Cause for Complaint?

An evaluation of the effectiveness of the NHS complaints procedure

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About the Public Law Project

The Public Law Project (PLP) is a national legal charity which aims to improve access to public law remedies for those whose access to justice is restricted by poverty or some other form of disadvantage.

Within this broad remit PLP has adopted three main objectives:

- increasing the accountability of public decision-makers;
- enhancing the quality of public decision-making;
- improving access to justice.

Public law remedies are those mechanisms by which citizens can challenge the fairness and/or legality of the decisions of public bodies and so hold central and local government and other public authorities to account. They include non-court-based remedies such as complaints procedures and ombudsman schemes and also litigation remedies, in particular judicial review.

To fulfil its objectives PLP undertakes research, policy initiatives, casework and training across the range of public law remedies.

Research team

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Executive summary

Background

1. In July 1997, the Public Law Project received funding from the National Lottery Charities Board to carry out the first, independent, national evaluation of the operation and effectiveness of the NHS complaints procedure introduced in April 1996. PLP's aim has been to evaluate the procedure from the perspective of health service users, looking at issues of fairness and independence, and complainants' satisfaction with both the handling and outcome of their complaints. This report presents the results and conclusions of the research.

Research methods

2. A combination of qualitative and quantitative research methods were used to carry out the evaluation. These included:

- a UK-wide survey of community health councils and their equivalent organisations in Scotland and Northern Ireland (response: 65%);
- a national survey of trust and health authority conveners (response: 58.5% from trusts and 69% from health authorities);
- a national survey of chairs of independent review panels (response: 51.5%);
- 72 in-depth interviews with complainants (36), health service personnel (26) and health councils (10), in four regions of the UK.

The data were collected between April and December 1998.

Local resolution

3. PLP accepts that the principle of local resolution, whereby health agencies themselves attempt to resolve the complaints they receive, is generally sound. When conducted properly it enables complaints to be dealt with promptly and at the point of service delivery, encourages accountability by requiring providers to investigate and explain their actions, enables less serious complaints to be dealt with promptly without invoking complex procedures and encourages resolution and conciliation rather than confrontation.

4. However, local resolution also has inherent weaknesses which seriously impede the ability of complainants to achieve satisfaction or resolution:

- it fails to take account of the imbalance in power in the health professional-patient relationship and does not recognise how difficult it is for complainants to have to confront and challenge the very organisation or people that treated them;
- it lacks impartiality. Organisations investigate their own complaints giving rise to a potential conflict of interest;
- it fails to demonstrate the accountability of the NHS. As local resolution is internally conducted it can be invisible to complainants, it is not open to external scrutiny and providers of care are not seen to be publicly accountable.

In the primary care sector and in relation to serious complaints these weaknesses are particularly apparent.

The problem with local resolution in primary care

5. At the heart of the problem with local resolution in primary care is the requirement that users complain directly to the practitioners they are criticising. Trusts usually have a separate department for dealing with complaints whereas in primary care the process can become very personalised. The research revealed that this was a concern for many complainants and in some cases was even acting as a deterrent to complaining. Complainants were fearful of retribution, such as being struck off the doctor's list, or being adversely treated. They also felt daunted at the idea of having to confront the person concerned, particularly if they were feeling vulnerable. Some were sceptical about whether they would receive honest and impartial explanations. Research participants highlighted a need for users to be able to address their grievances to an independent authority, who would take responsibility for overseeing the investigation of their complaints.

Complaints which raise serious questions about competence and conduct

6. Participants in PLP's research felt strongly that there were insufficient mechanisms in place to deal appropriately with complaints that raise serious questions about performance, conduct or competence that place patients at risk. It was in these cases where the credibility of local resolution was most undermined and its appropriateness questioned.

7. In the interviews with complainants there were a number of accounts which raised profound concerns about the justice of local resolution. None of these went beyond local resolution and none of the complainants were satisfied with the handling or outcome of the complaint. Examples of complaints included:

- alleged lack of supervision leading to a suicide on a ward in a mental health unit;
- a case of alleged profound neglect in nursing care;
- sudden death in epilepsy, due to alleged mismanagement of medication.

8. In these cases, complainants reported:

- delegation of the investigation of the complaint to people too closely involved in the background to the complaint;
- lack of honesty and openness in explanations and responses;
- a tendency to believe the accounts of the staff involved rather than those of the complainant;
- chief executives, or senior managers, failing to take a close enough interest in the complaints;
- the need for disciplinary action, or any other form of remedial action, not being taken seriously;
- because of the complexity of the cases, local resolution becoming very protracted.

9. All of these issues contributed to complainants' disillusionment with the impartiality of local resolution and of the accountability of the NHS. Their level of dissatisfaction with the process indicated a pressing need for alternative procedures to local resolution, which would allow for early referral of such complaints to more independent investigatory and remedial processes.

Convening

10. The role of conveners is to decide whether or not a complaint should be referred for independent review. They are usually a non-executive director of the organisation whose complaints they are assessing. Impartiality is crucial to the credibility of the procedure, yet the research revealed serious doubts about the ability of conveners to fulfil this goal. The most striking result was that nearly one half (46%) of conveners in healthcare trusts themselves felt that it was difficult to maintain their independence. They felt that being involved in the trust as a non-executive director and knowing the staff inevitably introduced a bias. Such difficulties were compounded in some cases by conveners taking advice from those who could unfairly influence their judgement. Conveners also recognised that complainants did not see them as independent. The requirement on a convener to consult a lay chair for an independent view on a complaint was not considered a sufficient safeguard against potential bias, because ultimately the decision whether or not to hold a panel still rests with the convener.

11. A further important finding in relation to conveners was the evident inefficiency in having a convener based in every trust. Trust conveners who had been in position for two years had considered on average only nine requests for independent review and nearly half (48%) had not attended a panel hearing. This compares with health authority conveners who had considered on average 18 requests, and just nine percent had not had experience of a panel. Conveners themselves stressed how important it was to have an ongoing caseload, both to develop the necessary expertise and maintain familiarity with the guidance, yet it was clear that many conveners did not have the caseload to sustain their expertise. The requirement to consult a lay chair had also led to delays in decision-making causing frustration for complainants. The findings highlighted a need for reform of convening to make the role both more efficient and independent.

Independent review

12. A flexible and informal approach to complaints handling may be desirable during local resolution, but is less appropriate at independent review stage. Having failed to achieve satisfaction at local resolution, complainants expect to see a level of formality in the conduct of stage two that does justice to the seriousness of the grievances being heard. PLP's research revealed that the way independent review panels are established and conducted did not give complainants confidence in either their independence or effectiveness in holding the NHS to account. For example, in trust cases the panel is established as a committee of the trust and paid for by the trust. They are also seldom held on neutral premises and are sometimes administered by the same staff who are involved in local resolution.

13. With regard to the conduct of panels, the preference was clearly for an investigatory style in which parties did not meet, question each other or hear evidence presented. This lack of transparency in the way the panel was conducted contributed to a lack of confidence among complainants about the fairness of the proceedings and the decisions they reached. Moreover panel members and clinical assessors did not always behave in a way which reassured complainants of their impartiality in the process. Some conveners and chairs themselves called for the introduction of clear standards for the conduct of panels both to enhance the

transparency of the process and to demonstrate to complainants that the process is conducted in a fair and rigorous manner.

Improving services and performance in the NHS

14. The emphasis of the complaints procedure is on 'quality enhancement' yet the research demonstrated that the NHS has only weak mechanisms in place for ensuring that this happens. Many of the complainants interviewed for the research were doubtful about whether their complaint would have any impact on the quality of services, although one of the main reasons for complaining was to prevent what happened to them from happening to others.

Acting on complaints at local resolution

15. Whilst many health organisations endeavour to use complaints as an indicator of the need to improve services, 'closing the loop' on complaints is hampered by the fragmentary organisation of complaints procedures, audit, risk management and other quality strategies within trusts. Moreover, they do themselves a disservice by not always informing complainants exactly what action has been taken in response to their complaint.

16. A major concern of research participants was the lack of external monitoring of primary care complaints. Because the emphasis is on practice-based resolution, and only limited data are formally collected about complaints in primary care, health authorities have no means of meaningfully monitoring trends in complaints. It was questioned how continuing bad practice or poor performance would come to the attention of the appropriate bodies, and be satisfactorily addressed, if no one was responsible for monitoring where failings in service lay, or if complainants could not direct their complaints to a higher authority. It was widely felt that this had led to a loss of accountability of primary care practitioners.

Acting on independent review panel reports

17. Among respondents there was a lack of confidence in the effectiveness of independent review panels in achieving improvements in services. The principal concerns raised were:

- the lack of commitment on the part of some organisations to the process. This, combined with the fact that panel recommendations are not enforceable, made respondents question whether recommendations would have any impact on the quality of services where there was not the will to implement change;
- in the absence of an external body formally charged with monitoring and overseeing the implementation of panel recommendations, there was concern across all groups that NHS organisations could too easily avoid their responsibilities to improve services where it was not expedient to do so.

Many respondents called for the introduction of formal procedures to monitor the implementation of panel recommendations.

The relationship between complaints and discipline

18. While recognising that the relationship between complaints and discipline is a sensitive one, there was anxiety that the separation of the procedures had resulted in not only a perceived loss of accountability of NHS employees and health professionals but also a real loss, particularly in primary care. Since the introduction of the complaints procedure, there has been a very marked decline in primary care cases that now go through the disciplinary procedures. Furthermore, fewer complaints are now proceeding to independent review than were previously upheld under the disciplinary process, suggesting that the complaints procedure is failing either to pick up or address serious breaches in care. In situations where failings in performance are identified, these are increasingly dealt with through more informal processes of review. While this may be positive in that the emphasis is on retraining and improving skills, the drawback is that they lack the threat of sanction. Furthermore, by being invisible processes, complainants are not seeing health professionals being held accountable.

19. In relation to those complaints that ***are*** referred for disciplinary action, this is also an invisible process for complainants and they have no right to know the outcome of such action except in general terms. Thus, in both instances, complainants may be denied information about one of the most important outcomes they seek in making a complaint – that remedial action has been taken to address failings in care for the benefit of future health service users. Without such information a common feeling and perception is that the health professional 'got away with it'.

Summary of main recommendations

20. The following highlights and summarises a selection of PLP's main recommendations for reform of the complaints procedure. A full review and discussion of all PLP's recommendations is given in the final chapter of the report.

Improving the operation of local resolution

- The Department of Health (and its counterparts in the other countries of the UK) should produce national guidance and standards of good practice for the conduct of local resolution. Measures should also be introduced which improve the efficiency and speed of local resolution for all complaints, and which will also allow those which are appropriate for independent review to proceed faster to that stage.

Reform of local resolution in primary care

- As a matter of priority, the Department of Health should reform local resolution in primary care to enable users to complain directly to an officer who is independent of the practice concerned and who has responsibility for overseeing investigation of the complaint.

Proposals for complaints which raise serious questions about performance

- The Department of Health should develop a framework for 'fast-tracking' complaints which raise serious questions about performance, conduct or competence which put patients at risk. Under this proposal, complaints which satisfied certain defined criteria would initially be examined by an independent 'screener' who would decide whether they justified immediate referral to more formal investigatory and remedial processes, such as independent review, discipline, litigation or to the professional regulatory bodies.

Proposal for the reorganisation of the independent review process

- The Department of Health should establish independent regional complaints centres which are responsible for handling complaints which fail to be resolved at local resolution. Under this proposal, conveners would no longer be part of the organisation complained about but an independent appointment. The rationale for this approach is to give the independent review process greater independence and efficiency.

The conduct of panel hearings - enhancing transparency and accountability

- The Department of Health should draw up explicit guidance on the rules of procedure for the conduct of panels. This should ensure that complainants have a right to a fair and transparent hearing. Guidance should direct that the hearing be held in the presence of both parties unless the complainant objects. All information relevant to the investigation, including documentation relating to local resolution and the clinical assessors' reports, should also be made available to parties before the start of the hearing.
- A contractual requirement should be introduced requiring all NHS employees to attend panel hearings if called to do so. Failure to attend without good reason should become a disciplinary matter.

Demonstrating the accountability of the NHS and its staff

- In primary care, health authorities should be given authority actively to monitor complaints handled under practice-based complaints procedures. As part of this process, primary care practitioners should be required under their terms and conditions of service to submit more detailed information to health authorities about the nature of complaints they have received, and their outcome.
- At independent review, panel reports should be able to recommend that disciplinary action be considered.
- The disciplinary process should be made more transparent and complainants should be routinely informed of the outcome of disciplinary action.

Ensuring the implementation of panel recommendations

- The Department of Health should introduce procedures for monitoring the implementation of independent review panel recommendations by an external body, and for ensuring that quality issues identified by panels are disseminated for the benefit of the NHS as a whole. This information should be collated and made publicly available, having due regard for confidentiality.

Improving support and representation for complainants

- The Department of Health should formally recognise the role of health councils in assisting complainants through the complaints procedure, by including it in their statutory remit. Resources should be specifically allocated to support this work, including funding for the appointment and training of a complaints officer for every health council.

1 Introduction: placing the research in context

What were the aims and objectives of the research?

1.1 The broad aim of this research project was to evaluate the effectiveness of the new NHS complaints procedure which was introduced in April 1996. The project was undertaken from a consumer perspective, with the following specific objectives in mind:

- to explore and describe current practice in complaints management in all sectors of the health service and at all stages of the procedure;
- to identify processes which are working well and efficiently, and those which are proving problematic;
- to explore complainants' satisfaction with both the handling and outcome of their complaints;
- to formulate principles of good practice and recommendations for reform of the procedure so that it is better able to fulfil the needs of users.

1.2 The ultimate purpose of the project is to ensure that the NHS complaints procedure is responsive to users' needs. From a public interest perspective this means it should be fair and effective in achieving redress for complainants and for holding the NHS and its employees to account. The research also has practical goals. In proposing recommendations for reform, PLP seeks to contribute to, and influence, policy debate about the need for change. It also seeks to improve the quality of complaints handling at all stages of the process. To this end, the report proposes suggestions for good practice in order to encourage those involved to improve their standards. The report will also be followed, in the autumn, by a complementary practical guide which will aim to help complainants and their advisers negotiate their way through what can often appear a daunting and complex system in order to achieve a satisfactory outcome.

Why is the research timely?

1.3 Changes in the NHS complaints procedure have to be seen in the context of broader shifts in policy relating to the management of disputes in the public sector. The new procedures were introduced in the wake of a series of initiatives aimed at improving the management of complaints and claims in the NHS. These placed emphasis on systemic handling of quality issues. The 1990 reforms of the service, the introduction of crown indemnity and the setting up of the NHS Litigation Authority and Clinical Negligence Scheme for Trusts provided new incentives to manage complaints more proactively, prevent their escalation and integrate their handling within risk and

quality management programmes. There has also been an increasing interest in informal handling of disputes. Within a few years of the reforms, the Department of Health launched a pilot scheme to test the case for the use of mediation in medical negligence disputes. This interest in alternative, and less formal, dispute resolution was also apparent in other quarters. Lord Woolf's report on the proposed changes to the civil justice system included a chapter on medical negligence claims and encouraged a more conciliatory approach to the handling of disputes in the NHS (Lord Chancellor's Department, 1996).

1.4 More specific attention was directed at the handling of complaints in the public sector with the launch of the Citizen's Charter initiative in 1991. Characterising complainants as customers in a quasi-contractual relationship with providers, the Charter initiative viewed effective complaints handling as a key component of a responsive organisation (Citizen's Charter Unit, 1991). Its Complaints Task Force published a series of discussion papers around the seven core principles which it believed should govern the management of complaints, all of which reflect public law principles. These were accessibility, simplicity, speed, fairness, confidentiality, effectiveness and quality enhancement (Citizen's Charter Complaints Task Force, 1993).

1.5 Since the launch of the Charter initiative the NHS has also witnessed the introduction of a host of other quality initiatives such as clinical governance and the Commission for Health Improvement. These have furthered the goal of improving the quality of care by reference to minimum standards and the development of national protocols. The Bristol Royal Infirmary Inquiry and the Kent and Canterbury Hospital cervical smear scandal have also served to remind us that even internal audit of quality may never be wholly effective. For this reason the making of complaints by the laity provides a unique and essential external check on the activities of NHS staff.

Why is it important to evaluate the procedure from a consumer perspective?

1.6 PLP is committed to promoting the interests of those for whom access to justice is restricted. Within the NHS there is a significant inequality of bargaining power between patients and the health professionals who treat them. Patients are disadvantaged in a number of ways. First, the NHS is virtually a monopoly and there is no alternative for those who continue to need care and do not have the resources to pay for private health care. Second, clinicians possess expert knowledge which it is difficult for patients and their carers to decipher or negotiate. As a result, they often have to trust in clinical advice and decisions. Third, many people use the NHS only intermittently and are not familiar with how particular services are, or ought to be, arranged or delivered. Finally, patients are often not at their best at the times in which they want to voice a grievance. For these reasons it is important to ensure that the service provided for them operates in a way which they find satisfactory.

1.7 The rapidly rising number of complaints in the NHS is often taken as an indication that users are becoming increasingly demanding and adversarial. Despite this, evidence from empirical research studies demonstrates that the majority of grievances about medical services actually go unvoiced (Brennan, 1991). Some users may prefer to put negative experiences behind them or to avoid confrontation, but for others it is inequalities in the user-provider relationship that discourage them from pursuing a grievance. Patients tend not to make formal complaints, for instance, when they have a long-term relationship with a service provider to preserve. Fears of disrupting such a relationship are further exacerbated in certain locations where a shortage of service providers exists (Annandale and Hunt, 1998; Mulcahy and Tritter, 1998).

1.8 In reality, complaints do not pose serious threats to the NHS. In their calls for redress, complainants most often place emphasis on 'soft' remedies. Studies show a variety of motives for complaining that do not threaten careers or NHS resources. Many people say that they are complaining to prevent what happened to them also happening to others. For others, formal expression of a grievance may be an end in itself, or complainants may want an apology or answer to a question. Some say they want a decision reversed, something done more quickly, a loss made good or something put right, a waiver or reduction of small fees, the payment of monies due, the restoration of possessions, or remedial treatment. Very few want compensation or someone punished (Allsop, 1994; Bark *et al*, 1994; Lloyd-Bostock and Mulcahy, 1994). Many of these remedies also serve the larger patient population by making the NHS more responsive, open and accountable.

1.9 However dissatisfied with the initial response they get to their complaint, only a small minority of complainants are likely to pursue their complaint further. In their study of first tier complaints about doctors, Lloyd-Bostock and Mulcahy (1994) found that despite considerable levels of dissatisfaction with initial handling fewer than two percent of the 399 complainants studied took their complaint further by consulting a solicitor or contacting the Health Service Commissioner. For these reasons, Ison (1997) has argued that complaints dealt with at service level should be given greater procedural protection than those which reach appeal structures, as it is at lower levels that problems are more likely to occur. To quote:

> '... the total volume of injustice is likely to be much greater among those who accept initial decisions than among those who complain or appeal. For this reason alone, thoroughness and procedural fairness are more important in primary adjudication than they are in appellate processes.'

What is the new NHS complaints procedure?

1.10 Complaint systems have two main functions. The first provides a way for people who are dissatisfied with the service they have received to air their grievance and to receive a response. In this way, those who provide a service are made accountable to individual users who may receive some form of redress if their complaint is substantiated. The second function reflects a societal interest in the efficient and effective resolution of grievances, as well as the management of the aftermath. Complaints have enormous potential to shed light on the problems faced by ordinary people in their dealings with the NHS and can serve as 'red flags' when service provision fails. They can provide a way of finding out the views of service users and, if necessary, lead to improvements that benefit the patient population as a whole. Public lawyers argue that the investigation and adjudication of complaints send out wider signals to NHS employees about what is considered acceptable behaviour within an organisation.

1.11 Prior to the new complaints procedure being introduced in April 1996, the Department of Health set up its own enquiry into NHS complaints procedures under the chairmanship of Professor Alan Wilson (DoH, 1994). The Committee had the unenviable task of steering a course between the needs of complainants, staff, managers and policy-makers. A number of possible models of complaints procedures were available to the Committee including those based on administrative law principles of procedural fairness, self-regulatory models of the kind operated by the General Medical Council, consumerist models which attempt to redress the imbalance in the user-provider relationship, managerial-bureaucratic models which place emphasis on organisational needs, as well as various combinations of them all. An analysis of submissions to the Committee by Moss and Stacey (1994) demonstrated that the Committee veered towards a managerial model despite the bulk of submissions favouring something more consumerist. In their view, this reflected a reformist rather than a radical approach to change.

1.12 In response to criticisms of the procedure, the Committee developed a checklist of general principles which ought to govern further reform of the procedure (see figure 1.1). While it made proposals for the broad features of the new complaints procedure, it suggested that the implementation and operation should be left to individual organisations in order to allow them to tailor processes to suit local conditions.

Figure 1.1 The Wilson principles

- responsiveness
- quality enhancement
- cost effectiveness
- accessibility
- impartiality
- simplicity
- speed
- confidentiality
- accountability

Source: Department of Health, 1994

1.13 The most important recommendation of the Committee was that complaints about clinical

and non-clinical matters should be handled under the same procedure and that there should be a lay element in the appeals system. It further proposed a simplified two-stage structure for both trusts and family practitioners. These and other recommendations about the handling of clinical complaints in the NHS were accepted by the Department of Health (DoH, 1995) and formed the basis of new regulations which came into effect in April 1996 and which remain in operation.

