience of the authors rather than detailed analysis. These reflections are set out under the themes of the Executive summary, which are not repeated here. Finally we present a summary of examples of typical and good practice by theme and country, this is of necessity, a brutal simplification.

Organisational responsibilities: In most countries local offices provide advice on self care, healthy lifestyles and choices in health and social care, alongside mediation and support for complaints. The creation of such offices in NHS Trusts could be based on current Patient Advice and Liaison services. In primary and social care it might be possible to operate locality based joint offices, noting that GP practices and smaller social care units require support to work with such services.

While other forms of advice and support may be provided from the same office, specific advocacy support for complainants should be independent and might be based on the current Independent Complaints Advocacy Services for the NHS and similar services contracted by Social Services Departments.

The countries reviewed had different structures for patient/client engagement associated with complaint handling. This brought the patient/client perspective to complaints and in some cases provided volunteer support for advice and complaints. For England it may be appropriate to combine Local Involvement Networks for health and social care users and engage this network in local advice and complaint support. Local patient /client engagement needs to be supported by regional/national structures able to apply patient/client perspectives to policy, as in the Netherlands. However, the experience of the Commission for Patient and Public Involvement in Health suggests such a structure should be developed from the bottom up, perhaps as a development of the Long Term Conditions Alliance and similar bodies.

National complaint support organisations can encourage and enable local complaints handling by training and systems support, but should not replace local resolution. Beyond this there is a need to enable shared learning from complaints at national policy level and to provide follow up from complaints putting lessons into practice, naming and shaming where necessary and initiating disciplinary action. In England support for local complaint and associated functions in both health and social care could be provided by the Health and Social Care Commission (to be created from merger of the Healthcare Commission and Commission for Social Care Inspections).

A complaints appeal process should be seen to be independent of the local process. In England this might be achieved by combining the appeals review and investigation functions of the Local Government and Health Ombudsman services. Given the scale of complaints that might be generated it will be important to develop well functioning local processes to reduce the number of appeals to manageable numbers.

Many respondents noted the importance of linking complaints to professional disciplinary action and arbitration for compensation. This was usually handled at regional level with trends towards independent representation on such bodies and greater legal support for the parties and separation of investigation and adjudication. In England similar proposals are already included in the recent White paper on the regulation of health professionals, which implies a regional structure. It would be helpful to consider how complaint and disciplinary processes should be linked.

Legislation and regulation: In most countries surveyed legislation provides a clear basis for patient rights as the foundation for complaints systems, as it is essential to set out what the patient/client should reasonably expect. Such rights provide the basis defining the contract between insurers or the state and patient/clients.

Patient /client rights should certainly include the right to complain, as in all the countries reviewed. This should bring with it the right to advocacy support in making complaints, with special provision for vulnerable people such as children in care, people with mental illness and those with language or speech problems.

In England, as commissioning health and care services is to have greater local autonomy and particularly as more services are operated by independent providers, it is even more essential to establish the minimum quality of services that patient/clients should expect and equally their duties in making responsible use of services. There have been various statements of patient/client rights and responsibilities, patient charters and welfare rights for England but clearer legislation is required.

Rights, such as described in the New Zealand Code of Health and Disability Services Consumers' Rights, set out basic entitlements but services change with medical and technical developments. Thus more detailed standards such as those established by the National Institute for Health and Clinical Excellence, the General Social Care Council and many other bodies form a basis for monitoring by the Health and Social Care Commission and should also provide a reference point for complaints.

This requires a comprehensive, dynamic database of standards as applied to health and care provision, as proposed in the Department of Health 2004 Health and Social Care Standards and Planning Framework and currently being developed for health by the Health Care Standards Unit at Keele University. Such a database will be very extensive and probably confusing for service users, it is therefore important to produce simple guides for specific user situations.

Objectives: Respondents noted the need for a positive approach to complaints and comments. In such an approach the objectives of complaints handling systems would be to engage patient/clients in dialogue to improve services and user satisfaction.

