

# HOUSE OF COMMONS HEALTH COMMITTEE INQUIRY INTO COMPLAINTS AND LITIGATION

## SUBMISSION FROM NATIONAL VOICES

### Summary and Recommendations

1. Effective complaints handling is a vital impetus to improving quality of care. Providers of care need to collect and act on complaints and other feedback information swiftly to resolve issues before they escalate to formal complaints, referrals to the Ombudsman and litigation.
2. They also need to be transparent about the work they are doing to resolve complaints and concerns, and what results from it. This material needs to be in readily understandable form and consistent so that data can be aggregated and compared.
3. We have recommended in this paper and elsewhere a statutory duty of candour. This will build on the rights and pledges to patients in the NHS Constitution.
4. We also recognise that staff need to see themselves as partners in the process of quality improvement and not the victims of the internal fall-out from complaints or other events such as the disclosure of service and clinical quality failures.
5. We want the work of the NHS Litigation Authority on the appropriate use of apology more widely acted upon and further recommend the development of incentives for staff to reward early recognition and action when patients and families express dissatisfaction. The Mid-Staffordshire Foundation Trust enquiries show what can happen when staff do not hear and act on these views.
6. More attention should be paid to measurement: we should stop simply counting numbers of complaints, which tells us little if anything, and start counting whether people feel their complaint was well handled. We should also measure the ratio of informal and formal complaints to understand organisational effectiveness at resolving issues at minimum financial and human cost.

### Introduction

7. National Voices welcomes the opportunity to submit evidence to the Health Select Committee inquiry on complaints and litigation. We are the coalition of national voluntary organisations with a mission to strengthen the voice of patients and citizens at all levels in health and social care.

We have structured our submission as follows:

- (a) A general observations section and (b) specific responses to the questions set out in the Committee's call for evidence

## General Observations

6. We are not a complaints handling body. Our interest is in making it much easier for people to voice concerns, to be heard and in turn to hear back on whether their contribution has improved matters. We support moves to create more responsive and listening services. That is the best guarantee that things will go right more of the time.
7. But we recognise that in complex care systems delivering care to millions of people, things will still go wrong. When that happens we want a system in which:
  - User and staff voices can be easily raised and something is done about it early.
  - People are clearly aware of and supported to exercise their rights in the NHS constitution.
  - There is transparency about serious lapses, so that people can understand and learn from them – we support a statutory duty of candour.
  - Everything is done to make a formal complaint less necessary, through a culture of listening and mechanisms of real-time feedback – while still inviting complaints if that is what people choose.
  - Where harm is done, there is apology, redress and demonstrable learning at local level.
  - Formal complaints are handled so that a key measure is the complainant is happy with the process.
  - The process is easy to navigate and there is support for people who do not speak English, have a learning disability or impaired capacity and others who may be excluded from a process that is not designed around their needs
  - The process is also easy to navigate regardless of where in the system the problem emerges – primary, secondary, social care, personal budget holder, carer etc – because the basic process is the same.
  - All key metrics concerned with above are published by all providers, appear in Quality Accounts etc.
  - A smaller proportion of formal complaints go to the Ombudsman, because they have been satisfactorily resolved earlier in the system.
  - Complainants make choices in favour of low cost dispute resolution/mediation/restorative redress systems and no longer feel it necessary to go for litigation to meet their needs.
7. All these elements are included in our observations that follow. Before considering the issues as set out in the Committee's invitation to provide evidence, we consider complaints and litigation together as parts of a wider redress system and look at whether the system as a whole provides good choices to the dissatisfied user who persists with his/her request that their problem is resolved.