1.14 Whilst recognising the need for both formal and informal elements in complaints handling, a major tenet of the new procedures was that, in the majority of cases, resolution and satisfaction could be achieved most effectively by the provision of rapid, personal and informal responses to complaints at the point of service delivery. The regulations required trusts, primary care practitioners and health authorities to establish a procedure for dealing with complaints which they received about their services. The guidelines were not prescriptive about how complaints should be handled, recommending instead an informal and flexible approach which enabled health organisations to respond to complaints in whatever way was most likely to satisfy the complainant. The procedure also allowed for the use of conciliators in the resolution of complaints although, like the terms of service which governed primary care complaints before April 1996, the new guidance was rather vague about how such conciliation should be conducted and how suitable conciliators were to be trained or appointed.

1.15 The second stage of the procedure, referral to an independent review panel, is not available as of right to complainants who continue to be dissatisfied. Complainants are required to refer the matter to a convener, giving details of the reasons for their continued dissatisfaction, within 28 days from the completion of the local resolution process. The convener will decide whether or not a panel should be established. Before making a decision the convener should consult with an independent lay panel chairperson from a list of people held at the regional office. In the case of a complaint involving the exercise of clinical judgement, the convener must also take appropriate clinical advice. In situations when the complaint is not referred to a panel, the complainant has the right to refer the matter to the Health Service Commissioner.

1.16 Independent review panels are composed of three members: an independent lay chairperson, the convener and a third panel member, who in the case of hospital complaints is a representative of the purchasing body. In addition, where a clinical complaint is being considered, the panel will be advised by two independent clinical assessors. The panel will give the complainant and any person complained about a reasonable opportunity to express their views on the complaint. The report of the panel must be sent to the complainant and any other people involved in the complaint, the trust or health authority chairman and chief executive, the regional director of public health and representatives of the purchasers. Following the circulation of the report, the chief executive must write to the complainant informing them of action taken in response to the report.

How was the research conducted?

1.17 In order to ascertain health and consumer groups' early experiences of the new complaints procedure and their views on how well it was meeting the needs of users, a literature review was conducted of studies and commentary on the procedure (see, for example, ACHCEW, 1996; NHS Trust Federation, 1996; Society of CHC Staff, 1996; Kyffin *et al.*, 1997; National Consumer Council, 1997; Wong, 1997; Health Service Commissioner, 1997 and 1998; Olszewski, 1998; Service First, 1998). These prompted PLP to frame a number of questions which needed addressing in the research (see figure 1.2). In posing questions, reference was also made to the rules of natural justice which require that grievance procedures be impartial and fair.

Figure 1.2 Key research questions

General

- Is the complaints procedure fair to complainants?
- Are complaints being handled impartially?
- How satisfied are complainants with the outcomes?
- Do complainants feel in control of the process?
- What are the major weaknesses in the process and how can these be remedied?

Specific

- Does the informality and flexibility of local resolution provide adequate protection of complainants' interests, particularly in primary care settings?
- Is the convening process sufficiently impartial? Does it have the confidence of participants in the process?
- At independent review, are complainants getting a fair hearing?
- How effective is the procedure at holding the NHS and its staff to account?
- Is the procedure effective in achieving improvements in services within the NHS?

1.18 A number of different methods were used in the research. These combined both quantitative and qualitative approaches to data collection. Although the project was primarily concerned with the needs of complainants, it was considered important to canvass the views of all key stakeholders in the complaints process. Thus, three national postal surveys were undertaken of:

- community health councils and their equivalent organisations in Scotland and Northern Ireland;
- conveners of trusts, health authorities, health boards and health and social services boards;
- independent lay chairs.

1.19 To complement the survey data, 72 in-depth interviews were carried out with health council staff (10), NHS personnel involved in complaints handling (26) and complainants (36) in four case-study areas throughout the UK. The data were collected between April and December 1998. The

various methods used are summarised in table 1.1 below. A full review of how the research was conducted is given in Appendix 1.

Table 1.1: Summary of main tasks undertaken during the research

Postal surveys	Details	Response
Survey of health councils	Mailed to 216 health councils in all four countries of the UK.	Number of responses: 141 Response rate: 65%
Survey of trust conveners	Mailed to all trusts in four health regions in England and to all trusts in Wales and Scotland. Total number 289	Number of responses: 169 Response rate: 58.5%
Survey of health authority conveners	Mailed to all health authorities in four health regions in England, to all health authorities in Wales and to all health boards and health and social services boards in Scotland and Northern Ireland. Total number 74.	Number of responses: 60. Response rate: approx. 69% (NB It was not possible to determine accurately the response rate for reasons explained in the appendix.)
Survey of independent lay chairs	Mailed to all chairs in four health regions in England and to all chairs in Wales, Scotland and Northern Ireland. Total number 371.	Number returned: 191 Response rate: 51.5%

Interviews	Details
Health council officers	Carried out with 10 health council staff in 4 health councils in North Thames region, North West region, and sites in Scotland and Northern Ireland.
Complainants	36 interviews carried out with complainants in the four case-study areas, invited for interview via the health councils.
NHS personnel	A total of 26 interviews undertaken including: complaints managers of trusts and health authorities in the 4 case-study areas, GP representatives and practice managers, and also staff at regional and national offices.

How is the report structured?

1.20 This report is in five substantive parts. In the next chapter the strengths and weaknesses of local resolution are reviewed. We evaluate how well local resolution is working in practice, drawing attention in particular to problems with the management of complaints in general practice and also complaints which raise serious questions about the performance, competence or conduct of NHS personnel. The third chapter evaluates the effectiveness of the convening stage of the complaints procedure, looking particularly at issues relating to its independence and efficiency. In Chapter 4,

the independent review process is examined. Here we look at issues concerning the conduct of panel hearings and the performance of panel members, with emphasis on whether complainants receive a fair hearing. The fifth chapter describes the processes by which complaints feed into quality initiatives and reviews how effectively the complaints procedure achieves improvements in standards of care and services in the NHS. In the last chapter, far reaching recommendations for reform of the procedure are proposed based on the analysis and conclusions presented in the earlier chapters.

Explanation of terminology

1.21 Various NHS organisations are referred to by different terms in the four countries of the UK. To avoid cumbersome reading, each time we refer to an organisation we do not include all the different terms by which it is known throughout the UK. Instead, we have adopted a shorthand terminology for some organisations which are referred to very frequently. In referring to other bodies we will adopt the term used in England but will endeavour, where appropriate, to reflect that there are equivalent organisations by a different name in the other three nations.

- The term 'health council' is used to refer to community health councils in England and Wales, local health councils in Scotland and health and social services councils in Northern Ireland;
- The term 'health authority' is used with reference also to health boards in Scotland and health and social services boards in Northern Ireland;
- The term 'Department of Health' is used with reference also to the offices with responsibility for health in Scotland, Wales and Northern Ireland.

2 Local resolution

Introduction

2.1 One of the most fundamental changes made to the NHS complaints procedure in the 1996 reforms was the increased emphasis on informal service-level handling of complaints. New directions and regulations introduced a requirement that trusts, health authorities and primary care practices establish procedures for the investigation and resolution of complaints at the point of service delivery. Central guidance on implementation of the procedure was not prescriptive about how health organisations should conduct the process of local resolution (NHSE, 1996). Instead emphasis was placed on the principles which should guide good complaints handling practice, such as openness, flexibility, fairness and understanding of what complainants want, rather than the processes by which resolution should be achieved (figure 2.1).

2.2 This chapter evaluates the effectiveness of local resolution in achieving satisfactory outcomes for complainants. It is in three parts. First, it identifies key strengths and weaknesses of local resolution. Second, it goes on to consider how well local resolution is working in practice. Third, it looks at the particular problems of informal resolution in primary care settings and in instances where serious allegations are being made about the standard and quality of care and services.

Figure 2.1 Local resolution

Trusts, health authorities and primary care practitioners are required to establish a complaints procedure and to take steps to publicise such arrangements. They must have a designated person, who is identifiable and accessible to the public, who will administer the complaints procedure and ensure that complaints are dealt with appropriately. Health authorities should also make conciliators available to facilitate resolution of primary care complaints where their assistance is requested either by the practice or the complainant.

All complaints, whether oral or written, should receive a positive and full response. For complaints made in writing, the complainant has a right to receive a written reply within time limits specified by the guidance. In the case of hospital or health authority complaints, these must be signed by the chief executive.

While not directing how local resolution should be conducted, the guidance makes clear that the aim should be to satisfy the complainant that their concerns have been heeded, to offer an apology and explanation as appropriate and refer to any remedial action that will follow.

Source: NHS Executive, 1996

What are the key strengths and weaknesses of local resolution?

2.3 Participants in PLP's research generally felt that the principle of local resolution was sound. When conducted properly, it was apparent that it:

- enables complaints to be dealt with promptly and at the point of service delivery;
- encourages accountability by requiring providers to investigate and explain their actions;
- enables prompt handling of less serious complaints without invoking complex procedures;
- encourages resolution and conciliation rather than confrontation.

2.4 There was evidence that NHS organisations were committed to trying to make local resolution work and that the spirit of the guidance was being accepted. Procedures were being put in place and publicised, there was recognition among health care organisations that it was important to be open and honest to resolve matters quickly and there was less defensiveness in response to complaints, especially in trusts.

2.5 However, data from the surveys also suggested that despite the many attractions of an informal approach to grievance resolution there were also weaknesses inherent in local resolution which seriously impeded the ability of complainants to achieve satisfaction. These were:

- lack of procedural rigour. The informality and flexibility of local resolution allows too much scope for grievances to be handled in inappropriate ways;
- failure to take sufficient account of the imbalance of power in the health professional-patient relationship. It was also argued that local resolution fails to recognise how difficult it can be to complain. Complainants reported feeling that they were one voice against a large organisation;
- failure to take into account the dynamics between parties in a dispute. Local resolution expects the parties to a dispute to be respectful and trusting of each other, to be open and honest and to accept that grievances and responses are voiced in good faith. In truth, these disputes are often emotionally charged, reputations may be at stake and professionals are worried about the escalation of the dispute;
- lack of impartiality. Participants were worried that organisations investigate their own complaints giving rise to a potential conflict of interest;
- failure to demonstrate the accountability of the NHS. The fact that local resolution is internally conducted means that the process can be invisible to complainants, it is not open to external scrutiny and providers of care are not seen to be accountable;
- lack of external monitoring. This means that wider lessons cannot easily be learned from complaints for the benefit of the health service as a whole.

How well is local resolution working in practice?

2.6 In addition to these flaws in the design of the procedure, it was clear that those who participated in the research were also concerned about the day-to-day operation of local resolution. Conveners, health councils and complainants were asked for details about their experiences and impressions of local resolution. In this section, each of these are considered in turn.

What are conveners' experiences of local resolution?

2.7 Conveners play a pivotal role in the complaints procedure and are most likely to see those complaints which have not been handled well at local resolution. A key indicator of how well local resolution is working is the proportion of complaints referred back to local resolution following a request for independent review. Conveners were asked in their survey to give information about the outcome of the most recent request for independent review which they had considered. In the 201 cases detailed in which a decision had been reached at the time of survey, nearly half (47%) were sent back for further attempts at local resolution, 26 percent were refused with no further action recommended and 27 percent were accepted for independent review. The fact that such a large proportion of complaints are being referred back strongly suggests that service-level complaints handling is being inadequately conducted across all sectors of the health service.

2.8 In order to explore the issue further, conveners were asked to identify the reasons for the failure to exhaust local resolution in relation to the cases which had been referred back. These reasons are shown in table 2.1.

Table 2.1: Conveners' reasons for sending complaints back for local resolution

Reason	Percentage (n=94)[1]
Failure to give an adequate explanation	43
Inadequate investigation of grievances	34
No attempt to bring the parties together to discuss the complaint	33
Failure to communicate what remedial action would be taken	29
Conciliation had not been attempted	27
Failure to clarify complainants grievances	20
Failure to apologise	18

1. Figures do not total 100% because conveners gave as many reasons as were applicable.

2.9 It is clear from these data that many of the key aspects of local resolution which are important for achieving complainant satisfaction are not being adequately performed and that such poor handling of complaints is encouraging complainants to pursue their complaints to independent review.

2.10 When conveners were asked why these problems were occurring at local resolution, many attributed it to poor staff training and inexperience in complaints handling (32% of cases). A main criticism was that training was often too process-orientated and did not focus enough on the aspects which contributed most to complainant satisfaction. This view was widely shared by other participants in the research. One convener summed it up thus:

> 'In a high percentage of cases I have seen I came to the conclusion that the complaint could have been resolved locally had a bit more care and forethought been given to dealing with the complaint. Much of the formal language used in communications with the complainant makes it appear that they have entered into a structured and fundamentally indifferent system. It is vital that the complainant sees a "human" as opposed to a bureaucratic organisation. A little sympathy goes a very long way.' (TC82)

What are health councils' and complainants' experiences of local resolution?

2.11 Although it is not a statutory function of health councils to provide support to complainants, the guidance recognises they have a very important role in assisting complainants through the process. Data from PLP's surveys showed that health councils took their commitment to supporting complainants seriously, spending on average 25 hours a week on complaints work and handling on average 124 complaints a year. Forty-nine percent of councils had at least one designated complaints officer to assist in this work, nearly a fifth of whom devoted all their time to complaints.

2.12 Health councils assisted complainants at all stages of the complaints procedure. Typical activities involved giving advice and talking issues through with complainants, helping complainants write letters of complaint, making calls to providers on behalf of complainants, arranging and attending meetings between the parties to the dispute and supporting complainants through the independent review process. Their depth and breadth of experiences of the complaints procedure enabled health councils to comment perceptively on its strengths and weaknesses and on the quality of complaints handling within the NHS.

2.13 A number of health council staff made clear that there was tremendous variety between NHS organisations in responding to complaints at service level, ranging from those who handled complaints very well to those who showed poor commitment to either the principle or practice of local resolution. In the words of one chief officer:

> 'Local resolution is good when the practitioners are forward thinking and [the complaint] results in a change in practice or where the situation can be monitored by the health council. However, local resolution means nothing

> to the defensive practitioners who merely "play the game" in order to pacify the complainant. This does not result in either a change of practice or attitude.' (HC18)

2.14 Thirty-six complainants were interviewed about their experiences of the complaints procedure. The outcome in terms of whether satisfaction was achieved is given in table 2.2.

Table 2.2: Complainants' satisfaction with the complaints procedure

Stage reached	Satisfaction achieved			
	No	Yes	Partial	Total
Cases completed at LR	14	8	6	28
Cases which went to IRP	5	-	-	5
IRP granted and withdrawn	1	-	-	1
Cases in which IRP turned down	5	-	-	5
Cases deterred from making a formal complaint	3	-	-	3
Total	28	8	6	42

2.15 It can be seen from this table that of the 42 separate complaints described by complainants, 28 were completed at local resolution. In nearly three-quarters of cases (20) the complainant was not satisfied or only partially satisfied with the outcome. Of those who expressed some satisfaction with the process, three were satisfied after a first written response. The rest achieved satisfaction only having attended meetings or having pursued further correspondence or contact with the organisation concerned. Thus, local resolution had often to be tirelessly pursued in order to obtain satisfaction. One complainant who was partially satisfied commented:

> '[The process] is far too complicated. It's taken so much out of us to go through it – I wonder how many other families have the strength to follow it through.' (case 9)

2.16 Many complainants spoke of the struggle involved in obtaining a satisfactory response, and also of the frustration at the length of time it took to deal with their complaint. The consequence could be undesirable in two ways. It could lead either to the escalation of complaints which could have been resolved early on had they been handled properly and appropriately at the outset, or to complaints deserving of independent review being dropped because complainants did not have the strength to pursue them.

2.17 Complainants and health councils also raised concerns about many other aspects of local resolution including:

- the process and quality of investigation;
- the quality of responses;
- the accountability of the NHS and individual staff;
- the process of learning from complaints.

2.18 Complainants were particularly sceptical about the impartiality of investigations:

- they felt that their account of events was less likely to be believed than those of the staff concerned;
- that staff denials were taken at face value and that no proper investigation of the facts behind the complaint was undertaken;
- investigations were felt to be superficial and failed to address the issues raised by the complainant.

2.19 The comments of one complainant about the quality of the investigation of her complaint reflect the frustrations felt by many others:

> 'If they had investigated properly at the outset, a couple of phone calls to myself or my GP, it would have cleared up any doubt about the referral letter. Instead there was no question of accepting responsibility. It was just instant non-acceptance of blame.' (case 28)

2.20 The inadequacy of investigations was also reflected in organisations' responses to complainants. NHS staff were criticised for failing to offer the necessary explanations or to answer specific questions raised. As one complainant commented: 'It was just generalised waffle.' Several complainants expressed concern that their questions had not been answered because the person concerned had left the trust. One said: 'A lot of our questions were not answered because the neurologist was no longer at the hospital. They just opted out of answering our questions.' These complainants were also frustrated that no one was prepared to accept responsibility or be accountable for what happened.

2.21 Responses were also criticised for being defensive, for making inappropriate excuses, for failure to apologise where necessary, or for expressing only insincere apologies. Complainants were also concerned about the lack of information concerning the remedial action which would be taken as a result of their complaint. They felt they received glib comments that things would be put right but were not told how specific changes would be implemented nor how failings in staff performance would be addressed.

2.22 Other criticisms raised about local resolution included: too many people handling the complaint giving a poor impression about the organisation's efficiency in dealing with complaints, persistent questions about the complainant's intention in relation to legal action, failure to close the complaint properly leaving the complainant unclear whether or not the complaint was still in the system.

2.23 A few examples were also cited of undue pressure being brought to bear on complainants to withdraw their complaint. One complainant described how a consultant had refused to treat her because she had complained. In her words:

> 'By complaining I had effectively excluded myself from treatment. In a later meeting the consultant said she would agree to reconsider, if I would reconsider my letter of complaint. I was being bullied to retract my complaint.' (case 34)

2.24 Not all complainants had had negative experiences of local resolution, and health councils had also observed many examples of good practice in complaints handling. Comments in this vein included:

- less defensive attitudes, particularly in trusts;
- thorough investigations;
- prompt and full responses, including admissions of fault and offers of apologies;
- the active involvement of hospital consultants in the process;
- ready offers of meetings;
- increased use of publicity on how to complain.

What are complainants' experiences of meetings and conciliation?

2.25 It is recognised by the guidance that bringing parties together to talk about the grievances raised in a complaint can be an important and successful way to achieve resolution. However, data from the conveners' survey revealed a reluctance on the part of some NHS organisations to attempt resolution in this way. As can be seen in table 2.1, in as many as a third of cases sent back for local resolution either meetings or conciliation had not been tried.

2.26 Achieving a satisfactory outcome at a meeting depends greatly on how the meeting is conducted. Although complaints managers interviewed for the project were confident that meetings were successful in resolving complaints, complainants' experiences of meetings had been very mixed. While most had welcomed the opportunity to meet with personnel to discuss the complaint, many were disappointed and dissatisfied with the way the meeting was conducted.

2.27 Common complaints were that staff had been defensive, aggressive or arrogant, that irrelevant comments and excuses were offered, that complainants' accounts of events were not believed and that no one was prepared to acknowledge that mistakes had been made or to offer genuine apologies or accept that improvements in care were necessary.

2.28 It was apparent that in some cases not enough thought was going into the planning of meetings, particularly with regard to the complainants' views on who should be present. Several

complainants were frustrated at not being able to meet with the person whose care was being criticised. One interviewee commented: 'I wanted them to see my pain, so I could bring it home to them how serious I felt their failures in care to be'. Another complainant wanted to meet the person concerned because she felt that only they could provide a proper explanation as to what happened.

2.29 However, it is also clear that this is an area where a flexible approach is of benefit since not all complainants wanted to meet the person complained about. One participant in the study was typical of this group when she said:

> 'It was a bad suggestion to offer a meeting with the consultant. I didn't want to be in the same room as that consultant ever again. I was not well enough to face her.' (case 29)

2.30 Some complainants were concerned that meetings had been handled by too junior staff, or by a member of staff insufficiently independent of the service or staff being criticised. Another criticism mentioned by complainants was the overuse of meetings. One complainant kept on being invited back for meetings which were no longer achieving anything. As she commented: 'It was just meetings about meetings.' Another complainant, whose request for independent review had been turned down because they had refused to attend a second meeting with a consultant, said:

> 'I was told that the matter had been dealt with fairly and there was no point having a review. The convener pointed out that I had declined an offer of a meeting. But I didn't see the point of another meeting because the first had been so inconclusive.' (case 31)

2.31 Despite the criticisms, several complainants had also had very positive experiences of meetings which had achieved a satisfactory outcome. Comments illustrating positive experiences included:

> 'The nursing manager was fantastic ... [he] believed everything we said, agreed that things had happened, accepted that things were wrong and said that things would change.' (case 16)

2.32 Another commented:

> 'The general manager said straight away, "the care of your father was totally unacceptable". We really appreciated the hospital holding up its hands and saying they were wrong.' (case 9)

2.33 About a meeting with a GP, a complainant said:

> 'She was friendly and open, not confrontational or intimidating and very relaxed. She admitted she hadn't grasped the full picture and said she had been wrong on the day. She said she hadn't meant to come across as dictating and apologised.' (case 36)

2.34 What frustrated these complainants was not the conduct or outcome of the meeting but that the meeting had been necessary at all. If the organisation had only believed their account of events and written a proper response in the first place they would never have requested a meeting.

Experiences of conciliation

2.35 The complaints procedure also allows for the use of conciliators to facilitate resolution. However it was apparent from both the interview and survey data that demand for conciliation had been very variable and that experiences of it had been mixed. Sixty-seven percent of respondents in the health council survey had been involved in attempts at conciliation and had expressed a range of views about it. The health authorities interviewed for the research had also had mixed success with their conciliation service.