Complaints should be resolved as locally and as quickly as possible to meet the reasonable expectations of complainants, whose objectives may include: explanation, apology, training or systems changes so that the same thing will not happen again and possibly compensation. It is important to reflect these objectives in performance measures for English complaint systems. Reports should focus on the basic aims of the system, thus more comments and complaints may reflect better dialogue. Outcomes of complaints should reflect not only the speed of local resolution but the actions that followed and the extent to which user objectives had been met.

Given the variability of complaints it is sensible to set standards for average performance levels possibly as percentage targets as in New Zealand rather than absolute limits on timescales and resolution of complaints.

Definitions: are of fundamental importance to the management of complaints. Most systems treat complaints as a sign of failure – because they only record complaints that are not resolved informally. Several respondents noted that, where complaints and comments were treated as a positive sign of engagement, informal feedback can help to improve service quality and responsiveness. Standards for defining and categorising complaints and guideline “comment and complaint forms” might help.

Processes: In general, it is clear that the complaints process should be as simple and straightforward as possible with local resolution leading to one further review or appeal stage as necessary.

Although most countries do not combine complaint handling in health and social care several respondents also noted that complaints about coordination of health and social care are increasing and difficult to deal with through separate systems. In England health and social care complaints could follow a common form and might be brought together by co-terminus Primary Care Trusts and Local Authorities operating

joint commissioning. Joint Oversight and Scrutiny Committees for health and social care (with seconded PCT board members) might take a role in independent review.

In England the complaint process might take the following form:

- Informal local resolution within the immediate care team.
- Formal resolution at the senior management level of the organisation.
- Either independent review conducted at PCT/LA level reporting to a joint Health and Social Care Oversight and Scrutiny Committee,
- Or appeal to a Health and Local Government Ombudsman Service.
 - Assessment of the complaint to accept or reject the referral
 - Review and decision or
 - Investigation and decision.

It is important to establish and explain at each stage why the complaint could not be determined at the preceding level and to have clear processes to close cases where appropriate (some countries seemed to have clearer procedures than England). All such decisions should be transparent and open to scrutiny. This approach requires that complainants and those complained about should choose independent review or appeal to the Ombudsman service. Independent review may be helpful when investigating a local system issue, where outcomes are not disputed but it is important to understand why things happened and how to improve. They should be used sparingly because such reviews can be expensive and are only justified when there will be benefits to local health or social care systems and the public.

There should be clear criteria for acceptance of appeals by the Ombudsman service. These criteria might include prima facie evidence to suggest that the patient/clients rights (or reasonable expectations) had not been met through personal or system failure and that the decision taken at the preceding stage was unreasonable. Appeals not meeting these criteria would lead to closure of the case, as respondents note, it is important to avoid bouncing cases back and forth between levels.

Timescales: Based on international comparison of good practice local informal resolution should be immediate where possible, certainly within 1 week. Formal local resolution may take 5 weeks. When moved on to a second stage, timescales should be kept as short as possible but related to the complexity of the issue, independent review might take 8-10 weeks. Appeal to the Ombudsman service might require 2 weeks for assessment, 4 weeks for review, 6-12 weeks for investigation and 4-6 weeks for decision and report.

Where policy issues are raised, separate longer term review may be required beyond the scope of the initial complaint. If a case raises such doubt as to require long term study to test its validity it might be better to accept the complaint in the first place.

Staffing: Front line staff and management teams need to share an understanding of the importance of listening, encouraging complaints and learning from them, this should be part of basic professional training. Local complaints support staff should further develop this shared understanding through training and example.

The associated tasks of complaint support staff including: patient/client advice and engagement and quality improvement are equally demanding and important in modern health and social care management. For this reason the role should be seen as a development opportunity for staff, leading to senior management positions. Their skills should be developed through learning networks and mentorship.

A large hospital or an office supporting complaints in primary care and social care may require a team of perhaps 3- 6 complaints support, patient/client advice and engagement and quality improvement staff. But this is not intended to imply that

staff roles should be specialised in this way, the role is essentially interdisciplinary. This is in any case necessary since the workload of complaints will be very variable.

