

EXPLANATORY MEMORANDUM TO
THE LOCAL AUTHORITY SOCIAL SERVICES AND NATIONAL HEALTH SERVICE
COMPLAINTS (ENGLAND) REGULATIONS

2009 No. 309

1. This Explanatory Memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

This memorandum contains information for the Joint Committee on Statutory Instruments

2. **Purpose of the instrument**

2.1 These regulations introduce a revised procedure for the handling of complaints by local authorities, in respect of complaints about adult social care, and by NHS bodies, primary care providers and independent providers in respect of provision of NHS care. The regulations align adult social care and health complaints processes into a single set of arrangements.

3. **Matters of special interest to the Joint Committee on Statutory Instruments**

3.1 These Regulations revoke the National Health Service (Complaints) Regulations 2004 (S.I. 2004/1768) (“the 2004 Regulations”). The 2004 Regulations were amended by the National Health Service (Complaints) Amendment Regulations 2006 (S.I. 2006/2084) (“the 2006 Amending Regulations”). In its First Report of Session 2006-07, the Joint Committee on Statutory Instruments drew special attention to the 2006 Amending Regulations, on the ground that regulation 9(d) was defectively drafted. Regulation 9(d) substituted a new paragraph (7) in regulation 15 of the 2004 Regulations, in relation to the provision for a “request” made by the Independent Regulator to the Health Care Commission in relation to reports about complaints.

3.2. In its Memorandum to the Committee dated 30th October 2006, the Department confirmed that the word “request” referred to a requirement in regulation 15(7), accepted the need to alter the wording of the regulation, and stated that it would take a suitable opportunity to make the change.

3.3. Regulation 15 of the 2004 Regulations makes provision for the Commission for Healthcare Audit and Inspection (“the Healthcare Commission”) to consider complaints about NHS foundation trusts, and regulation 15(7) provides for the Healthcare Commission to make reports to the Independent Regulator in respect of complaints about NHS foundation trusts. From 1st April 2009, the Healthcare Commission will cease to exist, and the provision for reports under regulation 15(7) will no longer apply.

3.4 These Regulations revoke the 2004 Regulations. The revocation is subject to saving provisions in regulation 20, including provision whereby any request made before 1st April 2009 for the Healthcare Commission to consider a complaint is to have effect as a request to the Health Service Commissioner to consider the complaint under the Health Service Commissioners Act 1993. As regulation 15(7) will no longer apply with effect from 1st April 2009, it appears that an alteration to regulation 15(7) is no longer necessary.

4. **Legislative Context**

4.1 The complaints procedures for NHS bodies and for Local Authorities, in respect of their adult social services functions, are currently laid down in secondary legislation (i.e. regulations): the National Health Service (Complaints) Regulations 2004, the National Health Service

(Complaints) Amendment Regulations 2006 and the Local Authority Social Services Complaints (England) Regulations 2006 respectively. The procedures for the primary care contractor groups (GPs, pharmacy groups, NHS sight providers and NHS dentists) are included in the regulations which set out the terms and conditions for contractors providing each service. NHS foundation trusts and independent providers are expected to have in place similar arrangements to NHS bodies, with this requirement being part of a contractual obligation with a Primary Care Trust or NHS trust.

4.2 The Government made a commitment in the 2006 White Paper “*Our health, our care, our say*” to develop a comprehensive single complaints system across health and social care by 2009.

4.3 The existing legislation dealing with complaints about NHS care provides for the Healthcare Commission to review complaints unresolved at local level. On 1st April 2009, the Healthcare Commission ceases to exist - the Health and Social Care Act 2008 provided for its dissolution. These Regulations also make transitional provision for complaints still being dealt with by the Healthcare Commission on 1st April.

5. Territorial Extent and Application

5.1 This instrument applies to England.

6. European Convention on Human Rights

6.1 As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

7.1 The Health and Social Care (Community Health and Standards) Act 2003 made provision for the Secretary of State to make regulations about the handling and consideration of complaints in relation to the functions of English NHS bodies, the provision of health care by or for such bodies, and also about the discharge of social services functions by English Local Authorities and the provision of services in the discharge of those functions. The Act provides regulation-making powers covering the procedures that are to be followed.

7.2 Prior to the 2003 Act, the NHS complaints procedure was set out in various Directions and accompanying guidance. It could sometimes take 18 months or more to exhaust all existing elements of the complaints procedure and therefore the purpose of legislation was to ensure that complaints were investigated rigorously and resolved as quickly as possible.

Failings within the current procedures

7.3 The Parliamentary and Health Service Ombudsman’s report “*Making things better? A report on reform of the NHS complaints procedure in England*” highlighted weaknesses in the current approach to complaints handling in health and social care, some of which were:

- complaints systems are fragmented within the NHS, between the NHS and private health care systems, and between health and social care and;
- the complaints system is not centred on the patient's needs

7.4 These findings were supported by the Healthcare Commission in “*Spotlight on Complaints*” (2006), as part of its work in reviewing complaints made to the NHS by patients and their representatives. The Local Government Ombudsmen have similarly identified problems in complaints handling and redress within health and social care partnerships. When the procedural frameworks are different, it is much more difficult to provide a seamless service.

7.5 The Department considered that retaining the current arrangements is not an option. It would not meet the White Paper commitment and fundamentally, local handling of complaints would not improve. In addition, changes to the current legislation were needed in any event to reflect the dissolution of the Healthcare Commission.

7.6 The Department considered whether to make prescriptive regulations that set out in detail what organisations must and must not do. This option would require organisations to operate within narrow and restrictive procedures, which would limit the flexibility needed for a more personalised approach to delivery of complaints arrangements at local level.

Way forward

7.7 These regulations align adult social care and health complaints processes into a single set of arrangements. They require the complainant to be involved in the way in which the complaint is handled, by requiring the body dealing with the complaint to offer to discuss this with the complainant. They also remove prescription around the timescale to be followed in terms of investigating a complaint. Less prescription around timescales allows organisations to assess and deal appropriately with all complaints, allowing these arrangements to meet the needs of the individual case and for proper consideration of learning and service development issues.

7.8 Specifically in relation to complaints about NHS care, the regulations remove the second tier (the Healthcare Commission reviewing individual complaints cases) from the arrangements, with the Health Service Ombudsman providing independent review of cases unresolved at local level.

8. Consultation outcome

8.1 In June 2007, the Department of Health launched a public consultation (*Making Experiences Count - MEC*) on its proposals to unify, and reform, the health and social care complaints procedures. The consultation was launched on 18 June 2007, ending on 17 October - a period of just over 17 weeks.

8.2 The consultation paper was available on the Department's website, with hard copies being sent to all who requested a copy. The Department publicised this via key stakeholder group websites such as the National Patient Advice & Liaison Service (PALS) Network, the Commission for Patient and Public Involvement in Health (for Patient and Public Forum members), the Association of Directors of Adult Social Services, the Audit Commission, General Medical Council, Foundation Trust Networks and the NHS Confederation. The Department also contacted other third sector interested partners, including Age Concern, the Carers UK and Citizen's Advice, to mention just a few. In addition, the Department published a more detailed paper that gave full details of the background to the proposed policy and the equality impact assessment; this also appeared on the Department's website, with copies also being sent to those requesting them.

8.3 A series of 'road-shows' were held at 15 venues across England. Each road-show comprised two sessions; the morning session gave patients, service users and the general public an opportunity to share their views about the consultation document. The afternoon session gave those working in complaints handling in NHS and social care organisations the same opportunity. In addition, several national conferences were held.