2.36 The lack of demand for conciliation was thought to be due both to the service being very underdeveloped in some areas, and also to lack of promotion of its potential benefits to complainants and health professionals alike. In situations where conciliation had been offered, health councils found that not all parties wanted to take up the offer. There were three common explanations for their reluctance:

- there was a feeling among parties that there was no point to conciliation because their differences were irreconcilable or that there was no relationship to preserve;
- many complainants did not relish the thought of face-to-face contact with the other side;
- complainants felt that conciliation just introduced another loop which they had to jump through before they could legitimately ask for their case to be referred to an independent review panel. As one health authority representative said:

> 'People don't want conciliation, they want to get it sorted out. They don't see what the conciliator can do, or that the process adds anything. It must seem like somebody is just going to paper over the cracks.'

2.37 Although it was widely believed that conciliation had much potential, concerns were expressed about the lack of resources that had been put into the training of conciliators. As a result, it had been used inappropriately in some cases and poorly conducted in others. Conciliation was considered to be particularly inappropriate for complaints which highlighted

issues concerning the safety of services, in which there was a public interest in having the complaint more formally and rigorously investigated. It was also felt to be inappropriate to recommend conciliation following a request for independent review, when the likelihood of a successful outcome was greatly reduced because positions had become entrenched. The health authority representatives accepted that this was not the best time to attempt conciliation. It was agreed that if conciliation were to be used, it should be undertaken only very early on in the complaints process.

2.38 On the conduct of conciliation meetings, several health councils and complainants questioned the impartiality of some conciliators and their skills in managing the process. In one case a health council described how the conciliator did not speak to the GP concerned, only to the practice manager and then was directive towards the complainant in telling them what they should accept. Another conciliator allowed the GP to negotiate an agreement whereby the GP would take the person back onto his list on the condition that the complainant did not complain again. In that same, case the health council felt that the conciliator had showed deference to the GP and allowed him to take control of the situation.

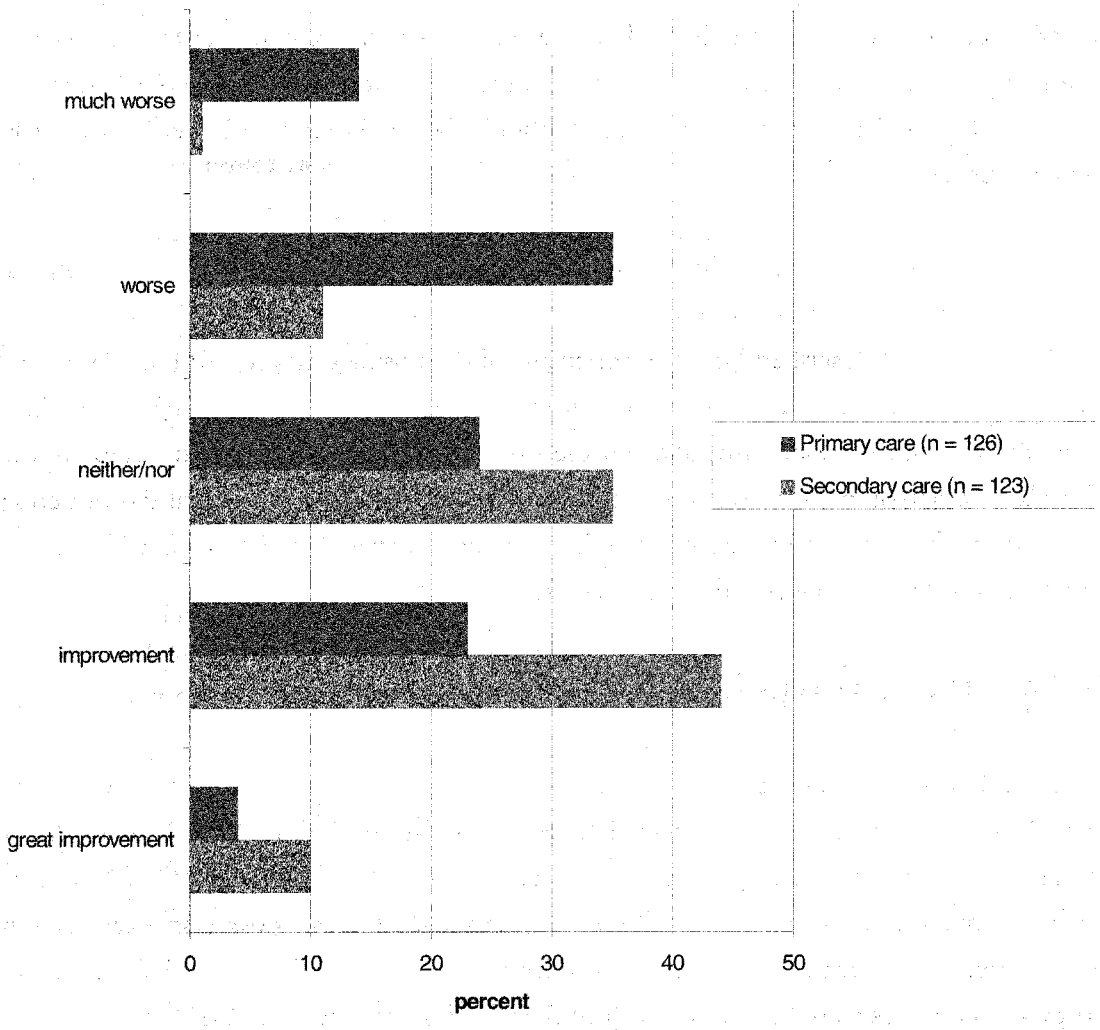
What are the 'crisis points' in local resolution?

2.39 In addition to the general concerns about informal resolution outlined above, there was considerable disquiet about the appropriateness of local resolution in two particular areas: complaints that are directed at primary care practitioners and those that raise serious questions about performance, conduct or competence. It was argued that in these two areas there was a particular need for greater formality in procedures in order to ensure that effective and appropriate outcomes were achieved. Each of these will be dealt with in turn.

The particular problems with primary care

2.40 Health councils were especially vocal in expressing their doubts about the use of local resolution in primary care. In the survey of health councils, respondents were asked to compare the effectiveness of the new procedure with that which existed prior to 1996. It can be seen from figure 2.2 that while complaints handling was thought to have improved in the secondary care sector the position was seen to have worsened in primary care.

Figure 2.2: Health councils' comparison of the new procedure with the old



2.41 At the heart of the problems with local resolution in primary care is the requirement that users complain directly to the practitioners they are criticising. Health councils were concerned that this was acting as a deterrent to complaining. They commented that many complainants had experienced, or were fearful of, retribution such as being struck off a GP's list or being treated adversely. Other complainants simply did not want to have to confront the person about whom they were complaining. One complainant, who had been deterred from making a formal complaint, captured the sense of fear referred to by a number of respondents:

> 'I didn't make a formal complaint because I was staying with the practice and was afraid it would come back on me. I wish I had now, now I am a lot better. But I was vulnerable at the time. It was no good having to discuss it with the GP. When you are vulnerable, the person who is giving you a bad service is the last person you want to speak to ... The system is not catering

> for people when they are vulnerable. It is all weighed in the doctors' favour.' (case 8)

2.42 Another complainant explained how he wanted a person in authority to complain on his behalf, feeling powerless to achieve anything on his own:

> 'What would talking to him do, what would I say, how could I confront him with it? Someone with authority needed to do it. He had behaved like that to dozens of people, it wasn't up to me to do it. In the end I didn't do anything – there was no point. The process doesn't work.' (case 3)

2.43 The difficulties were acknowledged by one of the GP representatives interviewed.

> 'My gut feeling is that there is an innate bias towards the profession. Not necessarily the medical profession but the whole NHS. My only reason I say that is the reluctance of people to take issues up at a practice-based level. If you want to complain about your dentist, and you are going to have to sit in his chair in fear and quiver as you do in dentists, it is going to effect your relationship ... That I see is the flaw of the primary care system. How big a problem it is, I have no evidence, but my own gut reaction is that it is not totally right.'

2.44 Dentists were included in the criticisms of complaints handling in primary care and were considered by some to be worse than GPs in dealing with complaints. A comment from one health authority representative about dentists reflected the experiences of others.

> 'In my experience GPs are better and more clued in to dealing with complaints than dentists. I've had more cooperation from GPs in trying to sort out complaints, and they do generally tend to take them more seriously than dentists. Dentists tend to ignore complaints until you write to them again. They hope things will go away.'

2.45 Although health authorities are able to act as 'honest-broker' in situations where complainants do not want to engage directly in local resolution with the surgery concerned, it was apparent this option was seldom used in practice. Where they did become involved, health authorities tended to act as no more than a 'post box' for correspondence between the complainant and the surgery, rather than actively facilitating resolution. Indeed, several commentators noted that in some cases complainants had been forced into going through practice-based procedures.

2.46 Health councils' concerns about the lack of procedural fairness in complaints handling in primary care were also made explicit in their assessment of how well the procedure complied

with the principles of natural justice such as fairness, impartiality, accessibility and accountability. Table 2.3 shows how they rated the procedure. What is particularly striking about these data is the strength of their concerns. More than two-thirds of health councils felt that the procedures did not stand up to the principles of natural justice.

Table 2.3: Health councils' assessments of local resolution in primary care

In general, local resolution in primary care:	% strongly agree/agree	% strongly disagree/disagree
Is equally fair (n=139)	14	65
Is biased in favour of staff (n=140)	69	8
Makes it easy to complain (n=140)	18	73
Is daunting for complainants (n=140)	88	4
Allows too much discretion in complaints handling (n=141)	80	4
Ensures accountability (n=141)	16	70

2.47 Although some of the same difficulties may arise in the hospital sector, and complaints handling in trusts was not free of criticism, the data suggested that trusts overall were considered better placed to deal with complaints at a local level than primary care practitioners. It was argued that there is a management hierarchy with a chief executive ultimately responsible for complaints handling who is removed from the front-line provision of services. Furthermore, the larger number of staff employed means that greater impartiality can be achieved by the careful selection of investigatory officers within the organisation who are not dependent on those complained about for references and remuneration.

Complaints which raise serious concerns about competence or conduct

2.48 The second area in which the principle of local resolution was questioned concerned the handling of complaints which raised serious questions about performance, conduct or competence which put patients at risk. In the interviews with complainants there were several accounts which raised serious concerns about the justice of local resolution. None of these cases went beyond local resolution, yet none of the complainants was satisfied with the handling or outcome of the complaint. Examples of complaints included:

- alleged lack of supervision leading to a suicide on a ward in a mental health unit;
- a complaint concerning allegations of serious neglect in nursing care;
- alleged poor treatment, bullying and other forms of mental abuse on a mental health ward;
- terminal care of a teenager with cancer, allegedly without adequate parental consultation or consent;
- alleged failure to visit an elderly man with a suspected heart attack;
- sudden unexplained death in epilepsy due to alleged mismanagement of medication.

2.49 Criticisms focused on the ability and willingness of front line staff to tackle grave allegations in a way which could gain the confidence of those complaining and the wider public. Above all, complainants were concerned about the independence or impartiality of local resolution in such situations.

2.50 In trusts, investigation of complaints is frequently delegated to a service manager within the unit where the complaint arose. In a number of interviews with complainants the appropriateness of such an approach to investigation was questioned. One complainant, for example, was concerned that the investigator had not been open about acknowledging the poor standards of care from staff within their unit, as it reflected badly on the investigator's own management abilities. Another complainant commented:

> 'They washed all hands of responsibility. The response was defensive and condescending, it was collective back-covering. All the allegations were denied, they twisted everything, made out as if I was telling lies.' (case 29)

2.51 Other complainants had had similar experiences. In one case, the response was based on nursing statements which were allegedly full of inaccuracies, untruths, denials and offensive comments about the complainant. The complainant was concerned that no account had been taken of her account of events, as might be required in a more formal procedure.

2.52 It was also evident that neither senior managers nor chief executives took close enough interest in the serious cases. In the case concerning the suicide, no one from senior management took responsibility for investigating the case until four months after the death. In two other cases, where disciplinary issues were apparent, the complainants were concerned that appropriate action had not been taken. One complainant who herself was a director of nursing said that the question of discipline was 'simply brushed aside'. She was given no assurances that the problems with the nursing staff were being addressed.

2.53 The overwhelming feelings that complainants were left with, following attempts at local resolution in these cases, were that issues had been covered up, staff had been protected, and that no one was prepared to take responsibility. Complainants' evident lack of confidence and trust in local resolution, indicated a need for alternative processes to deal with complaints which raise serious questions about patient safety. We will return to this issue in the final chapter.

Conclusion

2.54 This chapter has evaluated the operation of local resolution and explored whether it achieves satisfaction for complainants. In doing so, it has drawn on data collected from complainants, health councils, conveners and NHS staff. It is clear from the data presented in

this chapter that when local resolution works well it is expeditious and effective. It is also apparent that the new procedures have encouraged a number of providers to be more open in their handling of complaints and to be less defensive about admitting failings in care. The emphasis on flexibility has also encouraged health organisations to respond to complaints in ways that are most likely to satisfy the complainant. However, flexibility is not always a good thing. It can lead to health organisations conducting local resolution in inappropriate ways and serve to increase complainants' sense of vulnerability and dissatisfaction. In these circumstances the process of informal handling of complaints can actually lead to the exacerbation of the original grievance.

2.55 It is interesting that many of the impressions of local resolution reported by complainants and health councils are confirmed by conveners. It is clear from the explanations they provide for returning cases for further local resolution that fundamental aspects of the procedure, such as offering adequate explanations, are not being fulfilled by those involved in complaints management. The data further suggested that one of the main barriers to achieving a successful outcome is the lack of training or experience among staff engaged in the investigation and resolution of complaints. We argue that local resolution must be properly resourced, and staff adequately trained, if it is to have any chance of working.

2.56 Our research also demonstrated that local resolution was particularly discredited for complaints involving primary care practitioners and those which gave rise to serious concerns about the performance, conduct, or competence of individual health professionals. In such situations, internal investigation left complainants concerned about the impartiality and fairness of local resolution. Their level of dissatisfaction with the process indicated a strong need for alternative procedures which allowed for early referral of such complaints to an independent investigating authority. We argue that it should not be assumed that the diverse range of complaints received about the NHS are appropriately dealt with under the same system. While the same principles might guide procedures, it is clear that there is a greater public interest in securing the effective handling of complaints which threaten patient safety than those involving, for example, the efficient administration of non-clinical management processes.

2.57 In conclusion, while the principle of local resolution may be sound, it is an 'ideal' that in practice is hard to achieve because of the conflicting interests of those engaged in the process. Moreover, complainants will always question the fairness and impartiality of local resolution because health organisations are acting as judge in their own cause. For faith in local resolution to be restored, much tighter safeguards need to be introduced in both the design and practice of service-level complaints resolution, which also take account of the need for greater independence and formality as the seriousness of the allegations increases, or the ability to conduct an impartial investigation declines.

3 Convening

Introduction

3.1 The role of the convener as gatekeeper to the second stage of the complaints procedure is pivotal (see figure 3.1). They decide whether or not complaints should proceed to independent review and the terms of reference within which the panel should work. In coming to a decision, they must consider whether all opportunities to resolve the complaint locally have been exhausted, and whether referral to a panel is the only remaining option likely to achieve resolution.

Figure 3.1 The role of the convener

A complainant who is dissatisfied with the outcome of local resolution, may request an 'independent review panel'. The convener, who is usually a non-executive director of the health authority or trust, has responsibility for deciding whether a complaint should be referred for independent review. In reaching a decision conveners are not permitted to investigate the complaint nor should they attempt to resolve it. Their options are to:

- refer the complaint back for further action at local resolution, if they consider more could be done at this stage to satisfy the complainant;
- refuse a panel if they consider all practicable action has been taken and a panel would add no further value to the process;
- convene a panel if nothing short of independent review will achieve resolution.

When considering a request for independent review, conveners must seek advice from an independent lay chairperson. In cases where the complaint concerns issues relating to the exercise of clinical judgement, a convener must also seek advice from appropriate clinicians about any clinical considerations which should be taken into account in reaching a decision. Ultimately, however, it is for the convener to decide whether or not to set up a panel.

Source: NHS Executive, 1996

3.2 This chapter evaluates the effectiveness of the convening stage of the complaints procedure, looking particularly at its independence and efficiency. The chapter is in three sections. First, it analyses conveners' levels of activity and experience and looks at how they carry out their duties. Second, views about their independence, from the perspective of both conveners and others closely involved in the procedure, are explored. Finally, the efficiency of the convening role is examined in relation to conveners' workload and the procedure's need for real and perceived independence.

How experienced are conveners?

3.3 To gain an idea of the level of work involved in their role, conveners were asked for information about their workload since their appointment. Over 65 percent had been in post for two years, and 20 percent between one and two years. Table 3.1 compares the activity of health authority and trust conveners who had been in post for two years.

Table 3.1: Activity of chairs and conveners in post for two years

	Average no. of requests	Average no. of panels	% with no panel experience
HA conveners (n=44)	18	3.6	9
Trust conveners (n=92)	9	1.6	46
Acute (n=63)[1]	11.5	2.1	29
Community (n=29)[2]	4.5	0.3	79

1. This category covers any trust which provides acute services, including all district trusts and combined acute and community trusts.
2. This category includes trusts providing no acute service at all, i.e. only community and/or mental health and/or learning disability services.

3.4 It can be seen from the table that health authority conveners had about double the caseload of trust conveners and that conveners of community trusts had the lightest caseload of all. In two years, they had considered on average fewer than five requests for panels and 79 percent had had no experience of panels at all. The greater caseload of health authority conveners demonstrated by these data is confirmed by national statistics (Department of Health, 1998) and is also reflected in the average number of hours health authority conveners spend per month on convening duties (15 hours) compared with trusts (10 hours).

How do conveners carry out their duties?

3.5 To find out how conveners performed their duties, they were asked for information about the most recent request for a review they had considered. One hundred and fifty-seven trust conveners and all 60 health authority conveners who responded to the survey provided details. Asked whom they consulted in considering the case, 95 percent said a lay chair, as anticipated by the guidance. In the cases involving issues of clinical judgements as many as a fifth of trust conveners failed to seek clinical advice, despite the requirement that this should be so.

3.6 Other personnel who are not expressly referred to in the guidance were also consulted. In the case of trust conveners, hospital staff who were commonly approached included the complaints team (69%), the trust chief executive (29%) and, less commonly, staff implicated in the complaint (6%). In 20 percent of cases the complainant was contacted, and in 13 percent the

health council. In contrast, the only other personnel whom health authority conveners consulted with a frequency of more than 10 percent was their complaints team (79% of cases).

3.7 The people whom conveners choose to consult clearly may have a bearing on the impartiality of the decisions. These data suggest that health authority conveners were able to maintain a greater distance than trust conveners from NHS personnel who might influence their decisions inappropriately. It is worrying that conveners in trusts were not always even-handed in their approach. While they commonly engaged the complaints team, the chief executive and, more seldom, staff implicated in the complaint, in discussions about the complaint, the complainant was contacted in only one fifth of cases. There is a risk that the impartiality of conveners' decision-making will be compromised by discussions with other hospital personnel and that complainants might also be concerned about their possible influence on the convener's decision. As one complainant explained:

> 'My private and confidential letter to the convener was opened by the complaints manager who had already been involved in my complaint. He wrote to me saying that he had attached the relevant documents and passed these to the convener to help her assess my complaint. She therefore gets my letter second-hand with his attachments.' (case 16)

3.8 Opinions varied about whether or not conveners ***should*** have direct contact with complainants. Some conveners said they had been positively advised against speaking to the complainant so as not to compromise their impartiality. Others felt that it was reasonable to do so, particularly in order to keep them informed of the progress of the complaint, or to seek clarification of the complainants' outstanding grievances. It was clear in some cases, however, that conveners contacted the complainant in order to investigate the complaint or to attempt resolution, both of which activities are prohibited by the guidance. As one convener explained:

> 'The complainant's concern was that junior medical staff should "learn from their mistakes". After an interview with the medical director in my presence conciliation was achieved.' (TC71)

3.9 The data also revealed other problems in the performance of their role. A number spoke of the difficulty in drawing the line between investigating and making a decision. Conveners need sufficient information to make a considered decision on the need for a panel, yet seeking that information can result in criticism for investigation. Similarly, striking the right balance between making a decision and a judgement was fraught with difficulties. One convener summed up the trials of their position as follows:

> 'When an independent review panel is refused the convener has to give reasons. In order to give reasons the convener has to make a judgement.

> This is frowned upon apparently and is seen as over-exceeding the role. It is illogical, to say the least, to expect a convener to make a decision without making a judgement as to whether the NHS has let a patient down.' (TC74).

What are people's views on the independence of conveners?

3.10 Impartial and independent assessment of a grievance is at the heart of a fair complaints procedure. When the new procedure was introduced, concerns were raised very early on by health councils, and other user groups, about conveners being based within, and a part of, the organisation complained about (ACHCEW, 1996; NCC, 1997). This research sought to determine the extent to which this was a problem. The data revealed a number of concerns which have serious implications for the credibility of the new procedure.

What are the views of conveners about their role?

3.11 Conveners and chairs were asked whether they thought it was difficult for conveners to be fully independent when they also served as a member of the board of the trust or health authority concerned. Their answers are presented in table 3.2 below.

Table 3.2: Conveners' and chairs' views on the independence of the convening role

Is it difficult to maintain independence?	Yes (%)
Trust conveners (n=153)	46
Health authority conveners (n=57)	25
Lay chairs (n=166)	65

3.12 It can be seen from the table that almost half of trust conveners thought it was difficult for them to maintain their independence. By contrast, only 25 percent of health authority conveners were concerned about their independence although this is still a significant proportion. This difference can be explained by the fact that in the majority of cases health authority conveners assess complaints about services for which they bear no direct responsibility. Thus, they are posed with less of a conflict of interest than conveners based in trusts. In line with this interpretation, some health authority conveners, while confident of their independence in relation to primary care complaints, were uncomfortable with their position in relation to assessing complaints about their own health authority.