Local advice and feedback offices require on-line support and knowledge systems, including a kiosk with booklets and on-line information used with patients/ clients to discuss treatment and care choices, self care, personal care budget options, organ donation, contact with patient/client support organisations as well as complaints and suggestions. Basic rights, standards and reasonable expectations should be easily accessible here. It would be useful to combine health and social care advice.

Independent reviews can cause delays because it often takes time to find appropriately qualified people, prepared to sit on a review panel. This may require one independent chair, one person with experience of investigation and review and one person with an understanding of standards and practices in the field under question, with the complaint support staff preparing papers and minutes. In order to reduce the timescale, lists of relevant reviewers could be retained on regional panels. All members should receive at least introductory training for this task.

The functions of the Health and Social Care Commission in supporting these front line offices would be to set standards for complaint handling, patient advice and engagement and quality improvement, provide overall direction and ensure there were adequate resources for these tasks. This would require training and knowledge sharing for these staff, ensuring adequate publicly accessible offices and facilities. They would need to champion issues arising for policies and standards and challenge services to show how they would avoid a recurrence of problems (as in New Zealand). It is fortunate the Health and Social Care Commission would have powers to investigate problems where no complaint is made, to name and shame and to invoke sanctions such as closing units or prosecuting cases (also as New Zealand).

The Health and Local Government Ombudsman service may need to increase its investigative capacity to cope with the additional workload arising from the partial removal of the independent review stage. In Scotland the budget for the Health Ombudsman was increased to take into account the estimated doubling of the workload and the requirement for more rapid response. However, if more emphasis is placed on local resolution the increase in workload could be less than this.

The cases studies of New Zealand and Germany suggest it would be helpful for the Ombudsman to have a strong and clear media presence as this raises awareness.

Numbers of complaints: by 2008 has been estimated at 140,000 - 150,000 formal complaints submitted to health agencies in England, 3- 4% could result in independent reviews or appeals. Social care complaints are estimated at 20,000 – 25,000 with a higher proportion of appeals. Informal complaints are very much higher and may be regarded as a positive sign of engagement. Changes to complaints systems tend to raise awareness and generate increases in numbers.

Attitudes of the public: mean that patient/clients are reluctant to initiate complaints, this was borne out by attitude surveys from different countries that showed a similar position. In the German example, one of the hospitals took a much more open approach to comments and complaints. Taking lessons from private sector hotel operators, it encouraged feedback as a positive contribution. This was very successful in invoking comments and complaints. An attitude study from the Netherlands showed that patients who found that the hospital acted on their complaint were most likely to have a favourable view of services.

While there are dangers in pushing such an approach before staff are ready to accept it, this approach has great potential in England as part of a broad agenda of public engagement in their health and care and in the NHS and social care services.

Attitudes of staff: are the most crucial aspect of good complaint management. All respondents noted the importance of training for front line staff. In The Netherlands training in complaints handling, open communication with patient/ clients and relationship management is included in basic professional education. This has clear lessons for England where a future agenda of engagement with patient/clients for co creation of health and well being will only be achieved if it is embedded in professional attitudes and ethical standards of open disclosure. For current staff it is important that continuing education and learning should involve senior managers as well as front line teams since this is a leadership issue within local health and care organisations and not just a front line team issue.

Apology: is much easier where clear legal provision ensures they cannot be used as evidence in subsequent court or disciplinary proceedings, as in Australia. This seems a simpler approach for England than trying to express an apology in a stilted form that excludes acceptance of blame. Respondents stressed that it is the empathy that lies behind apology that is important for patient/clients and for staff.