## General Observations on Complaints and Litigation

8. We welcome the Health Committee's decision to consider these topics together. Complaints handling has been defined as bargaining in the shadow of the law with the law and litigation remaining as an option (in theory). Litigation, although very much more expensive, can be considered a sub-set of the complaints world and as one route amongst many for users looking for resolution. The hoped for outcome is the same whatever the route taken towards it – individual redress and system improvement.
9. We agree with the views expressed in June 2007 by the Health Ombudsman in a speech to the Institute of Advanced Legal Studies. There Ann Abraham argues for a rationalisation of the routes to redress, placing the Ombudsman system in the context of the justice system as a whole, and making the point that the Ombudsman option “although different, is complementary to the courts and tribunals on the one hand and to negotiated forms of alternative dispute resolution on the other: different from, yet receptive to elements of both”.
10. In contrast to the cases considered by the NHS Litigation Authority, where judgement can trigger large payments, pecuniary remedies are low. The Ombudsman scores by intervening and achieving more tightly focused change in health delivery process – for example in the provision of weekend care in a particular Primary Care Trust – an intervention of benefit to many more than the individual complainant. The high degree of compliance with the findings and recommendations of the Ombudsman is practical proof of the confidence in the findings of the process.
11. National Voices will support a rationalised system that recognises the need to ensure that “disputes find their way to the forum that is most likely to deliver the right level of adjudication, the right remedy and the best prospects of future prevention.” (Ann Abraham – same speech).
12. One of the primary goals in complaint handling is the avoidance of escalation with first time, front line, local resolution. Escalation is expensive and is generally more time-consuming and emotionally draining for all involved. It is not clear that it generally delivers better outcomes for individuals or health systems. An impetus to better and swifter local resolution would be created by clear evidence of its benefits. National Voices finds it frustrating that there is little publicly available data on what comes out of the initial stages of the complaint management systems of the NHS. Such information would allow us to see whether the outcomes of complaints do add value by providing resolution for individuals as well as achieving change of benefit for all who use health and social care services.

## The Health Committee's List of Issues

13. **The reasons for the sharp rise in NHS complaints** is not known. A rise in formally logged complaints can indicate a number of things – a decline in quality, an improved and more accessible complaint service which is widely promoted, data which are more comprehensively logged, a failure at the front line to address concerns at the time and on the spot, users with higher expectations and more confidence in pursuing perceived failures in service. So a rise in complaint numbers can be a positive indicator – increased public confidence that the complaints system

is worth using. This together with the publicity about the 'new' system and the rights and pledges embedded in the NHS Constitution may have encouraged people to pursue an issue formally. The Ombudsman is reporting a rise in complaints reaching her office as a result of the removal of the middle stage – has this also resulted in a backwash into the formal complaint systems of acute trusts and PCTs?

14. One of the most distressing aspects of the Mid Staffordshire NHS Foundation Trust event was the failure of staff to pass on the concerns of patients and their families. The NHS Constitution in its section on complaint handling gives patients specific rights and pledges including the pledge that “the fact that you have complained will not adversely affect your future treatment”. We would recommend that the group of citizens who are employed in the health service receive a similar reassurance in the context of their future career that their recognition and reaction to causes of dissatisfaction will not 'adversely affect your future treatment". The Constitution has a role to play in encouraging staff and patients to work together in the interests of patient satisfaction and quality improvement. This joint commitment would support the practical implementation of a statutory duty of candour and would share many features with the 'Being Open' initiative of the National Patient Safety Agency
15. Equally, where complainants have had the confidence to come forward, we note the possibility that front line staff have an incentive to encourage citizens to “go formal”. Referral onwards and upwards gets rid of the issue for a while at least (it may disappear altogether if the complainant gives up). “Outsourcing” the management of the complainant to others could be seen as a strategy to protect internal relationships and the institutional status quo as well as externalising costs. This attitude towards the complaint – get rid of it – might help explain why staff attitudes feature so strongly in any analysis of complaint cause. The policy implication is that managers need to be alive to the possibility of these and other cultural and behavioural barriers, when seeking to improve and embed local resolution procedures.
16. **The effectiveness of the new system introduced in April 2009** is not yet established. The impact on the Ombudsman Office is beginning to be seen with a rise in contacts or enquiries but a lowering in the percentage of those contacts which are taken further. 58% of closed complaints in 2009/10 were not 'properly made' or were premature. About 10 per cent of all formal complaints were referred to the Ombudsman. This seems quite high.
17. The removal of the middle layer will eventually contribute to the lowering of one cause of complaint – there were 513 complains about the Healthcare Commission itself which will disappear from the statistics. (It is always a significant finding if parts of the complaint process itself show up as an engine of dissatisfaction and further complaints in their own right.) Discussion of effectiveness is hampered by the absence of comprehensive data from the early stages both before dissatisfaction or a problem hardens into a formal complaint and also in the early stages of that formal process
18. In considering the **effectiveness of the constituent parts of the complaints system**, we must draw attention to the absence of any generally agreed and applied means of measuring that effectiveness. The Ombudsman's Office has developed the Principles of Good Complaint Handling but no organisation is currently assessed against them. The **ICAS** service although supported by the Ombudsman is divided between 3 suppliers in England and there is no consolidated