3.13 Asked ***why*** they considered their position to be difficult, trust conveners were very frank about the pressures and conflicts of interest they were under. They felt that being involved in the trust as a non-executive director and getting to know the staff inevitably introduced a bias and partiality. One convener commented:

> 'I believe that it is almost impossible for a non-executive director to be fully independent as one of their major roles is to get to know the staff at all levels from the chief executive down. By getting to know staff and working with them you do become part of the trust which in turn loses your independence.' (TC5)

3.14 A number spoke also of the natural respect and loyalty they felt for the trust, which they acknowledged might incline them to give staff the benefit of the doubt. As one suggested: 'Where you know the respondent personally it is sometimes difficult to believe the case against them.' Others were concerned that as non-executive directors they had access to information about the organisation and running of the trust which might unduly influence their decision and which would not be available to a truly independent person.

3.15 Recognising the constraints of their position, many conveners said that they tried their best to stand back and be fair to both parties. They were also very aware that the role was not seen to be independent by complainants which made them all the more careful to demonstrate their impartiality. About one fifth of conveners had been in a situation where a complainant had expressed concerns to them about their position.

3.16 Not all conveners, however, felt there was a conflict of interest in their position. They explained that independence was one of the functions of being a non-executive director, and having no part in the management and operation of the trust it was easy to maintain that position. Having to consult a lay chair for a second opinion on the need for a panel was also widely felt to be an important safeguard against possible bias, although some conveners and chairs were concerned that in the end the final decision still rests with the convener.

3.17 Others who claimed impartiality nevertheless made comments that certainly cast doubt on this. Some made denigrating comments about complainants, believing them to be manipulative, vexatious and intent on pursuing litigation while others seemed to misunderstand their role, believing that they were meant to defend the trust's position. One commented:

> 'I feel it is important for a board member to follow the course of action which is to the benefit of the trust and the NHS without feeling inhibited. Otherwise the position of non-executive is pointless.' (TC75)

3.18 Further evidence of possible bias in the decision-making of conveners was found in the outcome of requests for independent review. Conveners were asked to give information about the outcome of the requests which they had considered. These data are presented in table 3.3. As can be seen, trust conveners were less likely than health authority conveners to agree to a panel and also much more likely to send complaints back for local resolution.

Table 3.3: Outcome of requests for independent review

	No. of requests considered	% accepted	% sent back	% rejected
Trust conveners	813	19	51	29
HA conveners	571	25	36	36

3.19 Some of the reasons for sending complaints back to local resolution were explored in the previous chapter. What is interesting in the present context, is why there should be such a discrepancy between trust and health authority conveners' practice. There is no reason to believe that local resolution in trusts is poorer than in primary care, indeed the data presented in the previous chapter suggest the opposite. Nor is there evidence that more complaints in primary care merit referral to an independent review. Given the greater complexity of health care interventions in the hospital sector, one might assume the contrary. The possibility, therefore, that trust conveners are more generous than is warranted in giving hospitals a second chance at local resolution must be taken seriously.

How impartial is clinical advice?

3.20 The difficulties for conveners in maintaining their impartiality may be further exacerbated when seeking clinical advice. The guidance recommends in the first instance that trust conveners seek such advice from senior clinicians within the trust, unless they are implicated in the complaint. In line with this guidance, conveners most often consulted internal clinical staff (63% of cases), while in 17 percent of cases advice was given by external advisors, and in 20 percent by both.

3.21 However, some conveners were not comfortable about having to seek advice from within the trust concerned. They were concerned about the impartiality of such advice, a view also shared by health councils. It was argued that internal advisors may be worried about appearing critical of colleagues, or may be inclined to give colleagues the benefit of the doubt. They were also concerned that complainants might see the process as a 'closed shop'. When panels were refused, or sent back for further local resolution in such circumstances, they were not surprised that complainants were concerned about the fairness of such decisions.

What are others' views on the convening role?

3.22 The anxieties expressed by conveners about the independence of the convening role were widely shared by others involved in the process. Sixty-five percent of chairs thought it was difficult for conveners to be independent (see table 3.2), although many were generous in complimenting conveners on the efforts they took to maintain an impartial position. Nevertheless, chairs widely acknowledged that there were problems with the perception of the conveners' role from the complainants' perspective.

3.23 Health councils' concerns about the real and perceived independence of the convening role are well documented (ACHCEW, 1999) and these were reiterated in the survey and interviews. Overall, they tended to be more critical of conveners than were chairs. Both groups cited a number of examples of poor practice in the performance of conveners' duties which contributed to concerns about some conveners' ability to remain impartial. These included:

- conveners overstepping their role in relation to investigation. Twenty-nine percent of health councils had had experience of conveners personally attempting to resolve the complaint;
- conveners being protective of the trust and wanting to avoid panel hearings;
- conveners failing to consult chairs (in the survey of conveners, 5% failed to do so);
- chairs had also had experience of their advice being ignored or of being expected to rubber-stamp conveners' decisions. Where they had disagreed with the convener about the need for a panel, some chairs were concerned that their views had been misrepresented to complainants with conveners suggesting that the decision had been agreed;
- conveners' failure to seek clinical advice. In the survey, 20 percent failed to do this.

How efficient is the convening role?

3.24 Concerns were also expressed about the efficiency of the convening role. Questions arose in the context of the average convener's workload. As is clear from table 3.1, the caseload of the average trust convener even after two years was fairly limited. This was particularly the case for those in community trusts. What are the implications of a low caseload?

- Conveners stressed that it was important to have an ongoing caseload both to develop expertise and maintain familiarity with the regulations and guidance, yet for many conveners this level of work was not being sustained;
- lack of experience does not serve the parties involved in a complaint, especially if it results in inappropriate outcomes;
- moreover, is it an efficient or effective use of resources to have conveners who are seldom used?

3.25 These points were summed up by a medical director of one trust who commented:

> 'If you have good local resolution, by definition the convener is not going to be asked to do much and is therefore inexperienced. You spend time training them, but until they have done a few they don't know what they are doing ... People at the second stage never get to a level of confidence that they know what they are doing. Some of their interventions have been counterproductive.'

3.26 The problem is further compounded by a reported high-rate of turnover of non-executive directors of trusts and health authorities (Select Committee on Public Administration, 1999). Therefore, many conveners may not remain in the role long enough to gain the experience that develops with time.

3.27 Inefficiency was also apparent in the length of time it took for conveners to reach their decisions about the need for a panel. In nearly half of the most recent cases considered (47%), the convener failed to meet the performance target for deciding whether or not to set up a panel. Two main reasons were given for this. First, the difficulties in appointing lay chairs. One of the regions, for example, had experienced a 'bottle neck' of requests for independent reviews and did not have sufficient chairs to deal with the workload, resulting in eight-week delays in appointing chairs. Other difficulties cited in this context included practical problems contacting chairs, and chairs unable to take on new cases, with the result that some trusts or health authorities had to go back to the region two or three times before finding a chair who would accept a case. The second reason for failure to meet the performance target was delays in the chair and/or convener coming to a decision. These could be caused by a range of factors, not necessarily due to any fault of the convener or chair, such as:

- the complexity of the complaint;
- lack of a formal written statement of complaint from the complainants;
- delays in getting clinical advice;
- conveners or chairs being either too busy, or sometimes on holiday.

3.28 Despite some of the difficulties appointing chairs, having a second, independent person involved in screening complaints was widely felt to be necessary, particularly given the concerns about the independence of the convener's position. As one health authority representative argued: 'I wouldn't want to see the lay chair removed. It may take a bit longer but it makes the procedure stronger.' Not everyone agreed with this standpoint. One complaints manager did not think it should be necessary to consult a lay chair, given that complainants have recourse to the Health Service Commissioner if they are not happy with the convener's decision. A few conveners also felt it was a waste of time to have to consult a lay chair in cases which clearly should be referred back to local resolution. They felt it should be necessary to seek advice only in situations where they were unsure.

3.29 What the data most clearly illustrate is that a tension exists between independence and efficiency in the convening process. In the attempt to safeguard independence by requiring conveners to seek independent lay advice, an element of inefficiency is introduced. These two requirements, however, need not be in conflict with each other. Suggestions for reform of the procedure will be proposed in the final chapter, which will enable the process to be both independent and efficient at the same time.

Conclusion

3.30 In this chapter, we have evaluated the role of the convener. This has been done by reference to two main criteria; impartiality and efficiency. In both these areas, however, the procedure itself and the way some conveners carry out their duties have been found to be lacking. Impartiality is crucial to the credibility of the procedure, yet the data have revealed some important concerns about the ability of conveners to fulfil this goal. In particular, the independence of conveners appears to be seriously undermined by their position as 'insiders' in the NHS. Such criticisms came from a number of quarters including health councils, complainants and chairs. Most significantly, however, nearly one half of trust conveners and a quarter of health authority conveners felt compromised by their role as non-executive director on trust or health authority boards. Such difficulties were compounded in some cases by conveners taking advice from those who could unfairly sway their judgement.

3.31 The data also suggest that many conveners are not in a position to perform their functions efficiently. Low caseloads have left many conveners inexperienced and this is reflected most conspicuously in the tendency for some to act in contravention of the guidance by trying to investigate and resolve the complaint themselves. The requirement to consult a lay chair has also led to delays in decision-making. Such delays only serve to exacerbate the sense of grievance felt by the complainant and saps their confidence in the system. While those fortunate enough to secure an independent review of their case may hope eventually to achieve a successful outcome, for those referred back to local resolution, which has already been unsuccessful, satisfaction appears but a remote possibility.

4 Independent review

Introduction

4.1 This chapter evaluates the effectiveness of the independent review process in satisfying complainants. The new procedure completely revised the system for dealing with grievances which were not resolved at service level although it heralded a more dramatic change for trusts than for primary care practitioners. Under previous guidance, non-clinical 'appeals' concerning trusts were directed to the Health Service Commissioner and clinical complaints to the regional director of public health, where they were dealt with under a self-regulatory system managed by clinicians. GPs and health authorities by contrast were more familiar with an independent tribunal system, although the new procedure still introduced new roles and a different vision of independence (see figure 4.1). This final stage of the procedure promises more procedural protection than is available at stage one of the process, and this chapter will explore whether it is any more successful at satisfying complainants.

4.2 The chapter is in three parts. First, it looks at the level of activity and experience of independent lay chairs. The chapter then explores the characteristics of independent review panels and how they are conducted. Finally, it reviews opinions on the effectiveness of panel hearings at achieving satisfactory outcomes and also the performance of panel members.

How experienced are chairs?

4.3 In order to gain an idea of their workload, chairs were asked about their experience of complaints since their appointment. Of the 189 chairs who responded to the survey, 52 percent had been in post for two years and 39 percent for between one and two years. Thus, many had been in post long enough to have become familiar with the procedure and the responsibilities required of them. Chairs spent an average of 11 hours per month on their duties. Those chairs who had been in post for two years had considered an average of 12 requests for independent review and had been involved in an average of three panels. Just over one fifth (21%) had had ***no*** experience of panel hearings at all. Chairs' experience of panels was, therefore, relatively modest. Comparing this activity with that of conveners (see table 3.1), chairs had a greater caseload than the average trust convener, but less than that of health authority conveners who had the greatest caseload of all.

Figure 4.1 Independent review

The role of the lay chair

The role of the lay chair is twofold:

- To help the convener by providing independent advice and support during the convening period;
- To take responsibility for leading the panel's business, including overseeing arrangements for the panel, chairing the panel and preparation of the panel's report.

Chairs are removed from service-level resolution of complaints and also from the organisation being complained about. They are appointed by the NHS Executive regional offices in England, by the Welsh Office in Wales, by the health boards in Scotland and the health and social services boards in Northern Ireland.

Establishment and purpose of panels

Three people normally sit on the panel: the lay chair, the convener and a third panel member. Where the complaint relates to issues concerning clinical judgement, panels must also be advised by at least two independent clinical assessors.

The panel is established as a committee of the trust or health authority (with the exception of Northern Ireland, where all panel hearings come under the aegis of the health and social services boards) and all expenses arising out of the review process will be met by the body establishing the panel.

The function of the panel is to investigate the complainant's grievances, as outlined in the convener's terms of reference, and to write a report setting out its conclusions, with appropriate comments and suggestions for remedying any failings identified.

Source: NHS Executive, 1996

What happens at independent review?

4.4 In each of the surveys of health councils, conveners and chairs, respondents were asked a series of questions about how the most recent panel in which they had been involved had been conducted. One hundred and forty-nine chairs, 130 conveners (76 trust, and 54 health authority), and 98 health councils gave information. It is clear from the data collected that complaints about clinical judgement dominate independent reviews. Across all surveys, the large majority of panels concerned issues relating to clinical judgement, with the percentage ranging from 87 percent to 97 percent. In this section, we consider a number of characteristics of independent review panels, looking at where they are held, who attends them and how they are conducted.

Where are panels held?

4.5 It is important that panels should be held where all the parties can feel equally at ease. For this reason we were interested to find out the usual location of panel hearings. The results for the survey of conveners are given in table 4.1.

Table 4.1: Location of panel hearings

	Trust complaints (n=72)[1]	HA/primary care complaints (n=49)
Trust premises	82%	8%
Health authority	11%	82%
Complainant's home	3%	0%
Neutral location[2]	3%	8%
Not specified	3%	2%

1. Column adds up to more than 100 percent because in one case the panel took place in both the complainants' home and at the trust.
2. Independent premises included local government offices, a conference centre, hotel (x2) and the Royal College of Surgeons.

4.6 It is apparent from these data that little attempt was being made to conduct panel hearings at a neutral location. As many as 82 percent of panel hearings concerning trusts were heard on the trust's premises.

Who attends hearings?

4.7 When evaluating the fairness of procedures it is also important to consider who attends hearings with the parties to ensure that there is balanced representation. Complainants can easily feel outnumbered and overcome by a large team of people appearing to put the NHS point of view. It is also important that complainants are given notice of who will attend so that they can prepare themselves and their case. Data from across the surveys suggest that complainants felt the need for support. They were accompanied at the hearing in about 80 percent of cases. In 45 percent of these cases the complainant was accompanied by a member of the health council and in around 60 percent by a family member, either with or without the council officer.

4.8 NHS practices varied across sectors. In trusts, the respondent was accompanied in only about one third of hearings, while in health authorities they were accompanied in about three quarters of cases. Over half of primary care practitioners were accompanied by their defence organisation (62% in the survey of chairs, 51% in the survey of conveners), by a colleague in about a fifth of cases, and a local medical committee representative in about 10 percent of cases.

4.9 There was a particularly marked imbalance in representation between complainants and respondents at the health authority hearings. In nearly two thirds (65 percent) of the cases in which the respondent was accompanied by either their defence body or a union or local medical

committee representative, the complainant attended the hearing without any form of representation (other than members of their own family). These data clearly have implications for the confidence with which complainants present and argue their case.

4.10 The appropriateness of defence organisation representation at panel hearings was raised in a few interviews. One health authority representative commented that defence organisation personnel still behaved as though the panel were a disciplinary hearing, taking an aggressively defensive attitude rather than facilitating resolution. Such features are in marked contrast to the spirit of the new procedure which attempts to encourage a more conciliatory approach to complaints.

How are panel hearings conducted?

4.11 The guidance on the complaints procedure recommends a flexible approach to the way in which a panel goes about its business. The chair has discretion to choose, in discussion with the other panel members, the format which is most appropriate to the circumstances of the complaint. It is for the panel to decide whether the complainant and complained against should be brought together at the same meeting to discuss the issues in question, or whether the panel would be best conducted through separate meetings. This approach is in contrast to other complaints appeals in the public sector which are much more prescriptive about how such panels should be conducted (see, for example, Council on Tribunals, 1991).

4.12 Respondents to the surveys were asked a series of questions about how the panel was conducted, by reference to the principles of natural justice. Table 4.2 shows their responses.

Table 4.2: Conduct of panel hearings

In relation to the most recent panel you were involved in ...	% yes chairs (n=145)	% yes conveners (n=122)	% yes councils (n=97)
Were terms of reference agreed with complainant?	93	85	88
Was the complainant informed in advance how panel would be conducted?	93	95	82
Did panel meet parties together?	14	12	8
Were parties able to question each other?	9	8	8
Did the parties hear evidence from witnesses?	21	18	12
Were assessors reports made available during hearing?	40	41	14
Did the chair sum up to parties?	70	62	23
Was the complainant given opportunity to comment on draft report?	76	81	70

4.13 One feature that particularly stands out from these data is that panel proceedings were not conducted in a very transparent manner. Panels tended to follow a closed investigatory style of proceedings rather than a more open adjudicatory style of the kind more commonly used by

courts and tribunals. It was more usual for panel members to meet with the parties separately, rather than parties being brought together (between 8% and14% of cases). Consequently, parties were rarely given the opportunity to question each other or to hear evidence put by other witnesses.

4.14 Neither was the process of how the panel had come to a decision, nor the information on which decisions were based, very visible to complainants:

- according to health councils, the chairs apparently rarely summed up at the end of hearing the complainants' case. The marked difference in the responses between chairs and health councils suggests a failure of successful communication on the part of chairs;
- clinical assessors' reports were infrequently made available to the complainant before the end of the hearing, despite the fact that these can be very helpful for the complainant in explaining and clarifying any outstanding clinical issues;
- between a fifth and a third of complainants were not given an opportunity to comment on a draft of the panel's report.

4.15 These data raise very serious questions about whether panels are conducted in a way which accords with the principles of natural justice. It may be that the panels in question were carried out in an exemplary manner and that balanced decisions were reached, but the lack of transparency in the process meant that this was not evident to complainants.

How effective are panel hearings?

4.16 In all surveys and interviews, opinions were sought on the operation and effectiveness of panel hearings. Only five of the 37 complainants interviewed for the research had been involved in an independent review so the data on their experiences were limited. However, the health councils participating in the research revealed a strong commitment to supporting complainants at independent review stage and had extensive experience of the process as the following data show. In the year up to April 1998, the majority of health councils (83%) had helped complainants make a request for independent review. Of the 690 cases in which health councils were able to give further details of the outcome of the referrals:

- 38 percent were accepted for independent review;
- 23 percent were refused;
- 39 percent of requests were sent back for further local resolution.

4.17 By contrast, national statistics, reveal that between a fifth and a quarter of requests for independent review are referred to panel hearing. Thus, the PLP data suggest that health council

support increases the chances of a request for independent review being granted, a finding also confirmed by other research (Olszewski, 1998).

4.18 Health councils were also committed to supporting complainants at panel hearings. Three quarters of respondents (74%) made it their practice to always attend panel hearings if the complainant wished it. In the year covered by the survey, councils had attended a total of 289 hearings. Thirty-eight councils had not attended any hearings in the year, but for the remaining councils, the average number attended was three (range 1-20).

4.19 Based on their experiences of panel hearings, health councils were asked to give an overall assessment of the ability of the independent review process to achieve four of its main functions:

- ensuring a full and fair airing of the issues;
- making staff accountable for their actions;
- making appropriate recommendations;
- encouraging improvements in service provision.

4.20 Their assessments are presented in table 4.3.

Table 4.3: Health councils' assessments of the ability of independent review panels to achieve their functions

Overall assessment	% very good/ good	% adequate	% very poor/ poor
Ensuring full and fair airing of issues (n=115)	52	30	17
Making staff accountable (n=113)	27	38	35
Making appropriate recommendations (n=113)	42	38	19
Encouraging improvements in services (n=113)	35	41	24

4.21 These data suggest that health councils have witnessed some good or very good practice, but overall their assessments are disappointing. This is particularly the case in relation to staff accountability and encouraging improvements in services. In the sections following, weaknesses identified in relation to the first three functions will be explored. The last outcome will be discussed in the next chapter which explores the use of complaints for quality management.

Are panels achieving a full and fair airing of the issues?

4.22 Although the opportunity for complaints to be reviewed by an independent panel was widely welcomed across all groups surveyed, a range of concerns were identified which undermined the effectiveness of the procedure in achieving a full and fair airing of the issues, and consequently a satisfactory outcome for complainants.

4.23 First, there was anxiety about the independence of the review process. A number of issues were identified which undermined complainants' confidence in its independence, particularly in relation to complaints involving trusts. These were that:

- the convener is a member of the panel, and the terms of reference are set by the convener;
- the panel is established as a committee of the trust and is paid for by the trust (with the exception of Northern Ireland where the health and social services board pays for them);
- the panel is seldom held on neutral premises (see above);
- complaints staff who administered local resolution are sometimes involved in the administration of the panel.

4.24 Second, flexibility in the process was not always seen to be an advantage. Both conveners and chairs criticised the lack of clear guidance and common standards of procedure for the conduct of panels, and also the inconsistencies in practice. There was concern that this might lead to inequalities in the process and outcomes for both sides.

4.25 Opinions were divided among respondents about whether or not parties should be brought together at a panel hearing. The most common reasons given for not bringing parties together were to avoid a confrontational atmosphere, and to make it less intimidating for parties. Additional reasons suggested were to:

- protect the complainant from hearing what might be upsetting clinical information;
- safeguard confidentiality, particularly where complainant and patient are different individuals;
- allow parties to speak more freely and honestly without the inhibiting effects of the other party being present;
- avoid the process becoming too legalistic.