8.4 The Department received 376 written responses from a diverse range of organisations and individuals. Over 1,000 people attended the road-shows and national conferences (approximately 50% were health, social care and advocacy professionals and 50% were patients, service users and their representatives). The response to the proposals outlined in '*MEC*' was overwhelmingly positive, strengthening the rationale for intervention.

8.5 The Department responded in the *'Making Experiences Count – The proposed new arrangements for handling health and social care complaints Response to Consultation'* document published on 7th February 2008.

8.6 There has been ongoing engagement (and consultation) on the proposals for complaints reform since June 2007. To support this work, the Department set up an Early Adopter Programme – this was a pilot programme established in May 2008 which ran for over 6 months. Over 90 health and social care organisations volunteered to take part in the programme to, amongst other things, develop ways of responding to complaints that fulfilled the principles of *MEC* and to draw out the key components of good practice, responsiveness and organisational learning based on experience of what works well, and what does not.

8.7 Following the end of the programme, on 5 December, the Department published on its website details of the proposed changes to the legislative framework. This document built on *MEC* and ongoing engagement around the reforms, with an opportunity to comment of just over 4 weeks; the closing date for responses being 6 January 2009.

8.8 To ensure that both the public and health and social care staff had the chance to comment, news about the feedback exercise was cascaded via the Department's bulletin - namely 'The Week' (a weekly bulletin to all NHS chief executives and also copied to all Local Authority chief executives). Notice was also placed on the websites of the Local Involvement Networks Exchange, National PALS Network, Strategic Health Authority Patient and Public Involvement Leads and Early Adopter sites to seek views. In addition, a mailing was issued to all NHS and social care complaints managers in England. Both the public and healthcare staff had an opportunity to ask questions and share their views face-to-face at four regional events held in London, Leeds, Birmingham and Bristol during December and January.

8.9 The Department received over 190 written responses to the legislative framework document, from broadly 10 different stakeholder groups ranging from NHS bodies/Local Authorities to charities/voluntary bodies and members of the public. Overall, the responses were supportive of the general principles of reform and the rationale for them. However, around 25% of the responses to the feedback document were from the social care field whose objections mainly focused on the lack of timescales (this point was also raised in relation to the 2007 consultation) and removing the designation of a 'complaints manager' from the Regulations.

8.10 The Department acknowledged the second of these concerns and the Regulations now provide for the designation of complaints manager. However, with regard to timescales, the Department carefully considered their inclusion but concluded there was no practical mechanism through which to include set timescales whilst remaining true to the principles of reform.

9. Guidance

9.1 A national event was held on 10th February in London for all PCT and SHA chief executives, Directors of adult social services and all Early Adopter site chief executives, to help prepare services for the new system and ensure widespread engagement at the most senior levels across the NHS and social care. Following this event, a series of four regional exhibition events will take place for all NHS and social care front-line staff.

9.2 The Department will communicate the changes to NHS bodies, LA social services, primary care and independent providers, users of services and the general public by publicising the new system through various channels, including through Department of Health and stakeholder websites and asking providers and commissioners of services to cascade to their service users.

9.3 All NHS and local authority organisations involved in reforming their complaints systems will prepare appropriate communication materials to inform the users of their services in time for

April 2009 and there will be provision at the regional exhibition events for front-line staff to take away with them examples from Early Adopter sites.

9.4 A practical guide, *Listening, Responding, Improving*, is due to be published on 26th February (in time for the first regional event), which will contain a bank of good practice developed by the Early Adopters. The guide will help health and social care complaints managers, as well as commissioners and organisations providing services, to improve their own approach to the local resolution of complaints, based on what worked well for the Early Adopters.

9.5 Whilst we consider the Regulations to be sufficiently clear to be understood by complaints managers, the guide will provide further practical support. If feedback received during the regional roadshows suggests complaints staff would welcome further guidance, the Department will seek to develop this, in consultation with stakeholders, before the Regulations come into force.

10. Impact

10.1 The impact on business, charities or voluntary bodies is minimal. The regulations provide a general framework for complaints handling that enables organisations providing services to determine, in discussion with the complainant, how best to handle an individual case.

10.2 There is a specific requirement in the Regulations to include the complainant in these discussions. However, this is a practice which, as part of good complaints handling, should already be happening. It was included in guidance to support the implementation of the NHS (Complaints) Regulations 2004 and Local Authorities' Social Services (England) Regulations 2006. Many good performing organisations already ensure there is an effective dialogue with the complainant.

10.3 The impact on the public sector is minimal.

10.4 An Impact Assessment is attached to this memorandum.

11. Regulating small business

11.1 The legislation applies to small business.

11.2 To minimise the impact of the requirements on firms employing up to 20 people, the approach taken is that the legislation makes no attempt to lay down requirements on how an individual complaint should be handled. The aim is encourage organisations to respond to complaints quickly and effectively, to seek to meet the needs of the individual complainant, and so to prevent a complaint escalating. The regulations will apply to all providers of publicly funded health and adult social care services, including some small business, and so provides a level playing field.

11.3 The basis for the final decision on what action to take to assist small business was the need to ensure such businesses had the flexibility to develop better complaints handling within a general framework, as described above. The Regulations also provide that the complaints manager need not be an employee of the organisation for whom they act. This allows for greater flexibility for small businesses in establishing appropriate arrangements for complaints handling.

11.4 The Department sought views on the draft regulations from the General Practice Committee of the British Medical Association, NHS sight providers, pharmacy groups and the British Dental Association.

Monitoring & review

12.1 Whilst it is not possible to provide measurable outcomes in relation to the Regulations, there are benefits the Department envisages will be gained from reforming the current complaints handling processes. These are:

- more accessible, responsive and simpler to understand complaints arrangements,
- better data from complaints to feed into clinical governance and commissioning decisions
- greater user involvement and complainant satisfaction and,
- greater confidence in the organisation, which could also lead to positive reputational effect.

12.2 The Department will review the new arrangements after three years of implementation. This could include analysis of patient satisfaction surveys, the review of organisations' annual reports on complaints handling and liaison with the Health/Local Government Ombudsmen and the Care Quality Commission. The Department's findings will be published on the Department's website.

13. Contact

Chris Bostock at the Department of Health Tel: 0113 254 5130 or email: chris.bostock@dh.gsi.gov.uk can answer any queries regarding the instrument.

Summary: Intervention & Options

Department /Agency: DH	Title: Impact Assessment of the reformed complaints regulations for health and social care - consultation with stakeholders	
Stage: FINAL	Version: 7	Date: 23 February 2009
Related Publications: Government response to Making Experiences Count (MEC), Our health, our care, our say, NAO report: Feeding back?		

Available to view or download at:

<http://www.>

Contact for enquiries: Chris Bostock

Telephone: 0113 254 5130

What is the problem under consideration? Why is government intervention necessary?

Currently there are separate and different complaints processes for health and social care within England. External reports found complaints handling to be fragmented, and lacking in focus. In addition, the Healthcare Commission will cease to exist on 1st April 2009 - current regulations which govern health complaints will not longer be fit for purpose.

Patients and users of social care services could not improve the complaints system by themselves due to lack of knowledge and lack of influence. Government has both the knowledge and power to intervene to strike the right balance between consistency of approach and local flexibility.

What are the policy objectives and the intended effects?

Objective 1: To unify and simplify complaints handling arrangements, giving greater complainant focus

Objective 2: To provide improved data from complaints to support organisational learning and commissioning decisions

Intended effect 1: more accessible, responsive and simpler to understand complaints arrangements

Intended effect 2: greater complainant satisfaction, better outcomes, and better value for money complaints services

Intended effect 3: better information from complaints

What policy options have been considered? Please justify any preferred option.