Redress: is emerging as a practical element of some complaints systems. It would be helpful if there were provision for limited redress in appropriate cases in England. Redress may take the form of explanation and apology – in a personalised letter. It is appropriate to recompense additional costs – e.g. transport or costs incurred from additional stays in hospitals or service failures. Beyond this simple gifts in kind such as flowers or a donation to a relevant health or care charity in the complainants name may help restore relationships. This should be within local budgets, bearing in mind that an unresolved case is likely to cost at least £5000 in staff time.

No-fault compensation found in Denmark and New Zealand makes redress simpler and possibly cheaper as well as supporting feedback and system improvement.

Monitoring: should analyse the nature and topic of complaints and comments, since the aggregation of local complaints may have important lessons for system improvement. A common format for analysing the nature, severity and topic of complaints would be help to draw lessons from English complaint systems.

Monitoring of complaint systems themselves should include aspects like training and awareness raising and action taken on the outcome of complaints. Patient/ client objectives should be monitored to see to what extent expectations have been met.

Prime responsibility for monitoring and learning from complaints must lie with boards of health and social care providers, PCTs and Local Authorities, through joint Oversight and Scrutiny Committees. Comparisons between different organisations would help to share lessons as well as bringing out overall issues of national systems management and policy to be addressed by the Health and Social Care Commission.

Learning: from complaints should occur at local and national level. Adverse event reports, findings from professional disciplinary hearings, clinical governance and case reviews, staff and patient/client complaints and improvement suggestions all offer lessons for quality improvement. It would be useful to establish linked databases for fields of health and social care in England as a basis for learning networks, as is being done in Denmark and to some extent Canada.

Improvement suggestions: Home country respondents noted that there was scope for sharing experience between systems and using common frameworks and tools, without the need for a UK wide system. It was also apparent that there are significant differences between health and social care in the nature and handling of complaints and their ability to respond to feedback. Introducing a common approach across the systems will require significant culture change; this should start by recognising the different position and needs of their patients, clients and staff.

International examples of typical and good practice in complaints handling

Theme	Typical Practice	Good Practice Examples
Organisation	Local support office plus regional or national appeal agency and patient/client support network	Denmark: Patient Assistance and Support Offices Northern Ireland: combined health and social care systems
Legislation	Patient/client rights including rights to complain and advocacy support	New Zealand : Code of Health and Disability Services Consumers' Rights
Objectives	Patient/client centred services recognising complainant objectives	Canada: to respect the rights of users and to improve the quality of services
Definitions	Written statements of dissatisfaction	Wales: when the person making it says it is a complaint
Process	Informal + 1-2 stage formal local resolution + 1-3 stage appeal + professional conduct review	Scotland: health informal + 1 stage local formal process + 1 stage review/appeal
Timescales	1 week informal, 4-5 week formal local + 16-52 week appeal process	Australia Queensland: assess 2 wks, investigate 6 weeks, review 3 months
Staffing	Integrated complaints and advice teams: 3-5 staff inc 1-2 wte complaints per 100,000 users Appeals staff: range from 40- 124 complaints per staff member	Netherland, Denmark, New Zealand and Germany have integrated local support offices Denmark: 124 decisions per appeal staff member
Numbers	Usually around 150 – 250 per 100,000 users but this depends on how complaints are defined	German Hospital shows that complaints can increase 10 fold with a positive approach.
Public attitudes	Resistance to complaining feeling powerless and disregarded	German Hospital: example of positive approach to complaints
Staff attitudes	Resistance addressed by culture change training	The Netherlands: stress open disclosure in basic training
Apology	Guidelines and encouragement	Australia: provides legal exemption for apology
Redress	Separate systems: arbitration, tort or no-fault compensation	New Zealand and Denmark have no- fault compensation
Monitoring	Usually emphasis is placed on number of complaints and time to resolution	Scotland: integrated approach to monitoring and learning from complaints
Learning	Usually supported by central agency publications and sharing of lessons and experience between complaints managers	Denmark: integrated database supports learning from adverse incidents, patients' complaints and compensation. Netherlands: annual report
Overall	Most systems are regional, linked to professional disciplinary systems.	New Zealand: well regarded system with emphasis on patient/client rights.