4.26 However, there was also a strong voice in support of parties being brought together, particularly among some health councils. They favoured this approach primarily for reasons of transparency and openness. It gave complainants the opportunity to seek clarification of outstanding concerns, to hear and understand the evidence on which subsequent decisions were based, and to see the NHS explain and answer for its actions. Moreover, transparency was important to allay concerns about potential bias and to demonstrate the fairness and rigour of the procedure. The problem with hearing parties separately was summed up by the following statement from a council officer:

> 'Independent review panels and the way they are conducted seem to go against the laws of natural justice. Very few I have been involved with have allowed any face-to-face contact. Although service committee hearings were traumatic for patients, at least they were able to refute what was being said. The panels I

> have attended appear unfair to the complainant and have consolidated complainants' fears that doctors etc. are "all in it together".' (HC46)

4.27 There were also concerns that complainants were disadvantaged in other ways. A common criticism was the lack of prior information about arrangements for the panel hearing. Complainants were not always informed about such matters as the terms of reference, how the panel would be conducted, who the panel members would be, who would be called to give evidence, and whether the complainant would be allowed to present their case or ask questions. Not knowing what to expect from a panel made it difficult for complainants to prepare for it or to have an influence on the process. In a similar vein, there was also criticism about the short notice given for panel hearings. One interviewee argued: 'Panel chairs and assessors are very inflexible but the complainant has to be flexible as India rubber.' This also caused problems for health councils who were not always able to attend at short notice, therefore leaving the complainant unsupported.

4.28 Other criticisms relating to the conduct of panel hearings included:

- poorly chaired meetings;
- panel members and clinical assessors not appearing impartial;
- failure to address or adhere to the terms of reference;
- meetings being allowed to become confrontational;
- failure to allow the complainant to ask questions or clarify concerns;
- the quality of note-taking;
- tape recording without the permission of the complainant.

4.29 Many of the issues raised in this section highlight important concerns about the operation of the procedure. Central guidance promoted flexibility in the conduct of panels in the hope that discretion would be used in ways which would enhance the experience of the parties to the dispute. However, the overarching impression from the data is that the proceedings are ***imposed*** upon complainants and that flexibility as interpreted in practice has led to a disempowerment of complainants and to their disillusionment with the fairness of the process.

Are panel hearings effective in holding the NHS and its staff to account?

4.30 An important component of complainant satisfaction is seeing that the NHS and its staff are held properly accountable for failures in services or practice. Concerns about the rigorousness of the procedure in holding the NHS to account were raised by all groups. Fewer than half the chairs surveyed (48%), and only a small majority of conveners (56%) agreed with a statement that the independent review process ensured the accountability of staff. When health councils were asked a similar question, one third felt that panels were poor at holding staff to

account. Concerns about accountability lay in three particular areas: the conduct of panel hearings, the attendance of parties at panel hearings and the powers of panels.

4.31 It was argued that the way some panel hearings were conducted did not encourage open and honest discussion of the issues and often left complainants feeling that the NHS had not properly explained and answered for its actions. Related to this was concern that witnesses and respondents could not be required to attend to the hearing. One chair expressed this strongly:

> 'It is quite wrong that key people should have the option to attend tribunals or not. All employees in the medical profession should be made to attend. Non-attendance makes a farce of the procedures.' (CH92)

4.32 Similarly one complainant was dismayed that no staff were interviewed by the panel:

> 'Why didn't the panel interview the people concerned? The panel didn't get to the bottom of what happened. What's the point of all these procedures if no one is accountable at the end of the day?' (case 27)

4.33 None of the complainants interviewed who had gone through the independent review process were satisfied that the NHS had been held properly accountable, and expressed a sense of futility about the process. The following comment was typical:

> 'To this day I am still trying to find out exactly what happened. No one has provided any answers. No one has ever been held accountable. A complete wall of silence.' (case 27)

4.34 The final concern in relation to accountability, was panels' lack of teeth. They may only make suggestions or recommendations, and even then they may make no reference to discipline. Nor do they have powers to follow-up or monitor the implementation of panel recommendations. These issues will be explored further in the next chapter.

Are panels making appropriate recommendations?

4.35 Experience of panel reports was very varied among research participants. Some were praised for giving a full and clear response to the issues in question with concrete recommendations offered for improvements in services. Others failed to address the complainants' concerns and made weak recommendations on issues which were peripheral to the substance of the complaint. One council officer interviewed described a panel which, despite finding a GP practice at fault on a number of counts, declined to make ***any*** recommendations at all. The panel's explanation was:

> 'As the doctors were unwilling to accept that there had been the slightest error or omission in their treatment or relations with the patient, we think that in the circumstances there is no point recommending any measure of practice development or further training.'

4.36 While this example might be an extreme one, it begs the question as to the purpose of panel hearings if their recommendations appear to have no influence on the quality of services.

The particular problem with complaints involving more than one sector

4.37 Participants in the research raised particular concerns about the handling of multi-agency complaints or those involving more than one part of the health service. While conveners and chairs said that in most cases the different services liaised when dealing with such complaints, a number of difficulties in the process were mentioned. In some cases chairs and conveners had observed an element of 'buck-passing' between the services involved, making it difficult to disentangle exactly where responsibilities lay. Services were also criticised for not cooperating in the sharing of relevant information.

4.38 At independent review stage, sometimes separate panels were held for each service involved, while, at other times, all issues were considered within one panel hearing. Whichever the format, it was usual for one chair to lead the process. When separate panels were established, there was concern that the whole process became particularly drawn out for complainants who wondered why all aspects of the complaint could not be dealt with together. In cases involving outside agencies, such as social services, which have different complaints procedures from the NHS, the process became even more confusing and complicated for complainants. A number of respondents called for streamlining of the processes to deal with such complaints.

How well are the personnel involved in panel hearings performing?

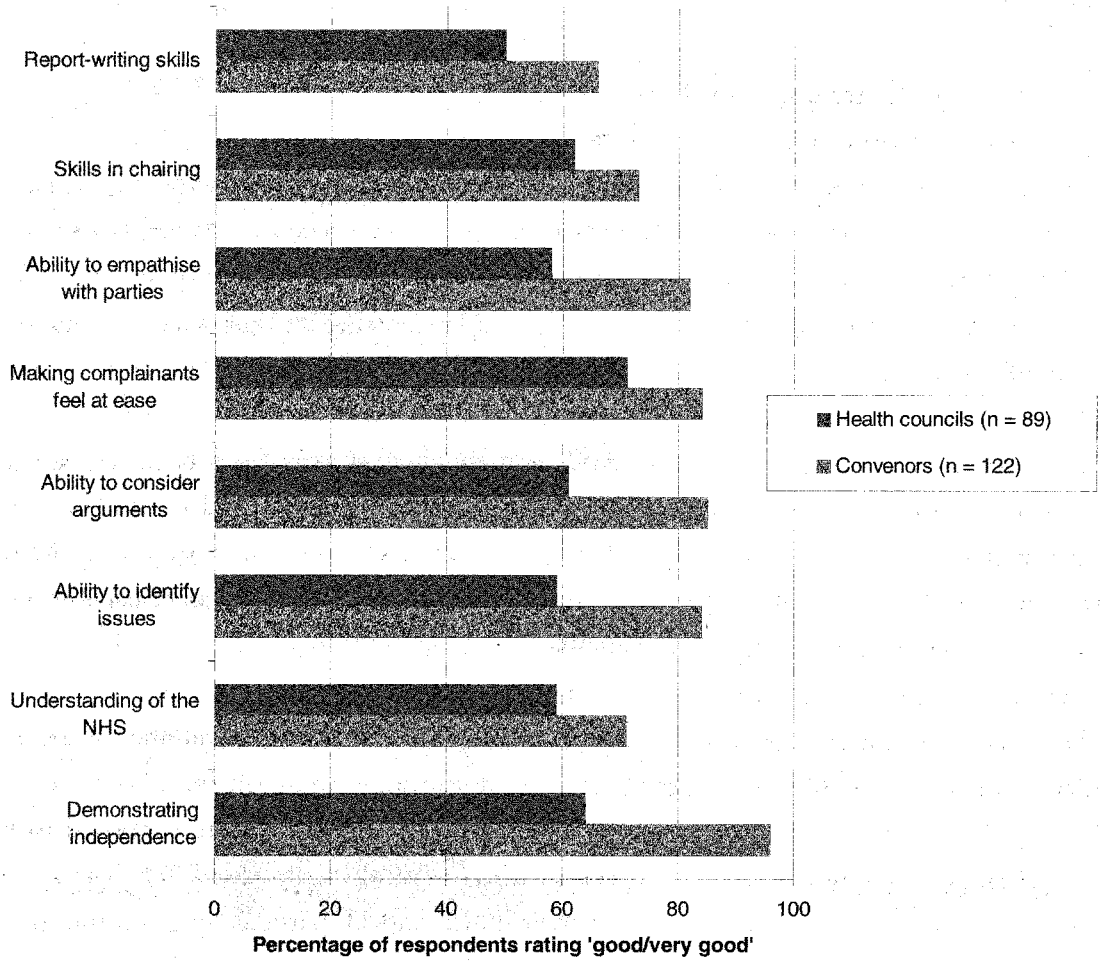
4.39 To gain an idea of how well panel members performed at independent review, the three surveys asked respondents to assess the skills of the panel members and clinical assessors who were involved in the most recent panel in which they had participated. A number of assessment criteria were suggested for each panel member, bearing in mind their different roles. The assessment criteria common to all groups included:

- demonstrating independence;
- making complainants feel at ease;
- ability to empathise with parties;
- understanding of the NHS;
- ability to consider the arguments.

How well are chairs performing?

4.40 The results of the assessment of the skills of chairs as rated by conveners and health councils are shown in figure 4.2.

Figure 4.2: Assessment of chairs' skills according to given criteria



4.41 As can be seen from the figure, chairs' skills were rated fairly favourably by both groups indicating that most chairs were generally performing their duties well. It is encouraging to observe that so many chairs were rated highly for making complainants feel at ease, suggesting that the message that panel hearings should not be allowed to be confrontational is being heard.

4.42 Despite this the results indicated room for improvement in other areas. Chairs' skills were judged to be weakest in relation to report writing, one of their principal responsibilities: 15 percent of conveners and nine percent of health councils gave chairs a poor or very poor rating

for this criterion. The Health Service Commissioner has also drawn attention to deficiencies in panel reports and has produced guidelines for their contents (HSC, 1997a). In addition, conveners and health councils were critical of their chairing skills and their level of understanding of the NHS. Although this might be expected given that chairs are deliberately recruited from outside the NHS to ensure their independence, some knowledge of how the NHS functions is important in order to formulate sensible and appropriate recommendations for improvements in service delivery. These critical assessments indicate a need for increased emphasis on skills' development in the training of chairs, an area which has been lacking in training to date.

What do chairs feel about their role?

4.43 Significantly, concerns about the role of chairs were shared by those undertaking the tasks. It was apparent from the survey of chairs that their morale was very low. The three issues which caused chairs most dissatisfaction were professional isolation, lack of provision of administrative support and also lack of remuneration for their time. Many chairs felt they were working in a vacuum, having little regular contact with other chairs or their appointing bodies, and receiving very little feedback on the outcome of their cases. While administrative assistance in an individual complaint should be provided by the health authority or trusts involved, the level of support varied enormously. Some organisations were said to be very helpful in assisting with panel arrangements and in the preparation of the panel reports, while others gave virtually no support at all. The burden on chairs to do the job without proper administrative back-up was very strongly felt and considered to be unacceptable.

4.44 Chairs drew attention to a number of problems relating to remuneration. First, the inequity in allowing employed chairs to claim loss of earnings, while chairs who were not working had no lost earnings to claim back. Second, although expenses were supposed to be reimbursed, in practice it was not easy to reclaim them. Third, many chairs felt that it was unreasonable *per se* to expect them to carry out their duties unpaid, particularly given the heavy demands on their time. One chair summed it up succinctly:

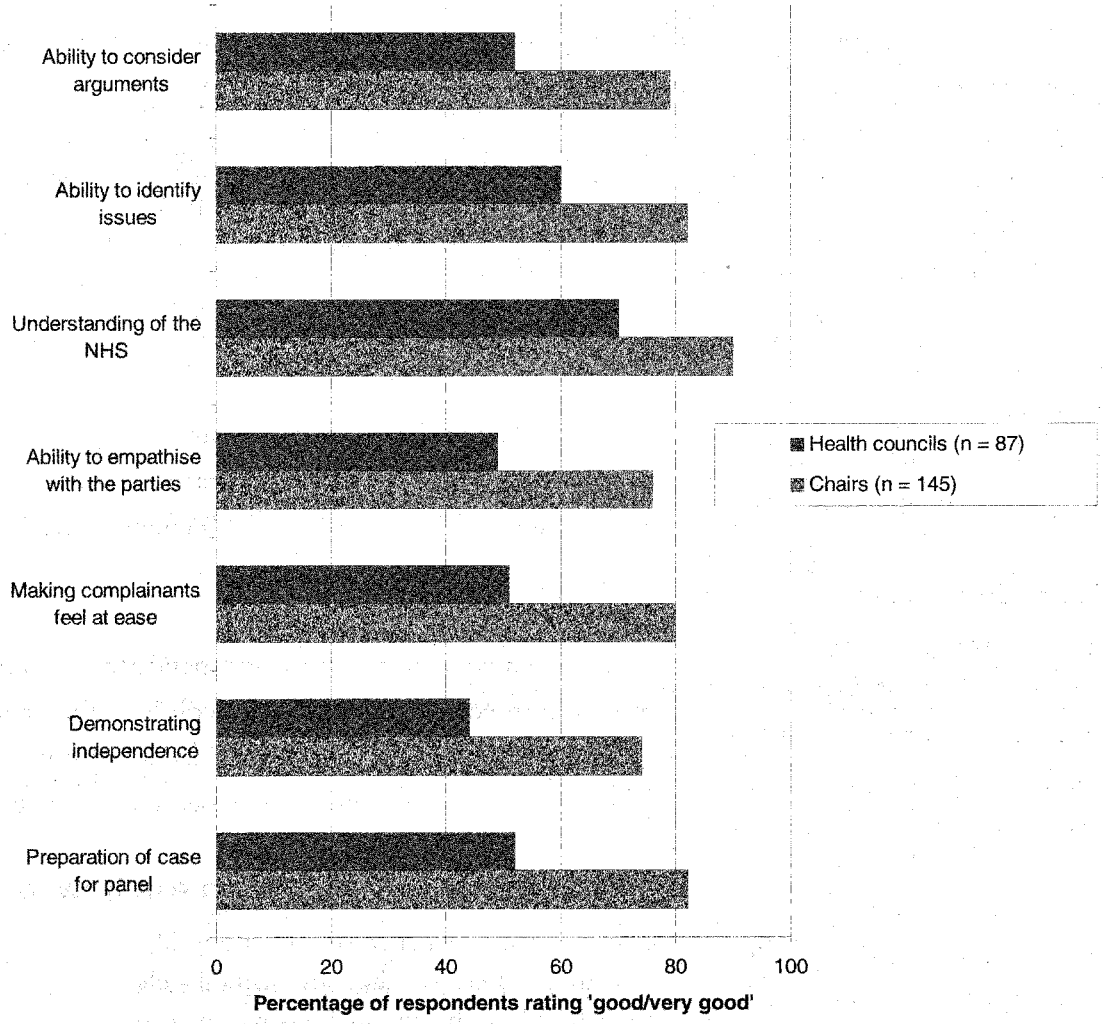
> 'Lay chairs should receive payment for the work they do! They have the heaviest workload in the independent review process and they are the only participants who are unpaid. It is very cumbersome trying to claim small amounts of expenses from individual trusts and health authorities. An honorarium or flat-rate payment per case, paid by the regional office would be better.' (CH86)

4.45 Such dissatisfaction may have long term implications. It was commonly thought that the lack of support and remuneration would drive chairs to resign, and would result in difficulties recruiting people of the calibre and professionalism that the role deserved.

How well are conveners performing?

4.46 The results of the assessment of the skills of conveners as rated by chairs and health councils are shown in figure 4.3.

Figure 4.3: Assessment of conveners' skills according to given criteria



4.47 As can be seen from this figure, in comparison with their assessment of chairs on the same criteria, health councils rated conveners less favourably on nearly all criteria. Their poor assessment of conveners' independence at the panel was most marked with 21 percent of health councils giving conveners a poor or very poor rating. The rating according to the other criteria is given in table 4.4.

Table 4.4: Health councils' assessments of conveners' skills

Assessment	% poor or very poor
Preparation of case for panel	11
Making complainants feel at ease	19
Ability to empathise with parties	18
Understanding of the NHS	4
Ability to identify issues	11
Ability to consider arguments	12

4.48 Chairs were more generous about conveners' skills, praising them particularly for their understanding of the NHS, an area in which chairs were judged to be lacking. Like health councils, chairs judged conveners to be weakest in demonstrating their independence. Again, these critical assessments indicate a need for improved training to develop conveners' skills.

How well are third panel members performing?

4.49 Conveners, chairs and health councils generally rated the skills of the third panel member favourably across all categories. Their weakest point was in relation to their participation in the panel. Five percent of conveners, 10 percent of chairs and 17 percent of health councils felt that their participation in the panel discussion had been either poor or very poor.

4.50 Eleven percent of health councils also expressed concern about the independence of third panel members. One complaints manager was concerned about the potential conflict of interest in having health authority representatives on trust panels. As a purchaser of services from the trust concerned, it was suspected that they too would be concerned not to see those services criticised. In her words:

> 'If they find there is a serious issue of medical negligence or something like that, they are not going to say so are they? Because they are immediately letting the trust, which reports to their health authority, in for some hellish legal fees and court settlements and loss of reputation. I don't think they would ever do that.'

How well are clinical assessors performing?

4.51 Finally, we turn to the role of clinical assessors in the independent review process which was widely felt to be essential. In all surveys they were consistently rated highly for their skills in identifying and explaining the key issues concerned in the complaint. Nearly a fifth of health councils (17%), however, felt their independence was poorly demonstrated and 13 percent felt that they had not performed well in relation to making the complainants feel at ease. Those respondents who had had poor experiences of clinical assessors were concerned that they were not always clear about what was required of the role, so that they sometimes muddied the issues rather than clarified them. Improved guidelines and training for clinical assessors were considered necessary.

4.52 The most common problems identified around the clinical assessors' role were the delays in finding suitable clinical assessors, the difficulties finding a date when they would be free to attend the panel and the length of time they took to produce their report. One example was illustrative of the difficulties:

> 'After six weeks of waiting and checking with his secretary, the consultant felt he was being unduly hurried and sent the case notes back without comment. It took another month to appoint someone else and resume the case. No wonder deadlines are not met.' (TC138)

4.53 In smaller communities, such as in Northern Ireland and Scotland, problems were described in finding assessors who were not known to the respondents and it was not unusual to use assessors from England in these cases. Similar problems were also said to arise in small specialties. One complainant interviewed found out that the clinical assessor involved in his complaint had been the tutor of the clinician criticised. When he challenged the panel on this, he was told that there was only a small list of suitable assessors to choose from. The complainant did not accept that explanation and felt that they should have tried harder to find someone truly independent.

How well are chairs and conveners trained?

4.54 The quality of chairs and conveners is obviously dependent on a number of factors but the data presented above demonstrate that training is essential for the development of skills. It is encouraging that 96 percent of chairs and 89 percent of conveners received training for their respective roles, although a number received their training only after they had been in the position for some months. Training for chairs and conveners was split almost equally between those who received up to one day's training, those that received between one and two days and

those who had experience of three or more days. However, only 53 percent of conveners and 71 percent of chairs felt that their training was sufficient.

4.55 For both groups, the most commonly used format for training was a workshop or seminar, often combined with other formats, such as case-study reviews, lectures, reading and experience sharing. Role-playing was used in fewer than 50 percent of cases. The content of training for both groups typically covered the duties involved in their respective roles, guidance on the complaints procedure and the role of the ombudsman. Less commonly, the role of the law was considered. Fewer than a quarter of chairs and conveners received training to improve the skills involved in their roles.

4.56 Those who felt the initial training was inadequate criticised it for being a case of the 'blind leading the blind'. Amongst this group it was felt that the trainers themselves were not sure about the procedures nor how they would operate in practice. Advice was offered in only the most general terms. Many commented that they had had to learn on the job, as only by dealing with real cases could the complex demands of the role be properly understood. Others were concerned that without a regular caseload of complaints, skills and knowledge could quickly became rusty.

4.57 Both conveners and chairs wanted an ongoing programme of training and guidance on best practice, including skills training in writing the terms of reference, report-writing, response-writing and chairing. They also wanted the opportunity to role play and discuss case studies to gain greater experience and confidence in handling the wide variety of complaints they may have to review. The idea of shadowing a colleague, acting as a third panel member before chairing a panel, or observing a panel, as part of initial training was also popular. Some thought it would be helpful to have an experienced chair or convener as a 'mentor' with whom particularly difficult cases could be discussed. More informally, regular meetings with other conveners or chairs to share experiences were also desired.

Conclusion

4.58 This chapter has looked at the second stage of the complaints procedure and the ways in which panels are being conducted. In the course of our analysis, certain key characteristics of panel hearings emerged which raised serious questions about their independence, fairness and ability to achieve satisfactory outcomes for complainants. The guidance allows for flexibility and informality in the way panels are conducted and advantage was evidently taken of such an approach by those involved. The preference was clearly for an investigatory style in which the parties did not meet, question each other or hear evidence presented. This lack of transparency in the way the panel was conducted contributed to a lack of confidence among complainants

about the fairness of the proceedings and indicated a need for much more formal rules of procedure for the conduct of panels.

4.59 An important aspect of complainant satisfaction is seeing that the NHS and its staff are held properly accountable for failures in services or practice, yet it was evident from the data that respondents doubted the ability of the procedure to ensure such an outcome. Because of the closed nature of panel hearings, complainants were frustrated by not being able to hear the NHS explain and answer for its actions before an independent panel. There was also widespread concern that witnesses and respondents could not be required to attend hearings and that panel recommendations were not enforceable.

4.60 We argue that while some complainants may prefer not to face or confront the NHS they have criticised, there should be a strong presumption that they have the right to an open hearing where both sides meet. Separate meetings between panel members and the parties may discourage emotional displays and protect complainants from hearing upsetting clinical information, as the research suggested, but independent review panels will cause some distress to complainants however they are conducted and it is important to respect and protect a patient's right to know what is being revealed about their clinical care. PLP is most concerned that decisions about the format for panel hearings are being decided for complainants without them being given a full opportunity to express their preferences. Given the imbalance in power that already exists between users and the NHS, the absence of such an opportunity only serves to disempower them still further.