1. Transfer the functions of the Healthcare Commission to another body and retain three stages in health

2. Implement via light touch regulation - a single, unified process across health and social care that puts the complainant at the heart of the resolution arrangements

3. Implement via prescriptive legislation - a single, unified process across health and social care, with centrally prescribed requirements

Option 2 is the preferred option as it allows flexibility for local implementation.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

The policy will be reviewed 3 years after implementation - ie in 2012.

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:

Ann Keen**Date: 23rd February 2009**

Summary: Analysis & Evidence

Policy Option:	Description:
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COSTS	ANNUAL COSTS	Description and scale of key monetised costs by 'main affected groups' Transitional increases for Ombudsmen £23m Upgrading & training costs for local resolution 10m Saving on fixed costs from redeploying staff from middle stages to local resolution -£2m			
	One-off (Transition) Yrs				
	£				
	Average Annual Cost (excluding one-off)				
	£ 10m		Total Cost (PV)	£ 31m	
Other key non-monetised costs by 'main affected groups'					

BENEFITS	ANNUAL BENEFITS	Description and scale of key monetised benefits by 'main affected groups'			
	One-off Yrs				
	£				
	Average Annual Benefit (excluding one-off)				
	£		Total Benefit (PV)	£	
Other key non-monetised benefits by 'main affected groups' Greater user involvement, reduced anxiety while the complaint is being progressed, increased satisfaction/ greater confidence in the organisation considering the complaint, therefore positive reputational effect for the organisation					

Key Assumptions/Sensitivities/Risks

Price Base Year	Time Period Years	Net Benefit Range (NPV) £	NET BENEFIT (NPV Best estimate) £
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What is the geographic coverage of the policy/option?	England
On what date will the policy be implemented?	1 April 2009
Which organisation(s) will enforce the policy?	PCTs/SHAs/LAs
What is the total annual cost of enforcement for these organisations?	£
Does enforcement comply with Hampton principles?	Yes
Will implementation go beyond minimum EU requirements?	Yes
What is the value of the proposed offsetting measure per year?	£
What is the value of changes in greenhouse gas emissions?	£
Will the proposal have a significant impact on competition?	No
Annual cost (£-£) per organisation (excluding one-off)	Micro Small Medium Large
Are any of these organisations exempt?	No No N/A N/A

Impact on Admin Burdens Baseline (2005 Prices)		(Increase – Decrease)
Increase of £	Decrease of £	Net Impact £

Key: Annual costs and benefits: Constant Prices (Net) Present Value

1. Characterising the Problem to be Addressed

1.1 Complaints handling systems are fragmented, complex and inflexible

Currently there are different and completely separate processes for handling health and social care complaints. This can cause problems for users of both services when things go wrong, and when complaints arise about packages of care that involve multiple services it is very difficult for complainants to navigate different procedures and for organisations to respond.

The process for escalating a complaint and the number and sort of stages involved is different in the NHS and Social Care systems. This is summarised in the table below:

	NHS	Social Care
Escalation	1: Local Resolution	1:Local Resolution
	2: Health Care Commission	2:Investigation
	3: Parliamentary and Health Service Ombudsman	3:Review Panel
		4:Local Government Ombudsman

The differences between health and social care vary, not only in the procedures to be followed but also in the circumstances in which a complaint may be made. In modern day care, there are increasing numbers of cases crossing the boundaries between types of health care provision and between health and social care. It is important that any system is effective and efficient across all these boundaries and that it is simple for patients and social care users to understand and to navigate. Where the boundary is between health and social care, many of those affected will be elderly, frail or suffering from long-term conditions. The current mechanisms are unnecessarily complex.

The Healthcare Commission currently handles the independent review stage in the NHS complaints procedure, though the Commission for Social Care Inspection has no role on the social care procedure. The Care Quality Commission (which replaces the Healthcare Commission and the Commission for Social Care Inspection from 1 April 2009) will not have direct involvement with individual health and adult social care complaints.

The current NHS complaints regulations apply only to designated NHS organisations – strategic health authorities, NHS trusts operating from premises wholly or mainly in England, primary care trusts, and special health authorities to which section 2 of the Health Service Commissioners Act 2003 apply.

The local resolution aspects within the regulations do not apply to foundation trusts, though they are subject to the independent review stage carried out by the Healthcare Commission in relation to complaints by or on behalf of patients – but not, for example, complaints about financial probity. Foundation trusts come within the jurisdiction of the Health Service Ombudsman. As an increasing number of trusts achieve foundation trust status, fewer NHS providers will fall within the scope of the current regulations.

Independent providers of NHS services and foundation trusts are under an obligation to have in place NHS complaints arrangements as if the regulations applied, but the obligation is contractual rather than being on the same legislative basis as NHS trusts.

Complaints arrangements in primary health care are also contractual. The overall framework for complaints handling is the same as in secondary care (local resolution, Healthcare Commission, Ombudsman), but there are differences in emphasis and detail. Most people see the NHS as essentially one organisation delivering one-off or ongoing packages of health care. The underpinning principle is that an NHS patient is an NHS patient, regardless of where they are treated. The current complaints procedures have evolved from a time when the NHS and local authorities directly provided services, and are not helpful in the new world where the vast majority of services are

commissioned by local authorities and PCTs and many are provided by private, voluntary and third sector bodies who deliver services on their behalf.

In the social care complaints procedure, a person is eligible to make a complaint where the local authority has a duty to provide, or to secure, the provision of a service. Social care complaints regulations apply to all local authorities and include directly provided services. The relationship between users and the social care system is complex, and service users tend to feel that they have a relationship with individual professionals rather than with 'the service'. Uncertainty about who to complain to is greater in social care than in health; the involvement of a range of providers and contractors complicates the picture.

1.2 Difficulties Experienced by Service Users

Research commissioned by the Department of Health in 2005 suggests that the processes in both health and social care are not easy to understand. People have difficulty in identifying the options available and understanding what each organisation can and cannot do at each stage of the process.

Further evidence is contained in section 6.1 – Evidence for the need for change.

1.3 Poor Performance in Complaints Handling

The majority of NHS complaints are resolved at local level and social care complaints at stage1 (local resolution). Nonetheless, the Healthcare Commission receives approximately 8,000 NHS requests for independent review each year and, in 20-22% of these cases, it has found that the health care provider could have done more to resolve the complaint. The Commission believes that relatively straightforward measures would often have resolved these complaints. Complainants regularly seek a better explanation of the care they have received or of a decision taken by the health care provider.

Other frequent problems seen in the way complaints have been handled at a local level include:

- failure to acknowledge that a complaint is valid;
- failure to apologise, even where local shortcomings are identified;
- responses which do not explain what steps have been taken to prevent the recurrence of an event, which has given rise to a complaint;
- responses which contain technical or medical terms and jargon, which the complainant may not understand; and
- failure to involve staff directly concerned in the complaint in the local investigation.

1.4 External Criticism

In the 2005 report *Making things better? A report on reform of the NHS complaints procedure in England*, the Health Service Ombudsman highlighted the five key weaknesses in the current approach to complaints handling in health and social care:

- complaints systems are fragmented within the NHS, between the NHS and private health care systems, and between health and social care;
- the complaints system is not centred on the patient's needs;
- there is a lack of capacity and competence among staff to deliver a quality service;
- the right leadership, culture and governance are not in place;
- just remedies are not being secured for justified complaints.