data available. Similarly **PALS** offices operate independently of each other and while there is a national body, lack of funds and resources limit their activities and their ability to combine in the interests of advocating improvement. We see merit in using the Ombudsman's principles to help frame the public accountability requirements that should be met by care organisations in relation to complaints handling. We propose the adoption of some key metrics, including, in particular, measures of the success of informal resolution in avoiding escalation and of individuals' satisfaction with the handling of their concerns and complaints.

19. **The failure of some Foundation Trusts to report numbers of complaints –** Foundation Trusts that take advantage of their dispensation not to publish complaint data are not fulfilling an important part of their accountability to their members and the NHS generally. We believe that no organisations providing services funded by the taxpayer should be exempt.
20. Aspects of the **Government's plans for future complaints handling arrangements** were welcomed by National Voices in our response to the consultations on the Health White Paper. We welcome a role for HealthWatch in complaints advocacy, but also support the Government's latest published intention (Command Paper 7993) that local authorities should be able to judge where best to source advocacy services at local level. This is consistent with our White Paper response in which we said that HealthWatch should be seen as a service rather than necessarily a single organisation and that new arrangements should support and not displace existing arrangements for involving patients and citizens if these are working well.
21. We support the Government's proposal in the Command Paper to legislate to strengthen the arrangements for the Ombudsman to share information on complaints handled by her office. We would have preferred to see a more wholehearted endorsement in that paper of the importance of local, responsive resolution of complaints.
22. On the issue of **how complaint data will feed into the new commissioning arrangements**, we would expect commissioners to insist that providers report against agreed metrics on complaints handling.
23. We note that in comparison with the well scrutinised hospital sector, primary care is a complaints "black hole" from which very little data emerges. Far fewer formal complaints are made. We do not know how much this is because of higher rates of satisfaction in primary care and how much because patients and families find it more difficult to complain about GPs and other primary care professionals because of feelings of dependency, deference and fear of the personal consequences - a particular risk for older patients with long term conditions who are both more at risk and less likely to complain. We know even less about the handling of informal concerns and complaints. Primary care professionals and managers need to consider what steps need to be taken to make a reality of the NHS Constitution pledge that patients will not suffer adverse consequences as a result of making a complaint.
24. **The costs of litigation against the NHS** are high and divert resources away from patient care. We support moves towards no fault compensation and **the option of a statutory right to compensation without the need to prove negligence**. **Conditional fee arrangements** are of potential benefit, but we note that intensive marketing by legal firms (readily observable by googling the NHSLA) could distort

people's choices. The test here is that individuals (who may well be in a state of emotional distress) need the information and guidance to make the right choice for them, and to make full use of their legal rights to redress if that is their choice.

25. We would urge the Government and NHS to explore other means of diverting people away from litigation.

26. In answer to the Committee's question about **the effect of litigation on the development of an open and learning culture** we note that there appears to be a widespread belief, despite the Authority's guidance to the contrary, that apology amounts to the acceptance of legal liability. More effort is needed to bust this myth and more generally to empower and equip care staff to issue early and appropriate apologies. There might be scope for a campaign led jointly by professional and patient and civil organisations to change attitudes and behaviours.

December 2010