4.61 While participants in the research felt that panel members and clinical assessors were generally doing their best to conduct their duties with appropriate skill, sensitivity and judgement, the performance of some members left room for considerable improvement. Panel members had not always behaved in a way which reassured complainants of their impartiality in the process, and the skills with which they conducted some of their key duties, such as report writing and chairing, were sometimes found to be wanting. Significantly, chairs and conveners acknowledged their weaknesses in some areas and many chairs and conveners requested additional training to develop their skills.

4.62 In conclusion, the independent review process has been shown in this research not to be operating optimally. This view is not only held by complainants and health councils but also by those who are responsible for conducting the process. Some of the problems lie in the design of the procedure itself and its failure to provide sufficient procedural protection for the handling of complaints at this stage, while others are due to shortcomings in how the procedure is administered and practised. Proposals for reform of the procedure to address these failings will be suggested in the final chapter.

5 Improving services and performance in the NHS

Introduction

5.1 One of the main reasons why people complain about their care is to ensure that what happened to them will not happen to others. When voicing their grievance, complainants often ask for action to be taken to prevent reoccurrence and one of the outcomes they seek in response is a commitment from the health service that the necessary improvements in services will be implemented. Glib comments that 'action will be taken' are not sufficient; information about the specific measures which will be taken and also an indication that these are followed through is what is sought. Less commonly, users also ask for action to be taken about a particular individual to address failings in their conduct or performance. This might be some form of retraining or, if warranted, disciplinary action. Rarely is this out of a desire for revenge but to ensure that the person concerned cannot continue in practice to make the same mistakes.

5.2 The Wilson review recognised these needs and emphasised the importance of monitoring of complaints both to 'make sure the complaints system is working well and that information about complaints is available for quality enhancement' (DoH, 1994, p48). This chapter will look at how well the NHS is fulfilling its obligations in this respect. In particular, three areas relating to quality enhancement will be explored. First, it will look at how health organisations monitor and use complaints to inform quality and risk management initiatives and whether their procedures are effective. Second, it will review the mechanisms by which the recommendations proposed in independent review panel reports are implemented. Finally, the relationship between complaints and disciplinary procedures will be examined.

How are complaints monitored?

5.3 Unless complaints are monitored there can be no assurance that the quality issues raised in complaints have been identified and acted on to improve services not only for complainants but also all potential users. Monitoring is also an important means for ensuring the accountability of the NHS and individual practitioners. The obligations placed on health service organisations to monitor complaints are detailed in figure 5.1.

Figure 5.1 Monitoring requirements

Trusts and health authorities must submit quarterly reports on complaints to their boards in order to consider trends in complaints, and to consider any lessons that might be learned from complaints to improve services. In the case of trusts, they must also submit an annual report on complaints handling to their regional office, to purchasing health authorities and their local health councils; and an annual statistical return to the NHS Executive.

Health authorities likewise must publish an annual report on complaints concerning the health authority itself (not primary care complaints) and submit these to the NHS Executive and all relevant health councils; and also an annual statistical return.

Primary care practitioners are only required to submit an annual return to the health authority, detailing simply the number of complaints they received during the year. Detailed information on local resolution is not required. These statistics are then forwarded to the NHS Executive, together with information provided by the health authority on the number of requests for independent review and the number of panels held.

Source: NHS Executive, 1996

5.4 In the survey of conveners, 93 percent of respondents said their organisation monitored the complaints procedure. In many cases this took the form of regular reports to the board, as required by the guidelines, but several trust and health authority conveners also mentioned having a complaints review group. In some trusts, complaints were integrated with quality and risk management systems. Others, apparently, had less well organised processes of review and some trust personnel interviewed admitted that they were not very good at 'closing the loop' on complaints. Furthermore, few actively canvassed complainants' satisfaction with the handling and outcome of complaints, so were unable to determine how well they were performing from the complainant's perspective. Sixty-two percent of health councils reported being involved in some form of monitoring activity with health authorities and/or trusts in their area.

5.5 In relation to oral complaints, a number of the trust staff interviewed had established procedures for collecting data about these, but all commented on the practical problems of doing so. First, there was a problem around the definition of a complaint and what should be logged. Second, it was difficult to persuade busy staff in any case to record the complaints. Third, there was an issue around what was done with the information once it was collected and whether anything useful came out of it. One trust had positively decided not to collect such data, believing it just added bureaucracy and paperwork with no obvious benefit.

How effective is monitoring?

5.6 Research participants were concerned about a number of aspects of monitoring, particularly in relation to primary care complaints. Because only limited data are formally

collected about complaints handled under practice-based complaints procedures, health authorities have no means of meaningfully monitoring trends in complaints. One health council representative interviewed commented:

> 'I have real concern that things are going on out there and they are not being monitored, and if you are not monitoring them, then people are not accountable, and people therefore won't change. At least under the old procedure it all went to the health authority and you knew what people were complaining about. Whereas now you don't because they are all collected at practice level. They do returns, but what do they mean?'

5.7 There was also concern about the accuracy of the statistical returns. One health authority representative commented how, in some cases, she had noticed that the returns from practices recorded fewer complaints than the health authority had forwarded to the practice to deal with. In her view local resolution had led to a loss in GPs' accountability. Another health council officer said they had been pressing the authority to monitor GP complaints much more closely, but the response had been that the health authority was concerned about 'disturbing' their relationship with primary care practitioners by seeking more information than is required in the statistical returns. Complainants themselves wondered how continuing bad practice would come to the attention of the appropriate bodies if no one from outside the practice had responsibility for monitoring complaints.

5.8 Some health authorities and GP representatives felt confident that really serious complaints would not be resolved at local resolution and would come to their attention at independent review stage, but this confidence was not shared by health councils. In the words of one health council officer:

> 'It is clearly the case that some complaints indicate a serious failure of care that at other times would warrant serious action. If the GP/dentist closes the complaint, health authorities are effectively denied the opportunity of monitoring or even being aware of bad practice or taking disciplinary action.' (HC 42)

5.9 This approach also relies on complainants pursuing their complaint to independent review, which they may not want to do, or they may even be persuaded against doing. As one GP representative acknowledged:

> 'You can imagine a scenario where people can be brow beaten into not going ahead and I don't know how you get past that. There has to be acceptance of professionalism, but you're right that there is no external moderation of that'.

5.10 Although the concerns about complaints monitoring in trusts were fewer than in primary care, health councils and other respondents expressed some reservations about the effectiveness of the monitoring process in delivering improvements in care:

- the fact that it is still ultimately an internal process of review means that the less committed trusts, or those simply without adequate procedures in place, can avoid implementation of improvements;
- by failing to record oral complaints systematically some trusts lose out on the opportunity to identify and remedy less serious but nevertheless persistent areas of user dissatisfaction (Kyffin, 1997);
- although the purchasing health authorities should receive an annual complaints report from trusts, participants in the research were not convinced that they took any action on them. Thus, opportunities for health authorities to bring pressure to bear on trusts to improve the services provided, for example as part of contract negotiations, were not being explored.

5.11 In both the primary and secondary care sectors, many complainants were sceptical that their complaint would have any impact on the quality of services provided, although this was one of their primary purposes for complaining. Although it was evident that health organisations did act on complaints, their weakness was in not always making this visible to complainants. Some complainants also commented that changes were only made when they doggedly pursued the matter with the trust. Others were given promises that action would be taken, only for those subsequently to be broken.

How do health organisations act on independent review panel reports?

5.12 Under the complaints procedure, responsibility for the implementation of panel recommendations lies primarily with the service complained about. The panel itself does not have any powers to follow-up or monitor the implementation of recommendations. In PLP's research, conveners and complaints managers were asked for information about how trusts and health authorities carried out their responsibilities with regard to implementing panel recommendations.

5.13 The most common practice in trusts was to refer the recommendations to the director of the service involved for action. If the recommendations had implications for the trust as a whole, they would be referred to the medical or nursing directors. One complaints manager said that under the new clinical governance arrangements, panel recommendations would go to the clinical governance committee. A number of trusts also reported having a follow-up procedure to ensure recommendations had indeed been implemented. In Northern Ireland, the health and

social services board said they referred the panel report to the chief executive of the trust concerned and requested a report back of action taken to implement recommendations.

5.14 In relation to complaints about primary care, the most common practice was for the chief executive of the health authority to write to the primary care practitioners inviting them to make appropriate changes to their services as recommended in the panel report. In only some cases did the health authority say they would follow this up to ensure action had been taken. In the cases where more serious issues were involved such as issues concerning the performance of primary care practitioners, health authorities described a range of procedures, of increasing formality, which might be invoked to ensure failings in a practitioner's performance were adequately addressed:

- at the lowest level, this might simply involve the health authority medical advisor informally meeting with the practitioners concerned or the local medical committee being asked to consider any training needs with the practitioner;
- at the next level, the health authority might refer a primary care practitioner to the new local performance procedures which seek to address failings in practice through more formal processes of assessment and review;
- finally, where it was felt serious terms of service issues were involved, the health authority could initiate formal disciplinary proceedings against the practitioner.

5.15 This flexibility of approach is in line with general guidance to health authorities which makes clear that disciplinary proceedings should be used only as a last resort where other action is inappropriate or where such action has proved unsuccessful (Pickersgill, 1997).

Are the necessary improvements in services and performance being achieved following independent review?

5.16 It was apparent from the interview data and written comments in surveys, that many trusts and primary care practitioners took their responsibilities seriously in relation to the implementation of panel recommendations and ensured that steps were taken to introduce improvements in systems and services. However, despite the evidence of good practice there appeared to be a general lack of confidence in the effectiveness of the procedure in achieving improvements in services.

5.17 Although over 70 percent of chairs and conveners agreed that the procedure *encouraged* improvements in the delivery of care, when chairs were asked how effective the process was at actually *achieving* improvements in services, the response was much less favourable. Eleven percent said it was very effective, 50 percent quite effective and as many as a quarter (26%) said

it was not very effective. A quarter of health councils felt the procedure was poor at encouraging improvements in services.

5.18 Many of the complainants interviewed for the research were very cynical about whether their complaint would have any impact on the quality of services provided. The reasons for respondents' lack of confidence became clear from the qualitative data:

- concern was expressed about the apparent lack of commitment on the part of some NHS organisations and professionals to the process. This, combined with the fact that panel recommendations have no force nor are allowed to make reference to discipline, made respondents question whether recommendations would have any impact on the quality of services where there was not the will to implement change;
- in the absence of an external body formally charged with monitoring and overseeing the implementation of recommendations there was concern across all groups that trusts and primary care practitioners could too easily avoid their responsibilities to improve services where it was not expedient to do so. Chairs commented that they did not even routinely receive feedback on the action taken as a result of their recommendations. Only one quarter reported having received any information and in some cases that was only because they had themselves chased it up;
- health councils were concerned that, despite having a clear monitoring role in the NHS, they were not entitled to receive copies of panel reports. What role the regional offices, or purchasers, were expected to take in overseeing the implementation process was also somewhat vague. One of the regional offices interviewed said they reviewed trends and circulated recommendations to the appropriate regional clinical directors to follow up, but a national office said they had no remit in this respect.

5.19 Respondents cited examples of recommendations which had been ignored or disputed by trusts or primary care practitioners and of lack of cooperation in their implementation. As one health council officer commented about a case:

> 'Disappointingly, in spite of the GP being found in error in four out of five areas, recommendations were not implemented and disciplinary action was not taken. So even though the client was vindicated and found to be correct, she felt the GP "got off with it".' (HC 120)

5.20 Many respondents called for enhanced powers for panels and also the introduction of formal procedures to monitor the implementation of panel recommendations. Their suggestions included:

- panels being allowed to recommend that disciplinary action be considered;
- a requirement, at the very least, on NHS providers to inform chairs of the outcome of action taken to implement their recommendations;

- extending the remit of panels to include a monitoring function; or
- charging this responsibility to a designated external body, with clearly defined powers to undertake such a function;
- giving health councils increased powers to monitor the follow-up of panel recommendations.

What is the relationship between complaints and discipline?

5.21 An important aspect of the complaints procedure is its relationship with the disciplinary process. Within the NHS, complaints and disciplinary matters are dealt with separately. This approach is aimed at encouraging staff to be as open as possible in responding to complaints. The procedures for dealing with disciplinary issues differ between the primary care and hospital sector (see figure 5.2).

Figure 5.2 Complaints and discipline

Within the hospital sector disciplinary investigation can be suggested at any point during the complaints procedure. If disciplinary action is initiated, the investigation of the grievance under the complaints procedure ceases.

In primary care, by contrast, local disciplinary procedures cannot usually be considered until after an independent review panel. It is not open to conveners to recommend disciplinary action as an alternative to independent review, even where they think it may be indicated.

Independent review panels may not recommend disciplinary action. The trust management, or in the case of primary care practitioners, the health authority which contracts the services of the practitioner, will decide the need for disciplinary action, on the basis of the panel's findings.

Complainants have no right to know the outcome of disciplinary action, except in general terms. Nevertheless, health organisations have an obligation to ensure that the complainant receives adequate information and explanations about the circumstances which gave rise to the complaint and what action has been taken as a consequence.

Source: NHS Executive, 1996

5.22 While the separation of complaints from discipline was welcomed by some when the new procedure was introduced, the data collected for this study have revealed concerns that the separation has led to a loss of real and perceived accountability of NHS staff, particularly of primary care practitioners.

5.23 Since the introduction of the complaints procedure, there has been a very marked fall-off in cases that now go through the disciplinary procedures in primary care. Unpublished research carried out by Wong (1997) demonstrated this clearly. Comparing the first year of the procedure with the previous year, the number of disciplinary hearings in 43 health authorities fell from 637,

of which 187 were upheld or partially upheld, to just 17. There were just 89 independent review panels. Similar findings were reported in our case study interviews.

5.24 Reasons for the decline in the number of disciplinary hearings were explored in interviews with the health authority and GP representatives and the following explanations were given:

- complaints previously went down a disciplinary route that they never should have taken. As this was the only process by which complaints about primary care practitioners could be heard, inappropriate cases were inevitably sometimes brought before the service committee; the independent review process now deals effectively with complaints which potentially raise disciplinary issues;
- issues that arise in panel recommendations are being addressed through local performance processes, with emphasis on retraining and improving skills rather than on discipline;
- complaints are now being dealt with under practice-based complaints procedures and therefore do not come to the health authority's attention;
- there is a wish to avoid the cost of disciplinary hearings.

5.25 Asked whether they felt the decline in the use of disciplinary procedures had led to a loss in accountability of primary care practitioners, the health authority and GP representatives had mixed opinions. They accepted that there might be a perceived loss of accountability. There was also some acceptance that, with the emphasis on local resolution, potentially serious complaints might not come to their attention. However, once a complaint had entered the independent review process they generally felt that they had effective systems in place for ensuring that poor performance issues were properly addressed. If practitioners were not taking seriously their obligations to address the problems identified through the use of informal means, increasingly formal mechanisms could be invoked by e.g. using the new local performance procedures, discipline, or ultimately the General Medical Council.

5.26 Health councils, however, were not so sanguine about the decline in disciplinary hearings, or convinced of the rigorousness of the new procedures in holding primary care practitioners to account. They generally disputed the claim that under the old system the disciplinary procedures were being used inappropriately. Even acknowledging that in some cases this might have been true, the numbers would not account for the size of the decline in the disciplinary cases heard since the introduction of the complaints procedure. Moreover, the number of cases now going to independent review fall far short of the number of cases that were upheld at disciplinary hearing under the old system, suggesting that the complaints procedure is failing to pick up or address serious breaches in care. Health councils were convinced that issues were getting 'lost' under local resolution.

5.27 The shift from discipline to a process based on unenforceable recommendations was also a concern. Although the emphasis on retraining and improving skills was positive, this was undermined by the fact that the more informal processes typically used for dealing with poor performance lacked the threat of sanction, and were reliant on the cooperation of the practitioner concerned. Furthermore, the fact that these processes were invisible, meant that complainants were not seeing staff being held accountable, when evidence that some form of remedial action had been taken was exactly what complainants sought. To be told simply that appropriate action would be taken was greeted with scepticism; they wanted to know what action and its outcome. As one health council officer commented:

> 'The process is not transparent enough. We have been told that the health authority medical officer has visited the practice and has been talking with the doctors and has recommended that they change their procedures. But that is not being shared with us or shared with the complainant and I feel that is unsatisfactory for the complainant because what the health authority is saying is, "Oh, leave it to us, we'll deal with it." But how?'

5.28 The expectation in the procedure that complainants should usually take their case all the way to the end of the independent review process before a health authority would consider the need for disciplinary action was regarded by health councils and conveners to be an unjust anomaly. It resulted in the complaint having to go through two processes which was stressful for both parties. There was also concern that serious issues might never be addressed because many complainants drop out of the process before it reaches the independent review stage, not because they are satisfied, but because they become disenchanted with the process, and worn out by the length of time it takes.

5.29 Where failures in performance are identified early on in the process, it was felt there should be a means whereby the health authority or the convener could divert the complaint into the appropriate performance or disciplinary procedures, without the need for the complainant to complete the independent review process first. As one convener said: 'Where there is a clear cut failure, why go through the independent review process?'

What happens to cases that are diverted into the disciplinary process?

5.30 In the hospital sector, when a decision is made to initiate disciplinary proceedings, the complaints procedure ceases with regard to all matters that are the subject of the disciplinary inquiry (see figure 5.2). Nevertheless, guidance makes clear that the complainant should receive the same level of information as if the matter had been dealt with through the complaints procedure i.e. 'the complainant should be able to understand what happened, why it happened, and what action has been taken as a consequence to ensure that it does not happen again' (NHSE, 1996). Any outstanding issues in the complaint not covered by the inquiry should

continue to be investigated. However, participants in the research cited examples of trusts closing the complaint without providing a satisfactory explanation of, or information about, the events in question, and also without following up other issues raised. Furthermore, as complainants have no right to know the outcome of disciplinary action, except in general terms, complainants were left feeling that no aspect of their complaint had been properly explained or dealt with.

Conclusion

5.31 Complaints provide a unique source of data for those interested in quality and risk management. They can also act as red flags for service providers where internal systems for auditing quality and performance are inadequate. This chapter has looked at how health organisations monitor and make use of information about complaints as part of their quality strategies and also at the effectiveness of the complaints procedure in achieving the necessary improvements in services and performance which are highlighted by complaints.

5.32 The data presented in this chapter suggest that while many health organisations endeavour to use complaints as an indicator of the need to improve services, the procedures for translating such information into action by the NHS are often haphazard. 'Closing the loop' on complaints is further hampered by the fragmentary organisation of complaints procedures, audit, risk management and other quality strategies within trusts. Consequently, there was little confidence among participants in the research that complaints were achieving raised standards of care and practice both in individual healthcare organisations and throughout the NHS as a whole. Participants were no more confident about the effectiveness of the independent review process in achieving improvements in service delivery. In the absence of formal mechanisms to monitor and follow up the implementation of panel recommendations, they were concerned that health organisations could too easily avoid their responsibilities to improve services where it was not expedient to do so.

5.33 Concern was also raised about the way disciplinary matters were handled in order to address failings in an individual's conduct or performance. Complainants' confidence was undermined by the lack of transparency in the process for referring such cases for disciplinary investigation, and also the lack of openness about the outcome of disciplinary, or other form of remedial, action. In situations where action had been taken to improve health professionals' performance, providers did not always do themselves credit by making this clear to individual complainants or the wider local community. This failure to be proactive and open about quality issues raised by complaints is disappointing as it can be a barrier to complainant satisfaction. It also fails to satisfy the wider public interest in service improvements and the accountability of the NHS and the health professionals it employs.

6 Conclusions and recommendations

Introduction

6.1 In this chapter we consider proposals for reform of the procedure, based on the results of the research and our analysis of existing guidance. The recommendations proposed aim to improve the procedure for both complainants and respondents alike, but place particular emphasis on the needs of complainants. In any sector where there is an imbalance of knowledge between the consumer and provider of the service, it is both daunting and challenging to make a complaint and argue one's case with confidence. In the health sector, where individuals are particularly vulnerable, the challenge is even greater. The task of policy-makers is to ensure that the NHS complaints procedure gives users the confidence not only to complain, but also confidence that their complaint will be handled fairly and promptly and will deliver the necessary outcomes.

6.2 Proposals for reform of the complaints procedure must also be seen within the context of wider changes in the NHS. Quality in health care is a key element of current policy initiatives for reform of the NHS. The introduction of clinical governance will place new obligations and duties on NHS organisations to deliver and be accountable for the highest standards of clinical care. At the same time the new Commission for Health Improvement, and other initiatives, will monitor whether quality in health care is being achieved. Professional self-regulation is also in a state of change with plans to introduce a process of revalidation of doctors' registration. Combined with the new performance procedures, these measures will help to ensure that doctors are maintaining their clinical skills and keeping abreast of advances in medicine. Finally, the reforms in primary care will have an impact on the quality of locally delivered health services, by commissioning and providing better coordinated services based on local population needs.

6.3 Bearing in mind these forthcoming changes in the NHS, and also the wishes and needs of users while pursuing a complaint, our recommendations aim to enhance the impartiality and efficiency of the complaints procedure and the accountability of the NHS.

What is the case for reform of the complaints procedure?

6.4 PLP's research has identified failings not only in the handling of complaints but also in the procedure itself. Some of these failings were observed in early studies of the new procedure and also by the Health Service Commissioner in his first annual report (NHS Trust Federation, 1996; Society of CHC Staff, 1996; HSC, 1997; NCC, 1997), but were identified as 'teething problems'. More recent research and commentary, however, have found that the same issues continue to

arise (Olzweski, 1998; ACHCEW, 1999; Select Committee on Public Administration, 1999). These failings can no longer be laid at the door of inexperience, but are indicative of more fundamental flaws in the process.