In a joint letter to the Department of Health in October 2006, the Health Service Ombudsman and the Local Government Ombudsman welcomed the commitment in *Our health, our care, our say* to develop integrated health and social care complaints arrangements. They believed that it would represent a significant step towards the delivery of a patient and user led complaints system.

In a report published by the NAO in October 2008 [*Feeding back? Learning from complaints handling in health and social care*], the NAO reiterated the same concerns as those expressed by the Ombudsmen.

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

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

The perception that nothing will be done as a result of making a complaint is consistent with the NAO census finding that 38 per cent of adult social service departments do not publicise changes they have made as a result of complaints.

1.5 The role of the Health Care Commission

The Healthcare Commission has encountered high numbers of requests for independent review with up to one third of requests made inappropriately as trusts have not made every effort to complete a successful local resolution. It is arguable that providing an independent stage through a separate organisation has worked against effective resolution of complaints at local level because NHS organisations are aware that the Healthcare Commission will undertake the work. This approach also duplicates the investigation function, with the Healthcare Commission tending to carry out its own investigations, even where work has been done at local level. Crucially, the investigation of individual complaints does not sit easily with the functions of a regulatory body and will not be replicated by the Care Quality Commission.

2. Reason for Intervention

2.1 Reasons why government should intervene

Patients and users of social care services could not improve the complaints system by themselves due to lack of knowledge and lack of influence. Government has both the knowledge and power to intervene to strike the right balance between consistency of approach and local flexibility.

2.2 Characteristics of a good system

An effective complaints process exists to

- respond promptly to complaints;
- inspire user confidence by meeting their expectations;
- facilitate effective handling at local level to the user's satisfaction;
- support organisational learning to prevent similar occurrences in future;

2.3 Summary of current problems

The difficulties experienced by service users would, alone, be sufficient justification to reform the complaints arrangements across health and social care. Users do not have confidence in the current arrangements. The current system places more emphasis on responding to complaints within set timescales than on providing a quality response that meets the needs of the person making the complaint. There should be greater emphasis on involving the complainant throughout the process – identifying at outset why the complaint has been made, and what the complainant is seeking in making the complaint. In other words, tailoring the response to the needs of the individual complainant and nature of the complaint. The emphasis should be on resolving complaints early and effectively, to the satisfaction of the complainant.

2.4 Public Consultation

In June 2007, the Department of Health launched a public consultation (Making Experiences Count) on its proposals to unify and reform the arrangements for handling health and social care complaints. The consultation ended in October 2007. We received 376 written responses and in excess of 1,000 people attended roadshows and national conferences at which Department of Health staff spoke (made up of over 500 health, social care and advocacy professionals and over 500 patients, service users and their representatives). In February 2008 the Department published its formal response. The response to the proposals outlined in *'Making Experiences Count'* was overwhelmingly positive, strengthening the rationale for intervention.

2.5 Links to other policy areas

By increasing the role of the complainant in the complaints procedure, providers will also become more responsive to their needs and preferences. Appropriate links to governance and risk management processes will assist in delivering better quality care. Involving complainants throughout the local process will help to make sure their views are taken into account and make the

system more responsive. It will also make sure the investigation of a complaint is robust and proportionate and that the findings are justified by the evidence.

The present procedures do not place sufficient emphasis on using information from complaints to improve service delivery. Complaints offer what might be seen as 'free feedback' on an organisation's performance. The link between this feedback, problems identified during a subsequent investigation into what happened and action taken to prevent similar situations arising in future needs to be strengthened.

Work in this impact assessment also links with the impact assessment conducted by Tony Bennett on independent consideration of complaints about non-LA adult social care.

3. Policy Objectives

3.1 Background

The Department believes there is a need to provide a single legislative framework for complaints handling within which all health and social care organisations must operate. This will facilitate:

- more accessible, responsive and simpler to understand complaints arrangements,
- better quality feedback from complaints to support organisational learning and commissioning decisions,
- greater user satisfaction, better outcomes, and better value for money complaints services

3.2 Objective 1a: To unify and simplify complaints handling arrangements

As health and social care services become increasingly community-based, with a greater plurality of providers, it is important to make sure there is a more integrated approach that crosses boundaries; in particular those between primary and secondary care and, more generally, between health and social care. The proposed new arrangements will result in simplified arrangements, with only two stages – local resolution and either the Health Service or Local Government Ombudsman.

Local resolution will seek to resolve the case quickly, and in a manner that best meets the needs of the complainant - there will be no set internal stages through which a complaint must be progressed. All NHS providers and local authority adult social services functions will fall within a single set of regulations.

Where a complaint crosses boundaries (for example, health/social care or primary/secondary care) the individual organisations involved will work together to provide a single coordinated response. This will bring them into line with the Health Service and Local Government Ombudsmen, who already produce single judgements and reports on complaints spanning health and social care.

3.3 Objective 1b: To give complaints handling a greater complainant focus

Complaints arrangements should focus on achieving the best possible results for those making the complaint. Service users should be given the answers and explanations they need to help them understand what happened and, where appropriate, an apology and action to be taken to prevent similar situations arising in the future. They need to be reassured that what happened to them will not happen to anyone else.

We shall seek to put in place a single set of arrangements that places emphasis on people being able to discuss their complaints directly with someone who represents the services involved. There must be the maximum opportunity for both sides to try to resolve complaints quickly and effectively through discussion of what the complainant is seeking to achieve in making a complaint. Complaints should subsequently be resolved through a proportionate response to the needs of an individual case (for example, its complexity and/or sensitivity) rather than by using potentially lengthy, set procedures. Any investigation should be robust, with both sides able to have confidence in its findings.

We see this as an improvement on the current system, where complainants are effectively presented with a decision, and invited to challenge it. This type of adversarial approach is outdated and works against the organisation's ability to learn from the complaint. It is in a provider's best interests to work with people who have experience of its services in order to identify where and how services might be improved.

This objective supports a pledge within the NHS Constitution: “The NHS will strive to ensure that if you make a complaint you receive a timely and appropriate response”.

To support this objective, we intend that all organisations will produce an annual report on complaints handling, to be available to all service users who ask for a copy.

3.4 Objective 2a: To strengthen the links between complaints feedback and organisational learning

Resolution of complaints is important and helpful to both the complainant and the organisation. However, information from complaints provides useful information to enable organisations to improve services, better to meet the needs of service users. Our proposals include a requirement for a ‘responsible person’ to be nominated within each organisation to have responsibility not only for the operation of an effective complaints handling process but also for ensuring that any appropriate action identified as a result of a complaint is taken forward. Where such action is identified, we intend to place an obligation on the organisation to inform the complainant, in the response to the complaint, of that action and what is proposed to take it forward. Each organisation will be required to produce an annual report which, amongst other things, will indicate in a general manner lessons learned by the organisation as a result of complaints it has received. Complaints data will be used to support continuous learning within health and care organisations. This represents a shift in the approach to complaints handling in which the aim of the complaints process is not just to resolve a complaint but also to prevent future harm, reduce risks and improve service delivery.

This shift supports the pledge within the NHS Constitution: “The NHS will strive to ensure that if you make a complaint...the organisation learns lessons and puts in place necessary improvements”.

3.5 Objective 2b: To link appropriate recommendations within Safeguarding Patients to the reformed complaints framework

Safeguarding Patients (2007) was the formal Government response to the recommendations of the Shipman Inquiry’s fifth report and the reports of the Ayling, Neale and Kerr/Haslam Inquiries. The Government recognised that complaints from patients or their representatives could provide vital information in identifying potential risks to patient safety, as well as more generally indicating how services can be improved.