6.5 Major changes need to be made to the complaints procedure in order to restore public confidence in its independence and effectiveness. Reform is needed to:

- ensure complaints are handled impartially and swiftly at local resolution;
- enhance the independence and powers of the independent review process;
- introduce tighter mechanisms for ensuring that lessons are learned from complaints to improve standards of care across the NHS.

How should local resolution be reformed?

6.6 It is appropriate to have a degree of informality and flexibility in complaints handling at local resolution as it enables health organisations to respond to complaints in whatever way is most likely to satisfy the complainant. However, if health organisations are to be given discretion in how they operate local resolution, then safeguards must be built into the procedure to ensure that they discharge their responsibilities appropriately and fairly. As the seriousness of the allegations in a complaint increase, the need for safeguards becomes all the more important. That there is a second stage to the complaints procedure does not in itself protect complainants against poorly conducted local resolution as it is clear that complainants often choose not to pursue their complaint further, despite remaining dissatisfied. Moreover, at present there is no right to an independent review. Of those who do try to pursue their complaint, only between a fifth and a quarter are referred to the second stage (DoH, 1998).

The conduct of local resolution

6.7 In PLP's research, participants drew attention to a number of failings in the operation of local resolution which seriously impeded complainants' ability to gain satisfaction. The cause of these failings was attributed primarily to the lack of training or experience among staff in complaints handling and also to the lack of guidance on how to carry out effective local resolution. Poorly conducted local resolution can cause exacerbation of a complaint and lead to unnecessary protraction of the process.

Recommendations:

- **The Department of Health (and its counterparts in the other countries of the UK) should produce national guidance and standards of good practice for the conduct of local resolution. These should include advice on how to carry out a proper investigation and how to write an effective response.**

- **Measures should be introduced which improve the efficiency and speed of local resolution for all complaints and which will allow those which are appropriate for independent review to proceed faster to that stage. For example,**
  - **a time limit to local resolution after which there is an automatic right to independent review;**
  - **complaints to be referred back to local resolution only once;**
  - **poor local resolution itself to be a ground for allowing an independent review.**

6.8 The importance of training for the effective handling of complaints was highlighted in central guidance, yet it is apparent that the training needs of staff who may be in contact with complainants or involved in complaints management have not been adequately addressed.

Recommendations:

- **All new clinical and non-clinical staff who are expected to come into contact with users should be required to undergo training in the complaints procedure and in responding to on-the-spot complaints, as part of their induction programme.**
- **Complaints managers, service managers or other senior members of staff involved in the investigation of complaints should be required to undergo formal training in effective complaints management.**
- **In addition to the training suggested above, continuing staff training should be provided by health organisations, as the need is identified.**
- **Training should place increased emphasis on skills in handling complaints and provide staff with practical advice and tools to carry out effective resolution.**

Local resolution in primary care

6.9 As highlighted in Chapter 2, at the heart of the problem with local resolution in primary care is the expectation that complainants should take up their grievances directly with the practitioners concerned. In some cases, this is clearly acting as a deterrent to complaining. For complainants' confidence in the procedure to be restored, the procedures for handling complaints about primary care need to be reformed as a ***matter of priority***. A means by which a complainant can address their grievances to a person or body who is independent of the practice concerned should be introduced. The function of such an officer would be actively to facilitate local resolution and not to act simply as a post-box for correspondence between the complainant and those complained about. How this process should be established will need to be considered within the context of the current reforms in primary care.

6.10 Proposals which might be explored include:

- chief executives of primary care groups and trusts (and their counterparts in Scotland, Wales and Northern Ireland) to be charged with responsibility for the handling of complaints concerning any practice or practitioner within the group or trust. As with hospital trusts a primary care group/trust might appoint a complaints manager to carry out this function on a daily basis. Users would be advised to direct their complaint to the chief executive or complaints manager rather than to the practitioner concerned. The expectation would be that this person would take responsibility for investigation and for responding to the complainant;
- health authorities to take responsibility for overseeing local resolution of complaints about primary care. Instead of complainants being expected to complain to the practice concerned, complaints would be directed in the first instance to the health authority, which would initiate an appropriate process of investigation and resolution in liaison with the practice concerned. Local resolution would not be by-passed but health authority complaints managers would become much more actively engaged in the process;
- as for the previous option, but with an enhanced role for conciliators in facilitating local resolution, taking into account the recommendations for conciliation proposed below. Conciliation would be offered as the first step in local resolution, rather than as an 'add-on' once initial attempts at resolution had failed, as is often the case at present.

Recommendation:

- **As a matter of priority, the Department of Health should reform local resolution in primary care to enable users to complain to an officer who is independent of the practice concerned and who has responsibility for investigation of the complaint. In planning reform, the proposals suggested above should be considered.**

The role of conciliation

6.11 Although there was wide support among respondents for the concept of conciliation, concerns were expressed about the lack of resources invested in the training of conciliators and also about the lack of guidance about how such conciliation should be conducted. This approach is in marked contrast to the use of conciliation or mediation in other fields where there is intense debate about the advantages of different mediatory models and the level of qualifications required of mediators. If conciliation is to form an important part of local resolution in primary care, it must be both adequately resourced and conducted by trained and professionally qualified conciliators or mediators.

Recommendations:

- **The Department of Health should review current arrangements for conciliation and the appointment and training of conciliators. In particular, training should be run by accredited bodies and it should lead to a formal professional qualification.**
- **Conciliation services should be properly resourced, both in relation to provision of training for conciliators and payment for their services.**
- **Good practice guidance should be developed on the appropriate use and conduct of conciliation. In particular, it should be voluntary for both parties and it should *not* be a requirement for progression to independent review.**

Local resolution and serious complaints

6.12 In PLP's research, respondents were concerned that there were insufficient mechanisms in place to deal appropriately with complaints that raise serious questions about performance, conduct or competence which threaten patient safety. The impartiality of investigations was questioned and, because of the complexity of the complaint, complainants often experienced very protracted local resolution. While the proposals suggested above will help to improve both the quality and speed of local resolution generally, the measures fail to address concerns about independence. They also still rely on complainants having the strength and perseverance to pursue a complaint to independent review. In the public interest, it is important that serious complaints are accorded a higher degree of procedural protection than local resolution currently provides. We propose that such complaints should be identified and directed at an early stage into more formal investigatory and remedial processes, as appropriate, such as independent review, discipline, litigation or to the professional regulatory bodies, such as the General Medical Council. In practice, how would such a process be implemented?

6.13 We propose the following model for discussion:

- as a first step, the classes of complaints which would justify a so-called 'fast-track' approach would need to be defined. The assessment of whether or not a complaint fits the criteria should be as simple as possible if the process is not to become too bureaucratic and cumbersome. It should also allow for health councils and complainants to determine when it was appropriate to request fast-tracking;
- complaints which fit the defined criteria would be referred immediately to an independent screener, based in the regional complaints offices proposed below. Referrals could be made by the health organisation or primary care practitioner concerned, or directly by the complainant or health council. In the case of primary care, complaints referral could also be made by the health authority;
- on the basis of statements provided by both parties, the role of the screener would be to check whether or not the allegations in the complaint indeed met the criteria, and whether

there was a case to answer. If both conditions were satisfied the complaint would be referred directly to the most appropriate investigatory and remedial process, such as independent review, discipline or litigation. If not, the complaint would be referred for investigation under local resolution;

- the screening role should be performed by a lay person, who would be required to seek appropriate clinical advice as necessary;

6.14 Those who oppose the introduction of 'fast-tracking' have argued that it might lead to a two-tier complaints procedure with attention being focused on serious complaints to the detriment of others. However, the public interest in seeing that complaints that raise issues of patient safety are speedily and appropriately addressed justifies such an approach, even if a two-tier complaints system is a consequence. Moreover, it could be argued that a two-tier approach is already operating at local resolution, because of the time and resources that are devoted to handling serious complaints, possibly at the expense of others. The early identification and referral of these complaints to other more appropriate investigatory processes would take them out of local resolution and allow trusts, health authorities and primary care practitioners to focus on other grievances which might be satisfactorily resolved at service level. If attempts at local resolution failed for these complaints, complainants could still request an independent review. Thus, no complaints would be excluded from access to the independent review process.

Recommendations:

The Department of Health should:

- **develop a framework for 'fast-tracking' complaints which raise serious questions about performance, conduct or competence which threaten patient safety, taking into consideration the model proposed above;**
- **establish the criteria by which such complaints would be defined, in consultation with the appropriate professional and consumer organisations.**

Monitoring of the operation of local resolution

6.15 It should not be presumed that if a complainant does not proceed beyond local resolution that they are happy with the handling and outcome of their complaint. As was shown in table 2.2 (p13), of those complaints which were completed at local resolution only 29 percent were wholly satisfied with the outcome of the process. More formal procedures for monitoring the conduct of local resolution, and also complainants' satisfaction with the process, should be introduced.

Recommendations:

- **Health organisations should be required to conduct and publish an annual audit of local resolution.**
- **As part of this process they should actively canvass complainants' experiences of the complaints procedure.**
- **As part of its rolling programme of review of clinical governance arrangements in trusts and primary care trusts, the Commission for Health Improvement (and its Scottish and Northern Irish counterparts) should undertake to monitor individual trusts' complaints handling performance.**

How should convening and independent review be reformed?

6.16 The results of the research suggest that the convening stage of the procedure is one of the most flawed and discredited aspects of the complaints procedure. There is widespread concern about the independence of the convening role, not only among complainants and health councils, but also among conveners themselves. PLP's data also suggest that the way the role is organised is inefficient. The root of these problems lies in having a convener based in every trust and health authority, who is not only usually a non-executive director of the trust or health authority, but also the person who decides whether a complaint concerning that same establishment should be accepted for independent review.

6.17 Concerns were also raised about the impartiality of the independent review process both in terms of how panels are established and conducted. For example, the convener is a member of the panel; in trust cases, the panel is established as a committee of the trust and paid for by the trust; panels are seldom held on neutral premises and are sometimes administered by the same staff who are involved in local resolution.

The case for independent regional complaints centres

6.18 The concerns cited above make a strong case for the establishment of independent regional complaints centres which would be responsible for handling complaints which fail to be resolved at local resolution. Such a proposal is not a novel idea. In submissions to the Wilson review, Action for Victims of Medical Accidents, the Association for Community Health Councils of England and Wales and the British Medical Association all made similar proposals. The UK, furthermore, lags far behind other nations throughout the developed world in establishing complaints procedures which are fully independent of the national health service and also professionally led (for a review, see Elder J, 1998).

6.19 Under our proposals, the purpose of these centres would be to provide an independent, administratively supported base for all activity relating to convening and independent review. It would ***not*** add a further stage to the complaints procedure, but would rationalise existing inefficiencies in the convening and independent review stages of the process.

6.20 The core responsibilities of the regional centres would be to:

- recruit and train chairs, conveners and clinical assessors and to have a role in the training of complaints managers and other senior staff involved in investigation of complaints;
- provide independent administrative support to those undertaking the convening and chairing roles;
- provide a source of independent clinical advice to conveners;
- cover the costs of independent review panels. Local health organisations would be required to pay an annual 'premium' to the regional complaints centre, akin to the risk pooling scheme for sharing clinical negligence costs;
- monitor the implementation of panel recommendations in liaison with the Commission for Health Improvement (to be discussed further in the section on quality enhancement below).

6.21 The main advantage of this arrangement would be not only that it would give stage two greater real and perceived independence but it would also make it more efficient.

Advantages for convening

- Conveners would no longer be part of the organisation complained about, but recruited independently. Most importantly, conveners would be seen to be independent.
- It would no longer be necessary to require conveners to consult a lay chair for an independent opinion. Discretion to consult a lay chair might be retained for complex cases, but in cases where it was obvious that local resolution had not been exhausted the requirement could be removed. This would help to speed up the convening stage and make it more efficient. In cases where a complaint was accepted for independent review, the convener would be expected to ***agree*** the terms of reference with the lay chair appointed to lead the panel hearing.
- A convener's caseload would no longer be dependent on the number of requests for independent review received by a single trust. The workload would be distributed more evenly between the conveners, thereby ensuring that conveners have a sufficient caseload to sustain their expertise.
- As the regional centres would provide a source of independent clinical advice to conveners, conveners would no longer compromise their impartiality by seeking advice from clinicians within the organisation subject to the complaint.

- The risk that conveners might be influenced in their referral decisions by considerations of the cost of panel hearings would be averted.

Advantages for the independent review process

- The independent review process would be likely to run much more efficiently having a dedicated administrative team responsible for all the arrangements during the review process.
- Chairs would have access to administrative support during the report-writing stage which would help avoid delays at this stage.
- The process would be seen to be more independent, as panel hearings would no longer be established under the aegis of the organisation subject to the complaint nor administered by their staff.
- Where convenient for the parties concerned, the regional centres could provide a neutral location for holding panel hearings.
- The provision of improved support and training for panel members would help boost morale and enhance their skills. This would help to improve performance and the pace of their turnover.

Recommendations:

The Department of Health should:

- **reform the appointment of conveners so that the role is independent of the NHS;**
- **establish independent regional complaints centres which are responsible for handling complaints which fail to be resolved at local resolution, taking into consideration the proposals suggested above.**

The conduct of panel hearings – enhancing accountability and transparency

6.22 A flexible and informal approach to complaints handling may be desirable at local resolution, but is less appropriate at independent review stage. Having failed to achieve satisfaction at local resolution, complainants will expect to see a level of formality in the conduct of stage two of the process which does justice to the seriousness of the grievances being heard. At this stage there is a need for identification of clear standards for the conduct of panels in order to:

- demonstrate to complainants that the process is conducted in a rigorous and fair manner;
- ensure consistency in practice across all panel hearings and that parties are treated equitably;
- improve the transparency of the process;
- instil confidence in the procedure.

Recommendations:

- **The Department of Health should draw up explicit guidance on the rules of procedure for the conduct of panels. This should recommend that:**
  - **proceedings be conducted openly in the presence of both parties unless the complainant desires otherwise. In such situations, alternative arrangements should be agreed with the complainant;**
  - **parties or their representatives be allowed to question each other;**
  - **all information relevant to the investigation, including staff statements and responses at local resolution and also the clinical assessors' reports, be available to parties prior to the start of the panel hearing.**
- **There should also be a contractual requirement for all NHS employees to attend panel hearings if called upon to do so, even if they have moved to another trust or organisation within the NHS. Failure to attend without good reason should become a disciplinary matter.**
- **There should also be a means to require cooperation of those who have left the NHS. Contractually this would be difficult to enforce, but an alternative strategy might be to make failure to cooperate in the investigation of a complaint a ground for a finding of professional misconduct.**

The role of clinical assessors

6.23 While the role of clinical assessors in the independent review process was generally praised, some concerns were raised about their performance and independence. There were also reports of lengthy delays in their appointment to cases due to insufficient numbers.

Recommendations:

- **The Department of Health should review procedures for the appointment of clinical assessors to regional lists. Nominations should be acceptable not only to the profession concerned (as the guidance already suggests), but also to the groups who represent users. To aid lay assessments of the suitability of nominated clinicians, information should be supplied by regional offices on why particular clinicians are suitable.**
- **Improved guidance and training should be offered on the function, duties and responsibilities of clinical assessors.**

Recruitment and training of panel members

6.24 Participants in the research expressed concern about the recruitment and training of conveners and other panel members, and the lack of professionalism in the conduct of their duties. Many conveners and chairs themselves reported dissatisfaction with the training they had

received for their role, particularly with regard to improving and developing the necessary skills. If the independent review process is to be formalised, as proposed above, the process of recruitment and training of panel members must ensure that they have the necessary skills to perform their duties to a high standard of professionalism.

Recommendations:

- **The Department of Health should review procedures for recruiting and training panel members as a matter of priority.**
- **Panel members should be required to undergo an intensive training programme before undertaking their first case, with particular emphasis on developing skills and good practice in the performance of their duties. This should include training in:**
  - **quasi-judicial processes and skills;**
  - **inquisitorial techniques;**
  - **report writing.**
- **An on-going programme of regular 'refresher' courses for panel members to update skills and review performance should be provided.**
- **Other initiatives should be introduced to support conveners and chairs in their work, such as 'mentoring schemes' and regular informal, experience-sharing sessions. Such initiatives should take account of the need to protect the identity of individuals involved in the complaints being discussed.**
- **In order to recruit and retain panel members of the necessary calibre, the NHS should consider compensating them properly for their time.**

Complaints involving more than one health service or sector

6.25 A number of problems were identified in relation to the handling of complaints involving more than one part of the health service or different sectors, such as health and social services. Most particularly, complainants were confused by the different procedures and also frustrated that the grievances raised could not be dealt with under one system.

Recommendations:

- **The Department of Health should streamline the processes by which complaints involving more than one part of the health service are heard, both at local resolution and independent review.**
- **Arrangements for effective handling of cross-sectoral complaints should also be reviewed in discussion with the appropriate agencies.**

How can services and performance in the NHS be improved?

6.26 One of the principal aims of the complaints procedure is to ensure that lessons are learned from complaints to improve services not only for complainants but for all potential users. The research revealed, however, that there are only weak mechanisms for ensuring that complaints feed into strategies to improve services, not only within the organisation concerned, but throughout the NHS as a whole. Although the new clinical governance arrangements in the health service will help to address this, there is still a lack of clarity about how complaints will be incorporated into clinical governance processes and also into the work of the Commission for Health Improvement and its counterparts in the other countries of the UK.

Recommendations:

- **In addition to the existing reporting requirements, trusts should be required to establish formal procedures by which failings in services identified by complaints are fed routinely into quality strategies, such as audit and risk management. This process would be facilitated if complaints, risk management, clinical audit and other quality initiatives within trusts were fully integrated.**
- **Trusts should be required to introduce procedures for recording, monitoring and acting on oral complaints.**
- **Users should also be given opportunities to make comments about the quality of care or services provided, other than through the complaints process.**
- **In relation to complaints in primary care, health authorities should be given authority to actively monitor complaints handled under practice-based complaints procedures and to establish procedures by which this will be achieved. As part of this process, primary care practitioners should be required under their terms and conditions of service to submit more detailed information to health authorities about complaints, including the nature of the complaints received, how local resolution was approached and the remedial action taken as a consequence.**

Quality enhancement following independent review

6.27 Among respondents in the research there was widespread lack of confidence in the independent review process's ability to effectively bring about improvements in services. At the root of their concern was the fact that panel recommendations have no force, nor are there mechanisms in place to monitor whether recommendations have been acted on.

Recommendations:

- **The Department of Health should require trusts and primary care practitioners to report back fully on action taken to implement a panel's recommendations within a fixed period, say six months following the panel report. Reasons for failure to implement any recommendation should be fully justified.**
- **These reports should be disseminated to: the complainant, respondent and panel members and, with due regard to confidentiality, to all members of the board of the trust or health authority concerned, the health council, the regional offices, the appropriate purchasers and also the proposed regional complaints centres. Where recommendations have concerned a primary care practitioner, the report should also go to the primary care group or trust.**
- **The regional complaints centres should be charged with responsibility for monitoring that trusts and primary care practitioners are fulfilling these reporting obligations. They should also be required to collate the information about the improvements in services which have been implemented, and to feed this back to trusts, health authorities and primary care groups across the region, in order that different parts of the health service might learn from each others' experiences. This information should also be published and made publicly available.**
- **The Commission for Health Improvement, in its review of individual providers, should include inspection of arrangements for addressing quality issues raised by complaints. In liaison with the regional complaints centres, it should also undertake monitoring of trends in panel recommendations to see what national lessons might be learned from complaints that go to independent review panels.**

Discipline and complaints

6.28 In some cases, complainants would like disciplinary action to be taken against personnel following a complaint. The motivation is not usually a desire for revenge or recrimination but the need for reassurance that failings in an individual's conduct or performance are addressed so that such events will not happen again. The complaints procedure was not set up to deal with disciplinary issues which are dealt with under separate procedures. While this separation may be appropriate, concerns were raised in the research about the process by which disciplinary matters identified following a complaint were referred into the appropriate disciplinary channels, and also about the visibility of the disciplinary process itself. In particular, in primary care, the very substantial decline in disciplinary cases heard since the introduction of the complaints procedure has raised concerns about the accountability of general practitioners. Some of these concerns might be addressed under the proposals for 'fast-tracking' and improved monitoring recommended above. In addition, further specific areas need attention.

Recommendations:

- **At independent review stage, where matters that might require possible disciplinary action are identified, panel reports should be able to recommend explicitly that the need for disciplinary action be considered. (NB we are not recommending that it should become the remit of panels to determine disciplinary action).**
- **In primary care, there is a need for clarification of the procedure by which complaints may be referred for disciplinary action. In particular, it should not be conditional on a complaint having completed independent review and there should be provision for conveners to suggest referral for disciplinary investigation.**
- **The disciplinary process itself should be made more transparent and complainants should be fully informed as a matter of course of the outcome of disciplinary action.**
- **Where alternatives to discipline are recommended, such as a process of retraining and skills' development, complainants should also be informed that this will happen, and of the outcome.**

How should complainants be supported and represented?

6.29 For many users of the health service, it is a daunting prospect to make a complaint about one's own care or treatment, or that of a loved one. For those who are particularly vulnerable for reasons, for example, of continuing ill health, mental illness or mental incapacity, or bereavement, access to assistance and support through the process is very important. In some cases the absence of such assistance may result in a justified complaint never being brought against the NHS.

6.30 Health councils currently perform a very valuable role in providing support to complainants and the important role other advice agencies and voluntary sector organisations play must also be recognised. This role was supported by the Wilson Committee and further encouraged in the NHS guidance on the complaints procedure. However, it is not a statutory function of health councils or of other advice agencies to undertake NHS complaints work, and the support they offer varies widely both in quality and quantity across the UK. There is also a lack of clarity for complainants as to what assistance they can expect from health councils.