Amongst other proposals, *Safeguarding Patients* acknowledged the need for the Department to:

- discuss further with complaints handlers how to promote good practice in triaging complaints
- amendment of the regulations to allow patients to make a complaint direct to the PCT.

3.6 Objective 2c: To provide commissioning bodies with better data on an organisation’s performance

The people who purchase services, or commissioners, in PCTs and LAs will have a major role in making the new approach work effectively and making sure that the lessons learnt from complaints feed into continuous improvement of the quality of services. The Commissioning framework for health and well-being identifies steps that will help drive more effective commissioning. These include:

- putting people at the centre of commissioning;
- understanding the needs of populations and individuals; and
- sharing and using information more effectively."

Information about how providers respond to complaints about their services should be routinely used when making decisions about how services should be commissioned. Organisations who do not have efficient, effective local arrangements in place to respond to complaints would be at a disadvantage as they would not be able to show, for example, how the views of people using services have been used to improve those services. Anecdotal evidence suggests that few organisations take complaints data into account when deciding which organisations should deliver services on their behalf – many complaints managers have expressed their frustration that this is often the case. All organisations falling within the scope of the regulations will be required to send an annual report on complaints handling to the body (or bodies) commissioning their services.

4. Coverage of IA

The Impact Assessment relates only to the proposals for the reform of local complaints arrangements across publicly funded health and adult social care. Whilst a longer-term aim of the programme will

also see greater attention paid to handling 'concerns' and developing a greater 'customer services' focus, these aspects are part of a wider reform programme to be taken forward after April 2009.

The revised complaints framework will apply to:

- all NHS bodies (including Primary Care Trusts and Strategic Health Authorities),
- all statutory providers of NHS care (including foundation trusts and primary care providers)
- voluntary and independent sector organisations who provide services under contract to the NHS and to
- local authorities who provide adult social services.

Each of these organisations will have to have in place arrangements for handling complaints in line with the legal framework.

Private healthcare arrangements do not fall within these arrangements. Buying 'over the counter' medicines is also classed as a private transaction, and is also not included.

Adult social care services arranged or paid for privately will not be covered by the new regulations. This includes the situation where a person uses a direct payment provided by the local authority to purchase the services they need.

The Department of Health has agreed with the Department for Children, Schools and Families that complaints about children's social care will not be included within the 2009 complaints reforms.

5. Surveying the Evidence (plus Annex: Sources of Evidence)

5.1 Evidence of the need for change

The Individual Voices for Improvement project commissioned a qualitative research study to explore the views of service users and professionals on complaints and feedback systems in health and social care. In health, the research demonstrated that patients' experience of healthcare had to be either very good or very bad to elicit any form of formal criticism or praise. In addition;

- There was ignorance about the complaints process – members of the public have little awareness of the current three stage process and the support mechanisms such as PALS and ICAS which are available
- The perceived size and bureaucracy of the hospital structure made the system feel impenetrable
- Assumptions were often made about the nature of the complaints process – for example that it would be lengthy and bureaucratic
- Some complainants felt awkward at the prospect of complaining to their GP practice and worried about the impact on their relationship with the GP

In social care, the research found that;

- service users tend to feel that they have developed a relationship with individual professionals rather than a service and, as a result, many saw no point in making a complaint
- Some felt that they would not be treated fairly if they complained
- Many were uncertain as to who they should complain to and doubted the possibility of change (this is exacerbated by the involvement of contractors)

"Spotlight on Complaints" published by the Healthcare Commission (2006), highlighted frequent problems seen by them in the way that health complaints have been handled at a local level, including;

- failure to acknowledge that a complaint is valid
- failure to apologise even where local shortcomings are identified
- failure to involve staff directly concerned in the complaint in the local investigation

(also see section 1.4)

5.2 What happened when Scotland removed the independent review stage from complaints handling in 2005-06?

Local Resolution Complaints data are available on the ISD Scotland website and complaints to the Ombudsman on the Scottish Public Services Ombudsman's (SPSO) website. From 2005-06, when

the independent review stage was removed from the process, data suggest a decrease in the number of local resolution complaints (this may have been due to problems collecting the data?) and an increase in the workload of the Ombudsman. However, no work was done to build the capacity or capability of local organisations ahead of the change in legislation, as has been done in England over the last few years, by the Department and others such as the Healthcare Commission and Health Service Ombudsman.

6. Options Considered

6.1 Option 1: Transfer the Healthcare Commission's function to another body (after the Healthcare Commission ceases to exist)

Transfer the Healthcare Commission's independent review function for the NHS to another body to retain a three stage process (local resolution, independent review, Ombudsman)

6.2 Option 2: Implement via light touch regulation, a single, unified process across health and social care, placing an emphasis on local organisations developing local arrangements that best meet the needs of their users

Option 2 would allow health and social care organisations to create a flexible and tailored response to each complaint. There would be more focus on outcomes than process and this would facilitate appropriate resolution and provide better data, in a shorter timeframe, to support organisational learning and commissioning decisions.

The role of the Health Service and Local Government Ombudsmen would remain unchanged. They would continue to carry out independent investigations into complaints about poor treatment or service provided through the NHS or Local Authorities in England.

6.3 Option 3: Implement via prescriptive legislation, a single, unified process across health and social care, with centrally prescribed requirements on complaints handling

This option appears similar to option 2, but it would continue a process in which many of the operational requirements are laid down centrally by the Department of Health and enshrined in secondary legislation. Providers would operate within narrow and restrictive procedures, which would limit the flexibility needed for a more personalised approach to delivery of complaints arrangements at local level. Complaints would be handled in line with a process, rather than by the needs of the circumstances of an individual case.

7. Mechanism of intended impacts for the preferred option

"I want to feel that I'm being listened to by someone who is interested and can do something about the problem. And when they come back to me with an answer, I want to be able to trust what I am being told. I don't want to have to fight the system - I just want things sorted out". This quote exemplifies the problems encountered under the current arrangements. The new approach, developed by the Making Experiences Count project and refined and implemented by the Early Adopters, has been successful in responding to complaints in a more personal way and resolving them more quickly, supporting organisational learning in the process.

More than 10,000 complaints have been approached in this way and in health, the Department is not aware of any those complaints being escalated to the Healthcare Commission because of dissatisfaction with the process at a local level. Staff report that making a personal approach, usually by telephone as soon as the complaint is received, and working with the complainant to fully understand all of the issues, agree a plan of resolution and keeping complainants informed throughout, greatly increases rates of satisfaction in the process and the end result.

The regulations will be less prescriptive than the current regulations in relation to the actual handling of the complaint investigation. Nonetheless, there will remain a series of basic requirements, seen by the Department as essential elements of 'good complaints handling'. The regulations accord with the rights and pledges in the NHS Constitution in relation to Redress. So, for example, there will be a requirement for organisations to ensure that:

- complaints are dealt with efficiently;
- complaints are properly investigated;

- complainants receive a timely and appropriate response;
- action is taken if necessary in the light of the outcome of a complaint.

Within each organisation, a person will be authorised to be responsible for ensuring compliance with the arrangements made under these Regulations, and in particular ensuring that action is taken if necessary in the light of the outcome of a complaint. Complaints must be acknowledged within 3 working days, and the organisation must offer to discuss with the complainant the manner in which the complaint is to be handled, and the period within which the investigation is to be completed – if there are any delays to the timescale, the complainant must be informed. At the end of the local resolution phase, the response must include an explanation of how the complaint has been considered, the conclusions reached, and confirmation that the body is satisfied that any action needed in consequence of the complaint has been taken or is proposed to be taken. In this way, the reformed regulations place far greater emphasis on involving the complainant throughout the process, seeking to meet the needs of the complainant and ensuring action is taken as a result of the complaint. The regulations will be supported by guidance on interpretation of the legislation.

The legislation will be supported by ‘good practice guidance’, collated from the experiences of the organisations that took part in the Early Adopter programme. It will cover examples of effective arrangements for handling complaints, in terms of both timescales for response and user satisfaction. The Department will work with colleagues working on user surveys to ensure that organisations have the opportunity to use information from those making complaints to achieve ongoing improvement of their complaints handling arrangements.

There will also be an independent stage for those not satisfied with the outcome of the complaint at local level. Depending on the nature of the complaint, the complainant will retain access to the Health Service Ombudsman and/or the Local Government Ombudsman.

There will also be an increased emphasis on performance management by commissioners of services, with annual reports on complaints handling, including action taken as a result of its handling of complaints going to the Primary Care Trust. This will enable them to have a major role in making the new approach work effectively, allowing them to monitor the performance of complaints handling within those organisations commissioned to provide services in their local area. Where performance does not meet expected standards, the commissioning body will take appropriate action. Within the wider scope of ‘World Class Commissioning’, PCTs will be expected to use patient experience data to determine its commissioning decisions – one aspect of which will be information from complaints.

Service users will retain the right to complain to the commissioning body about services commissioned by that body. Additionally, in the NHS, users will be able to complain directly to the commissioning body instead of (though not in addition to) making a complaint to the provider of services. In this way, we expect PCT to become more aware of what is happening in terms of complaints handling at local level.

Once operational, the CQC will develop and consult on its methodology and criteria for assessing compliance with the requirements. However, one criterion is expected to relate to how organisations respond to people’s comments and complaints. Compliance guidance, which will be developed by the CQC to monitor whether or not providers are meeting the registration requirements, is expected to include the criteria (sources of information and evidence) and the methods the Commission will use to test compliance. Criteria might include performance indicators, other clinical/quality outcomes data, the experience of people using the service, complaints information, the results of site visits and inspections, information on the provider’s performance held by third parties (such as commissioners) and evidence of good governance and management systems.

7.1 What happens next?

Over the next two months, a dedicated implementation field team will work with local groups of health and social care organisations, supported by Early Adopters, to provide support as they prepare for new regulations from 1st April. A national conference for very senior managers, and four regional market place events are planned which will allow DH to:

- Ensure Chief Executives and Directors of Social Care are briefed on the final regulations and have an opportunity to hear about the experiences of the Early Adopter sites.
- Ensure complaints professionals have an opportunity to talk to Early Adopters from their own region, to hear about their experiences and discuss with colleagues locally how they will work

together to implement the new arrangements.

- Ensure complaints professionals have an opportunity to talk with other key stakeholders including Ombudsmen, about their role locally.

8. Valuing Impacts: Benefits and Disbenefits

It has not been possible to put monetary values to benefits, but these will be about:

- a more patient focussed service
- better feedback, including more systematic recording of complaints, feeding into organisational learning through other policies such as clinical governance and the evaluation/strategic planning in the commissioning cycle

9. Costs and Cost-savings

Estimated additional costs of the various options over 3 years (£million in today's money)

Figures may not add up because of rounding

Option 1	NHS	Adult Social Care	Total
Estimated costs of continuing the work undertaken by the Health Care Commission	9		9

Option 2	NHS	Adult Social Care	Total
Scenario 1			
Extra demand for Ombudsman services based upon what happened when Scotland made a similar change in 2005	22	1	23
Salary & training costs to strengthen local resolution	8	2	10
Possible savings on fixed costs from redeployment of staff from middle stages of resolution to local resolution	-5	0	-5
Total	25	3	28

Scenario 2	NHS	Adult Social Care	Total
Extra demand for Ombudsman services based upon what happened when Scotland made a similar change in 2005	22	1	23
Salary & training costs to strengthen local resolution	8	2	10
Possible savings on fixed costs from redeployment of staff from middle stages of resolution to local resolution	0	0	0
Total	30	3	33

Final costing (average of scenarios 1 and 2)	NHS	Adult Social Care	Total
Extra demand for Ombudsman services based upon what happened when Scotland made a similar change in 2005	22	1	23
Salary & training costs to strengthen local resolution	8	2	10
Possible savings on fixed costs from redeployment of staff from middle stages of resolution to local resolution	-2	0	-2
Total	28	3	31

Option 3	NHS	Adult Social Care	Total
Costs as Option 2	28	3	31

Extra cost of additional stage for cases going to the Ombudsmen	5	1	6
Total	33	4	37

An additional cost is incurred by providers who have to expend resources to improve services in order to rectify problems or to avoid complaints. This is a compliance burden that is in addition to the costs involved in providing a higher standard of complaints handling for organisations who need to improve to meet the minimum requirements. Where a complaint reveals a serious quality problem not otherwise detected, there would be resources required to rectify the problem. However, it is difficult to estimate these costs, and part or all of such costs may also be attributable to different incentives, for example the regulatory regime of the Care Quality Commission, whose registration requirements will include complaints handling, or the contracting requirements of PCTs or local authorities.

Social care costs

Just under £1million will be given to the Local Government Ombudsman (LGO) in the first year of operation to cover the initial set-up costs and transitional costs to the new arrangements. The Department expects to fund the LGO in the subsequent two years. Social services complaints will generally be expected to become more time consuming and resource intensive for LGO to investigate, whilst the burden on local authorities will, initially, be expected to reduce. The formal change in the regulations means that the current independent review stage by the LA is no longer required, and is replaced by the Local Government Ombudsman's review. This saving for local government offsets some of the additional costs to local authorities resulting from the policy change.

For those local authorities who are already performing well and ensuring there is an effective dialogue with the complainant from the start, there is no reason why the regulations would result in additional costs. The new regulations are less prescriptive, and so provide the local authority with flexibility to tailor the response to the individual needs of the case. However, there will be some local authorities who are providing sub-optimal services in complaints handling and the regulations seek to ensure those local authorities raise their standards. However, this is not a new idea; it has been in good practice guidance since 2006.

Poor performing local authorities will need to direct their funding accordingly, but this would be expected even if the legislative framework underpinning complaints handling were not changed i.e the new regulator, the Care Quality Commission, is developing its methodology and criteria for assessing compliance with the requirements. One criterion is expected to relate to how organisations respond to people's comments and complaints.

The CQC will have a range of escalation measures available should local authorities who provide adult social care services not improve their standards of complaints handling. CQC will also carry out periodic reviews of those authorities who commission adult social care services. These reviews will contribute to the performance assessment of local authorities (in respect of adult social care) and will contribute to the Comprehensive Area Assessment in the future. CQC will produce an overall judgement of social care commissioning performance, based on the outcomes they have achieved for their population, and it retains the power to recommend special measures to Secretary of State.

10. Summary Measure of Net Benefit

It has not been possible to put monetary values on benefits - though there are benefits to improving complaints handling arrangements.

User satisfaction and confidence in complaints being taken seriously, with information from complaints being used to improve service delivery, will be expected to lead to a longer-term reduction in the number of complaints received and, as handling improves, a reduced proportion of complaints going to the relevant Ombudsman.

A good complaints system results in greater user confidence in the organisation, with 'customers' happy to continue dealing with that organisation. This has a positive impact upon reputation – an important aspect as greater choice is offered for delivery of health and social care services.

Organisations that are able to demonstrate user-friendly complaints handling in their annual reports will potentially attract service users.