Recommendations:

The Department of Health should:

- **formally recognise the role of health councils in assisting complainants through the complaints procedure by adding it to their statutory remit;**
- **allocate the necessary resources to support health councils in their work on complaints, including provision of funding for the appointment and central training of a complaints officer for every health council;**

- **develop standards of good practice for advising and supporting complainants;**
- **request the NHS Health Information Service to establish a database of local organisations throughout the UK which provide emotional support, advocacy or other forms of advice and representation for complainants and other users.**

Access to independent medical advice

6.31 In relation to clinical complaints, access to independent clinical advice is particularly important to help complainants understand and clarify the issues involved, yet the availability of such advice is very limited. This imbalance in knowledge places complainants in a vulnerable position, and may result in complaints not being pursued due to lack of awareness or understanding of the failings in care or treatment involved. Conversely, lack of access to early independent clinical advice and information may result in complaints being pursued where there is indeed no case to answer.

Recommendation:

- **The Department of Health should establish a process whereby complainants can receive access to free independent clinical advice in pursuit of a complaint.**

What further research and policy work is needed?

6.32 During the course of the research, PLP identified a number of areas which deserved further in-depth research and policy-work, but which could not be undertaken in the time or resources available to PLP.

Recommendation:

- **Within the context of the NHS Executive's evaluation of the complaints procedure, further research and policy-work should be undertaken concerning:**
  - **the management of complaints about mental health services, dental services, ambulance services and services provided by special hospitals;**
  - **arrangements for provision of financial redress to complainants under the NHS complaints procedure.**

Conclusion

6.33 The NHS complaints procedure is not operating optimally. This view is apparent not only among complainants and health councils but also among those responsible for conducting the process. While undoubtedly many of those involved in the handling of complaints at all stages of the procedure are striving to satisfy complainants, and to ensure that complaints result in improvements in services within the NHS, their ability to achieve such positive goals is severely constrained by the limitations of the procedure within which they are working. Furthermore, the absence of detailed guidance on the implementation of the procedures, as well as the inadequate provision of training for the personnel involved, has contributed to poor practice in the conduct of local resolution and independent review and consequent dissatisfaction for complainants.

6.34 In focusing on the weaknesses and problems with the design and operation of the complaints procedure from the complainants' perspective, PLP has sought to highlight the areas which policy-makers most need to address to reassure complainants of the independence and fairness of the process, and the appropriateness of its outcomes. PLP has also endeavoured to be constructive in its criticisms by proposing, in this final chapter, solutions to the problems raised. Some of the recommendations are far-reaching and would require a substantial overhaul of the procedure, while others make proposals as to how existing processes can be optimised. In addition, suggestions for good practice at different stages of the complaints procedure are proposed to encourage those involved to improve their standards.

6.35 The NHS complaints procedure has now been up and running for over three years. Sufficient time has elapsed for all those engaged in the process to judge how well the procedure is working, and this research has revealed that many complainants and NHS personnel find both the procedure itself and its operation to be wanting. In the interests of users and the NHS alike, PLP urges the Department of Health and the NHS Executive to take action to reform the NHS complaints procedure as a matter of urgency in order to restore public confidence in the accountability of the NHS.

Suggestions for good practice

Good practice in local resolution

General:

- For oral complaints, offer a sympathetic and immediate response from front-line staff wherever possible.
- Offer an early meeting with the complainant to discuss the matter to facilitate speedy resolution.
- Where a complainant seeks access to records, provide them promptly and do not charge for access.
- Where delays are expected in responding to the complainant, notify the complainant and indicate when they should expect a response.

In relation to investigation:

- Talk to the complainant to clarify their concerns and account of events.
- Advise the complainant who is responsible for conducting the investigation of their complaint.
- The investigating officer should not be the line manager or colleague of any staff subject to the complaint.
- Where serious grievances are raised about the standard or conduct of clinical care, ensure the chief executive is informed and/or involve a senior member of clinical staff in the investigation, e.g. the director of nursing or medical director.
- Ensure that a thorough and prompt investigation is conducted, taking full written statements from all staff concerned.
- Where differing accounts are given of events, do not assume the staff are right and the complainant is wrong, but investigate further.
- Produce a report of the investigation which establishes the facts, answers the questions raised and includes recommendations for action to be taken.

In relation to meetings:

- In arranging a meeting:
  - think about the appropriate time and setting for the meeting;
  - allow enough time for a full discussion of the grievances;
  - discuss with the complainant whom they would like to be present and suggest involvement of the health council.
- Handle the meeting sensitively and effectively, i.e. do not be defensive or dismissive and listen to the complainant's concerns.
- Always follow up the meeting with a written record of what was said and agreed.
- If no further action at local resolution is required following the meeting, ensure the complaint is closed with a formal written response.

In response:

- Personalise the letter.
- Give full information about how the investigation was carried out and from whom statements were sought.
- Explain clinical terms clearly and avoid jargon.
- Provide open and honest explanations which address each grievance raised.
- Offer sincere apologies, or statements of regret, where appropriate.
- Offer reassurance that action will be taken to address the failings identified, and indicate how.
- Offer to meet with the complainant if they are not happy with the response.
- Inform the complainant of their rights under the NHS complaints procedure if they are not happy with the response.

Good practice in convening

The convener

- On receipt of a request for independent review, write to the complainant to introduce yourself. Explain your position in the organisation and also your role in the process.
- In correspondence, use the headed paper of the NHS organisation to which you are attached, but clearly distinguish yourself from the complaints department.
- Personally sign all correspondence to the complainant i.e. do not permit the complaints manager to sign correspondence on your behalf.
- In considering the complaint, do not discuss the complaint with people who may be able to influence your decision unfairly.
- For complaints involving clinical judgement, seek independent clinical advice on the facts of the complaint from outside the organisation concerned.
- Forward all relevant documentation to the lay chair for him/her to review; i.e. do not simply discuss the complaint over the telephone.
- Explain in full the reasons for referring a complaint back to local resolution or for refusing an independent review and how you came to that decision.
- If the chair disagrees with your decision, be open with the complainant about that and explain why you have come to your decision.
- Be explicit about having sought independent clinical advice and from where this advice was sought.

Where panel agreed:

- Discuss and agree terms of reference with chair.
- Agree terms of reference with the complainant.

The chair

- Request to see the complainant's statement of complaint and all documentation relating to local resolution.
- Put your advice to the convener in writing and the reasons for your view.

Good practice at independent review

Before the panel:

- Give a choice of dates to all parties involved for the panel hearing.
- Inform and advise complainants in advance:
  - who the panel members and clinical assessors will be;
  - who will be called as 'witnesses';
  - what the terms of reference are to be, and seek their agreement;
  - how the panel is to be conducted, and ask whether this is acceptable to them;
  - how long the panel hearing is likely to take and whether there will be breaks;
  - when they will have an opportunity to ask questions;
  - that they may bring family, friends or the health council to the hearing;
  - when they will hear the outcome of the panel hearing.
- Seek the complainants' permission to tape-record the meeting if that is planned.
- Make available to the complainants any background clinical information that will help inform the discussions and aid resolution, e.g. the clinical assessors' reports.

In planning the panel:

- Find as neutral a location as possible for the hearing, if possible off health service premises.
- Consider appropriate layout of room and seating arrangements.
- Choose an appropriate method for recording the meeting and seek administrative assistance from personnel not involved in local resolution.

At the hearing:

- Introduce the panel members and clinical assessors.
- If anyone else is present inform the complainant who they are and why they are there, e.g. if there is someone to take notes.
- Explain again how the hearing will be conducted.
- Conduct the hearing as openly as possible by meeting parties together if the complainant agrees.
- Allow complainants the opportunity to explain their grievances and to ask questions of the clinical assessors, witnesses, or respondents, if they wish.
- Do not allow the discussion to become confrontational.
- Keep to the terms of reference and ensure that all the concerns raised are covered.
- Be fair to all parties and avoid comments that appear partial.
- Listen carefully and equally to both parties.
- In drawing the hearing to a close:
  - sum up the discussions;
  - ask the complainant whether any issues have been forgotten;
  - explain the report-writing process and how long it will take.

Report writing:

- Give complainants the opportunity to comment on the facts of the draft report.
- Keep to the time limits in preparing the report.
- Offer the complainant the opportunity to talk to the chair about the final report, and if necessary the clinical assessors, in order to explain their findings.
- Inform the complainants of their right to complain to the Health Service Commissioner.

Appendix 1: research methods

How was the survey research conducted?

A combination of quantitative and qualitative methods were used for the research. Three national postal surveys were undertaken of:

- community health councils and their equivalent organisations in Scotland and Northern Ireland;
- conveners of trusts and health authorities and health boards;
- independent lay chairs.

To complement the survey data, 72 in-depth interviews were also carried out with health council staff, NHS personnel involved in complaints handling and complainants, in four case-study areas throughout the UK. The data were collected between April and December 1998.

Preparation and piloting of the surveys

The same approach to the preparation of each of the three surveys was used. Following a review of available literature on the new complaints procedure and a number of exploratory interviews with health council staff and policy-makers, the three surveys were drafted and circulated for comment to all members of the advisory group. On the basis of the comments received, the surveys were further revised and then piloted. A number of additional amendments were made following the pilot, if it was apparent that particular questions were confusing or ambiguous.

The survey questions sought information about respondents' experiences of all stages of the complaints procedure and their opinions on the operation and effectiveness of the process. Where possible, precoded responses were used in order to minimise the time taken to complete the questionnaire. However, respondents were also given the opportunity to supplement their responses with written comments and opinions on particular issues.

Sampling and response

Survey of health councils: The survey was mailed to 216 health councils in all four nations of the UK in April 1998. The 11 councils which responded to the pilot phase were excluded from the mail-out of the main survey. For all three surveys, a reminder letter was sent out some six weeks after the initial mailing.

One hundred and forty-one health councils responded to the survey, giving a response rate of 65 percent. The majority of questionnaires were completed by chief officers (66%) followed by

deputy chief officers (15%), complaints officers (6%) and a variety of staff with other titles ranging from quality officer to development officer (11%).

Survey of trust and health authority conveners: The survey was mailed to all trusts and health authorities in four diverse health regions in England (Anglia and Oxford, North Thames, North West and Trent) and to all trusts and health authorities and health boards in Wales and Scotland. In Northern Ireland, the surveys were mailed only to the health and social services boards which is where conveners are based. Two hundred and ninety-seven surveys were mailed out to trusts and 74 to health authorities and health boards in early May 1998.

One hundred and sixty-nine completed or partially completed surveys were returned from trust conveners. Some responses received indicated that trusts had merged or dissolved. Taking these into account, the number of possible responses from trusts declined to 289, giving a response rate of 58.5 percent. A breakdown of the number of responses received from different types of trust is given in table A1.1.

Table A1.1 Breakdown of survey responses according to type of trust

Type of trust	Number	% of respondents
Acute	74	44
Community & Mental Health	24	14
Community	23	14
Combined Acute & Community	21	12
Ambulance	13	8
Mental Health	6	4
All district	6	4
Learning disability	2	1
Total	**169**	**101**

Of the 74 surveys mailed to health authorities and boards, 60 completed or partially completed surveys were returned. This represented a response rate from health authorities and boards of between 66 percent and 73 percent. It was not possible to calculate the figure accurately because some health authorities or health boards were represented more than once (having more than one convener who completed a survey) and some conveners did not specify their health authority or board. All 60 surveys were included in the analysis. Since the surveys asked only about conveners' own experiences of the complaints process, not that of the health authority or board as a whole, no data were duplicated.

Survey of independent lay chairs: Assistance for the distribution of the survey of chairs was sought from four regional offices in England (Anglia and Oxford, North Thames, North West and Trent), from the Welsh Office and from each of the health boards in Scotland and health and social services boards in Northern Ireland. Without exception, all agreed to distribute the survey. Three hundred and seventy-one surveys were mailed out in early June 1998 and 191 completed or partially completed surveys were returned giving a response rate of 51.5 percent.

Analysis

The quantitative survey data were analysed using the statistical package SPSS 7.5 for Windows. The written responses to survey questions were typed up in table form and postcoded to identify common concepts, themes and opinions.

How was the case-study research conducted?

Selection of sites

The four 'case-study areas' were selected on the basis of geographical spread and variation in their socio-economic and ethnic characteristics. The research team had no prior knowledge of the quality of complaints handling in the trusts and health authority in each area, nor of the health council's activity in complaints. Sites were chosen in North Thames and North West regions and in Scotland and Northern Ireland. In planning the case study research, co-operation was first sought from the health council in each of the four chosen areas. Further interviews in the area were arranged only when the council had given its agreement to participate in the study.

The interviews with health council officers and NHS personnel

The interviews at the health councils included both chief officers and other staff whose remit included complaints. Wherever possible more than one interview was carried out at the council in order to hear different advisers' opinions on the complaints procedure. These interviews averaged one hour in length.

In addition, the person with primary responsibility for complaints management both at the health authority and also at each trust within the catchment area of the council was invited to take part in an hour-long interview. In each of the areas, the researchers also undertook to carry out interviews with appropriate GP representatives e.g. the local medical committee secretary or BMA representative.

All the interviews were undertaken by the project manager. They were conducted face-to-face, and were tape-recorded with the prior agreement of the interviewee. The same set of questions

formed the basis for all interviews. These addressed a wide range of topics including the organisation's approach to complaints handling, the systems in place for ensuring lessons are learned from complaints, the strengths and weaknesses of the procedure and complainants' satisfaction with the procedure. The interviews were informal and conversational in style, allowing the interviewer to follow through a particular line of enquiry in response to issues raised by the interviewee.

With the help of the Association of Managers in General Practice, practice managers from each of the case-study areas (with the exception of North Thames) were identified and invited to be interviewed over the telephone about their practice-based complaints procedure.

Uptake of interviews

Without exception all health councils, trusts and health authorities invited for interview agreed to take part in the research. One trust in the North Thames region first requested that the approval of its ethics committee be sought to carry out the interview with its complaints officer and also charged the project for the interviewee's time. One local medical committee secretary declined to be interviewed for the reason of having limited experience of the complaints procedure. A further GP representative agreed to be interviewed but for a fee of £200 which the project was unable to meet. No response was received to a request to drop the charge and the interview did not go ahead. In total 33 interviews were carried out with health council staff (10) and NHS personnel (23) in the four case-study areas. A summary of the interviews carried out in each area is given in table A1.2

The interviews with complainants

An 'opt-in' approach was used to recruit complainants for interview. Health councils in each of the case study areas were asked to send a letter to between 20 and 30 complainants inviting them to participate in telephone interviews. Those complainants who returned a form to PLP indicating their agreement to be interviewed were contacted by the project manager. This approach was used to protect the confidentiality of complainants. No names and addresses were passed to PLP by the health councils. To help ensure that a range of experiences were reflected in the interviews, councils were asked to select complaints covering all sectors of the health service and all stages reached in the complaints process, and also a cross-section of those that were apparently handled well or poorly.

The interviews with complainants averaged 45 minutes (range:10 minutes to two hours). Complainants were asked about their experiences of the complaints procedure, what they had hoped to achieve from complaining, whether their expectations were met both in terms of the handling of their complaint and of the outcome and what improvements they would like to see

in the procedure. Contemporaneous hand-written notes were taken during the telephone interviews and were typed up in detail afterwards.

Uptake of interviews with complainants

Forty-two complainants (approximately 50%) returned a form indicating their willingness to take part in interviews. Of these, 34 interviews were undertaken. Two complainants in the North Thames region also came forward for interview of their own accord, having heard about the project from other sources. Thus, a total of 36 interviews were carried out. A breakdown of the number of interviews carried out with complainants per region is given in table A1.2.

Twenty-six women and 10 men were interviewed, with an average age of 50. In the 36 interviews, 42 separate complaints were described. In 15 cases the interviewee had complained about their own care. In the remaining cases the subject of the complaint was the interviewee's partner (9 cases), parent (8), offspring (6), aunt (2), niece (1) or friend (1).

Table A1.2 Number of people interviewed by area and position in the NHS

	North Thames	North West	Northern Ireland	Scotland	Total
Health council	2	2	4	2	10
Acute trust	4[1]	2	2	1	9
Community/mental health	1	1	2[2]	1	5
Health authority	1	1	1	1	4
General practice[3]	1	1	2	1	5
Complainants	10	7	6	13	36
Total	**19**	**14**	**17**	**19**	**69+ 3[4]**

1 These interviews involved 4 staff in 3 trusts.
2 One interview was with a complaints manager in a combined acute and community trust.
3 The interview subjects were 3 practice managers, 1 LMC secretary and 1 GP representative from the BMA.
4 Three further interviews were carried out with staff from 1 regional office, 1 national office and 1 practice manager from Anglia and Oxford region.

Analysis

The in-depth interviews were analysed using a process of content analysis to identify common concepts, themes and opinions. While the views expressed in the qualitative data cannot be generalised, the opinions and experiences of participants provided rich, contextual detail that helped to validate and further explain the findings from the questionnaires.

Other interviews, observation and research activities

In addition to the interviews conducted in the four case-study areas, an interview was carried out with a practice manager in Anglia and Oxford region. Two further interviews were carried out with complaints personnel at one of the regional offices of the NHS Executive in England and also at one of the national offices. The project manager also observed a training day for

independent lay chairs and a feedback session for experienced chairs arranged by one of the regional offices.

In March 1999, the Public Law Project organised a major conference on the NHS complaints procedure at which it presented its preliminary findings. This was attended by over 100 representatives from the health, legal and consumer sectors. In July 1999, a small meeting with representatives from the health and advice sectors was also held, the purpose of which was to discuss in greater depth ideas for reform of the procedure. The discussions at both these occasions informed the preparation of our recommendations.

References

Allsop J (1994)Two sides to every story: complainants' and doctors' perspectives in disputes about medical care in a general practice setting, *Law and Policy* 16(2):149-183

Annandale E and Hunt K (1998) Accounts of disagreements with doctors, *Social Science and Medicine* 1:119-129

Association of Community Health Councils for England and Wales (1996) The new NHS complaints procedure, *Health Perspective,* London: ACHCEW

Association of Community Health Councils for England and Wales (1999) *The NHS Complaints Procedure: ACHCEW's memorandum to the Public Administration Committee*, London: ACHCEW

Bark P, Vincent C, Jones A, Savory J (1994) Clinical complaints: a means of improving quality of care, *Quality in Health Care* 3:123-132

BrennanT, Leape L, Laird N. *et al* (1991) Incidence of adverse events and negligence in hospitalised patients: the results from the Harvard Medical Malpractice Study I, *New England Journal of Medicine*, 324: 370-6

Citizen's Charter Complaints Task Force (1993) *Effective Complaints Systems: Principles and Checklist,* London: HMSO

Citizen's Charter Unit (1991) *The Citizen's Charter: Raising the standard*, Cm 1599, London: HMSO

Council on Tribunals (1991) *Model Rules of Procedure for Tribunals,* Cm 1434, London: HMSO

Department of Health (1994) *Being Heard: The report of a review committee on NHS complaints procedures*, London: Department of Health

Department of Health (1995) *Acting On Complaints: The Government's proposals in response to 'Being Heard', the report of a review committee on NHS complaints procedures,* London: Department of Health

Department of Health (1998) *Handling Complaints: Monitoring the NHS complaints procedures. England, 1997-98,* London: Department of Health

Elder J (1998) *Who cares about the health victim?* Chepstow: Klaxon Books

Health Service Commissioner (1997) *Annual Report 1996-97*, London: TSO

Health Service Commissioner (1997a) *Checklist for Reports of Independent Review Panels,* London: Office of the Health Service Commissioner

Health Service Commissioner (1998) *Annual Report 1997-98* (para 3.7) London: TSO

Ison, T (1997) *Administrative Justice – Is it such a good idea?*, paper presented at the Bristol Administrative Justice Conference 1997

Kyffin R, Cook G, Jones M (1997) *Complaints Handling and Monitoring in the NHS: A study of 12 trusts in the North West Region*, Institute of Medicine, Law & Bioethics, University of Liverpool

Lloyd-Bostock S and Mulcahy L (1994) The social psychology of making and responding to hospital complaints: an account model of complaint process, *Law and Policy*, 16(2):123-148

Lord Chancellor's Department (1996) *Access to Justice,* London: HMSO

Moss P and Stacey M (1994) *Digest and Analysis of Submissions to the NHS Complaints Review Committee,* report to the Health Committtee of the House of Commons

Mulcahy L and Tritter J (1998) Pathways, Pyramids and Icebergs? Mapping the links between dissatisfaction and complaints, *Sociology of Health and Illness,* 20(6):825-847

National Consumer Council (1997) *NHS Complaints Procedures: The first year,* London: NCC

NHS Executive (1996) *Complaints: Listening ... acting ... improving. Guidance on implementation of the NHS complaints procedure,* NHS Executive

NHS Trust Federation (1996) *Working Hard to Please: An NHS Trust Federation investigation into the first six months of the new NHS complaints procedure*

Olszewski D (1998) *Health Councils' Complaints Project*, Scottish Association of Health Councils

Pickersgill D (1997) The new disciplinary procedures, Chapter 6 in Pickersgill D and Stanton T (eds) *Making Sense of the NHS Complaints and Disciplinary Procedures,* Oxon: Radcliffe Medical Press

Select Committee on Public Administration (1999) *Second Report* (session 1998-99), London: TSO

Service First (1998) *How to Deal with Complaints?* London: Cabinet Office

Society of CHC Staff (1996) *Are you being heard? A six month review of the new NHS complaints procedure*

Wong K (1997) *Above All, Fairer to Everyone? The new NHS complaints procedures in action*, unpublished MA thesis

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