11. Risks, Sensitivities and Assumptions

11.1 Capacity issues – local resolution

There is very strong evidence that organisations vary greatly in the current resources they spend on complaints handling and the efficacy of the current local service. There is no ideal level of investment so some organisations would need to invest simply to meet the minimum standard of a 'no change' option and the requirements of the regulators. It is not possible to strip out this effect from the other effects in the modelling.

There are two drivers of capacity – the number of complaints and the amount of time required to achieve satisfactory local resolution.

An increase in the number of complaints recorded is anticipated. There are two main reasons for this. Firstly, the way that complaints are recorded will change. In the NHS currently, only complaints considered through the formal process are recorded and reported, and the many 'informal' complaints or concerns currently raised and resolved through PALS are not. The best organisations already record all PALS contacts locally, and subsequent information gathered is used within internal governance to support patient safety and organisational learning. Under the new arrangements, any concern that takes more than 1 working day to resolve must be recorded locally, which will have an impact on numbers.

Secondly the new arrangements aim to help people find complaining easier, less stressful and more efficacious so they may (initially at least) lead to greater numbers of complaints.

Data from the Early Adopters suggests that the amount of time to resolve complaints can be reduced, net of the effect of the definitional changes. The Early Adopters have shown that a high proportion of complaints can be dealt with in a shorter period of time than is currently the case which increases capacity within the system. However, this may be more challenging for local authorities than health organisations who have the benefit of Patient Advice Liaison Services that are particularly successful at early resolution of complaints. Whilst local authorities have customer service resources, data from local authority early adopters suggest that few complaints, if any, are actually dealt with by customer services and therefore this may require a longer period of adjustment during which capacity could be an issue.

Overall, the Early Adopters have all implemented the changes without any additional dedicated new funding, although many have taken the opportunity to use the available resources in different ways, most commonly combining different functions (customer services/PALS/formal complaints departments) or by a number of organisations pooling resources.

11.2 Capacity issues – Ombudsman's workload

It is likely that the proposed complaints process will, initially at least, lead to more complaints for both Ombudsmen than they currently receive but markedly less than the combined total of current Healthcare Commission and Ombudsman referrals. Combined with the effect of the improvements in local resolution being demonstrated by the EAs in the NHS, then we would anticipate a reduction in complaints not being resolved locally.

The change required across the NHS is significant, given the removal of the Healthcare Commission, and may take time to become embedded in the systems of service providers and commissioners. While this process takes place it is likely that the proportion of complainants dissatisfied with local resolution will decrease, but initially only slowly. The Health Service Ombudsman is considering the resource implications for her office.

The change required across social care, whilst being less significant in terms of volume, will also be expected to lead to a small increase in the numbers of complaints received by the Local Government Ombudsman.

11.3 Capacity issues – increased waiting times

Net of any definitional changes, if the number of complaints increases without an increase in staffing and resources for those organisations who currently deliver poor complaints handling, there

may be increased response times which local management will need to address. However, for those organisations already delivering effective local resolution, waiting times are unlikely to be an issue.

11.4 The process is reformed but no real effect on the ground

If a minority of organisations continue to handle complaints as before and do not adhere to the aims behind the framework, there may be no overall change in their complaints handling. However, the Department assumes that the combined impact of the Commissioning framework, CQC registration requirements and a legal duty for each organisation to have in place a person responsible for ensuring complaints are handled appropriately, significantly reduces the probability of this happening.

11.5 The cost of complaints handling could increase

Net of any definitional changes, if there is a significant increase in the number of complaints received by service providers, commissioners may encounter capacity issues and concomitant increases in costs. These will need to be monitored over time to assess the impact on service providers and commissioners.

11.6 Sensitivity analysis for estimated costs of reformed complaints handling

The cost for Option 1 is £3 million a year for three years.

For the preferred option (Option 2), costs have been calculated under various alternative scenario assumptions (section 9 on costs has 2 such scenarios). Scenarios are based upon Early Adopters data and on what happened in Scotland in 2005 in terms of the volume of complaints but does not include the net effect of reclassification nor any information on the local changes in resources or costs, which in the case of the EAs was no additional resource.

12. Weighing the options

Option 1 (Transferring Healthcare Commission functions) would not lead to an improvement in local handling of complaints. There is evidence (see Survey of Evidence) that the current system has numerous problems, and does not meet the needs of service users – or the organisations themselves. A more fundamental problem this is that the current procedures offer little by way of user satisfaction, and this option would not address the need to improve complaints handling across health. Attempts to resolve a case would be based upon set procedures, rather than on the wishes of the complainant and the needs of the individual case. User satisfaction and confidence in the process would remain low, and the proportion of cases progressing to independent review, through the Health Service and Local Government Ombudsmen, would not fall.

The government made a commitment in the White Paper “Our health, our care, our say” to develop a comprehensive single complaints system across health and social care by 2009. This option would not meet that commitment.

The Care Quality Commission (CQC) will replace the Healthcare Commission on 1 April 2009. During the passage of the Health and Social Care Act 2008, Parliament determined that it would not be appropriate for a regulator i.e the CQC, to have involvement in the handling of individual complaints. If local resolution is not improved, an unacceptable number of cases will go to the Ombudsman.

Option 2 (Light touch, unified arrangements across health and social care); case handling would depend upon the needs of the individual complaint, with a commitment to seek to resolve complaints quickly, rather than through a set process laid down centrally by the Department of Health. Local organisations would be able to resolve complaints early and effectively. Action would be taken following resolution of a complaint, and users would be made aware of that action.

Effective complaints handling, with greater user involvement, will lead to reduced anxiety while the complaint is being progressed, increased satisfaction and greater confidence in the organisation considering the complaint. Fewer complaints are referred for independent review. In turn, this has a positive effect upon an organisation’s reputation – users will be confident their views are being taken into account and the system will become more responsive, with internal links being made to governance and risk management processes, leading to better quality care. Over time, this increased user confidence would lead to a reduction in the number of cases progressing to the Ombudsman, as users accept that all appropriate action has been taken to resolve a complaint.

Option 3 (Prescriptive legislation on handling a complaint, and unified arrangements across health and social care) would provide for complaints to take into account the wishes of the complainant, but there would be loss of flexibility, with set linear procedures for handling. Complainants would not be able to influence case handling, and would continue to feel excluded from the process.

The regulatory provisions would be set centrally by the Department of Health. The ability of local organisations to develop local processes that best meet the needs of that organisation, and its users would be restricted. Organisations would not be able to introduce innovative ways in which to reach early resolution of complaints, potentially they may have to take unnecessary (and ineffective) actions in seeking to resolve individual cases, and complainants would be able to insist upon all set processes being followed. Even if a speedy way to resolve a complaint could be identified, organisations would not be able to use them, unless the legislation expressly provided for it. Over time, the number of cases progressing to the Ombudsmen would be expected to fall, but not as much as a fall offered by option 2. Option 3 would also cost more than option 2.

Option 1 offers no benefits in terms of reforming complaints arrangements currently beset by difficulty. As the arrangements for provision of health and social care become more diverse, local organisations are increasingly best placed to determine the complaints arrangements that best meet the needs of their local populations and their organisations; they are also best placed to talk to those using their services and to listen to their views.

Options 2 and 3 involve a moderate increase in funding over three years, but offer considerable benefits in terms of user satisfaction and confidence, and the impact upon the reputation of service providers. In the longer-term, this will lead to reduced costs through speedier resolution of cases (complainants having confidence that the organisations response will be open, based upon a proportionate and robust investigation, and fair), and a reduction in the number of cases progressing to the relevant Ombudsman. Option 3, however, remains unnecessarily restrictive and is therefore unlikely to deliver the full range of benefits offered by option 2. Option 2 is also cheaper than option 3.

Option 2 is the preferred option.

13. Evaluation Strategy

13.1 Formative Evaluation

94 NHS and LA organisations in England took part in the Early Adopter programme to support the development of the new approach to handling complaints.

As Early Adopter sites tried out different styles and approaches, they reported back on what worked well, and what didn't. This intelligence has been fed into a central pool of resources on a website, and into an implementation guide which has been developed in time for the national rollout. These resources show how effective the early adopters were in locally collaborating to develop co-ordinated ways of working and applying the principles of the new approach.

13.2 Summative Evaluation

The Department of Health believes that the arrangements described in *'Making Experiences Count'* provide the framework within which effective complaints can be developed across health and social care. Some local health and social care providers are already delivering high quality complaints handling within their organisations, though constrained by the current legislative requirements. Others have some way to go to meet the basic principles of good complaints handling, and we have offered general support as we move through the transition process, prior to April 2009.

However, the Department believes it is important to evaluate the impact of the new arrangements, in meeting their policy aims. A formal evaluation will be undertaken three years into the new arrangements, when we would expect there to be real benefits accruing to local organisations and service users.

Health Impact Assessment

Following a review of the screening questions a full Health Impact Assessment is not required .

Nevertheless the proposals are expected to have a positive impact on health by supporting organisational learning from complainant experience and a concurrent improvement in service provision and risk management.

Specific Impact Tests:

Competition Assessment

The Department does not envisage any impact on competition as a result of this proposal.

Small Firms Impact Assessment

The Department envisages minimal impact on small firms as a result of this proposal.

Legal Aid

The proposals will not introduce any new criminal sanctions or civil penalties.

Sustainable development

The Department does not envisage any impact on sustainability from the proposals.

Carbon assessment

The Department does not envisage any change in emission of greenhouse gases as a result of this proposal.

Other environmental

The Department does not envisage any other adverse environmental impacts from the proposals.

Related Publications

The National Audit Office - Feeding back? Learning from complaints handling in health and social care
REPORT BY THE COMPTROLLER AND AUDITOR GENERAL | HC 853 Session 2007-2008 | 10
October 2008

http://www.nao.org.uk/publications/0708/learning_from_complaints.aspx

University of the West of England, Bristol National Evaluation of Patient Advice and Liaison Services (PALS) Final Report David Evans, Sarah Booker, Norma Daykin, Jane Powell, Pat Taylor and Susan Weil January 2008 Chapter 6 The economic evaluation of PALS in England

<http://hsc.uwe.ac.uk/net/research/Data/Sites/1/Gallery/Images/NationalEvaluationofPALSFinalReportJan2008.pdf>

Government's response to Making Experiences Count

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082714

Our health, our care, our say

<http://www.dh.gov.uk/en/Healthcare/ourhealthourcareoursay/index.htm>

Specific Impact Tests: Checklist

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	No	No
Small Firms Impact Test	No	No
Legal Aid	No	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	Yes	No
Race Equality	No	Yes
Disability Equality	No	Yes
Gender Equality	No	Yes
Human Rights	No	Yes
Rural Proofing	No	Yes

Annexes

Equality Impact Assessment for Health and Social Care Complaints Reform

Title and description of the policy

Health & Social Care Complaints Reform

Across health and social care services different processes exist for handling complaints; these processes differ in the number of stages, timescales and investigative procedures.

In the White Paper of January 2006 (Our health, our care, our say), the Department outlined a commitment to ensuring that 'people are given a stronger voice so that they are the major drivers of service improvement'. Specifically the Department would develop by 2009 'a comprehensive single complaints system across health and social care' that will 'focus on resolving complaints locally with a more personal and comprehensive approach to handling complaints'.

The aim is to develop an integrated health and social care complaints framework that is accessible, effective, unified across all providers from public, private, voluntary and charitable sectors.

Section 2.53 in the Operating Framework states that "people's comments and experiences, particularly concerns and complaints, provide invaluable evidence to help organisations continually improve patient experience".

The Department aims to ensure that everyone wishing to complain about their experiences of using health and/or social care services is able to do so. Access to the new arrangements is designed to be inclusive of all groups. There is some evidence to suggest that, particularly in the case of learning disability, the current NHS and social care complaints procedures contain too many barriers for people to overcome. There is also anecdotal evidence that some groups are under represented within the profile of people who currently complain. By putting in place arrangements to ensure a more patient focused service, which require the response to be tailored to individual needs, the Department will reduce inequalities through promoting equality of access.

The proposals will benefit all complainants but integrating and streamlining the current systems will lead to a simplified process that will be more easily accessible to vulnerable groups.

The evidence base

Making Things Better? A report on reform of the NHS complaints procedure in England Ombudsman - 2005

Responses to **Making Experience Count** consultation - 2007

Death by Indifference – MENCAP report into care of people with learning difficulties - 2007

IVI Research Reports – 2006

Spotlight on Complaints – Healthcare Commission - 2007

Is anyone listening? A report on complaints handling in the NHS - Healthcare Commission - 2007

Feeding back? National Audit Office report – 2008

Anecdotal evidence from complaints staff, PALs officers and ICAS advocates

Feedback from Early Adopter (EA) sites.

The Individual Voices for Improvement project commissioned a qualitative research study to explore the views of service users and professionals on complaints and feedback systems in health and social care. In health, the research demonstrated

that patients' experience of healthcare had to be either very good or very bad to elicit any form of formal criticism or praise. In addition;

- There was ignorance about the complaints process – members of the public have little awareness of the current three stage process and the support mechanisms such as PALS and ICAS which are available
- The perceived size and bureaucracy of the hospital structure made the system feel impenetrable
- Assumptions were often made about the nature of the complaints process – for example that it would be lengthy and bureaucratic
- Some complainants felt awkward at the prospect of complaining to their GP practice and worried about the impact on their relationship with the GP

In social care, the research found that;

- service users tend to feel that they have developed a relationship with individual professionals rather than a service and, as a result, many saw no point in making a complaint
- Some felt that they would not be treated fairly if they complained
- Many were uncertain as to who they should complain to and doubted the possibility of change (this is exacerbated by the involvement of contractors)

“Spotlight on Complaints” published by the Healthcare Commission (2006), highlighted frequent problems seen by them in the way that health complaints have been handled at a local level, including;

- failure to acknowledge that a complaint is valid
- failure to apologise even where local shortcomings are identified
- failure to involve staff directly concerned in the complaint in the local investigation

Evidence tells us that the perceived complexity of the existing arrangements is one of the major disincentives to engaging with the process. The simplification of these processes will help them to work better at the local level and will reduce the obstacles faced by complainants from vulnerable and seldom heard groups. The increased input from these groups will support the promotion of equality and elimination of discrimination.

The difficulties experienced by service users would, alone, be sufficient justification to reform the complaints arrangements across health and social care. Users do not have confidence in the current arrangements. The current system places more emphasis on responding to complaints within set timescales than on providing a quality response that meets the needs of the person making the complaint. There should be greater emphasis on involving the complainant throughout the process – identifying at outset why the complaint has been made, and what the complainant is seeking is making the complaint. In other words, tailoring the response to the needs of the individual complainant and nature of the complaint. The emphasis should be on resolving complaints early and effectively, to the satisfaction of the complainant.

Consultation

The Making Experiences Count consultation was launched in June and concluded in October 2007. This comprehensive consultation received well over 350 responses from a diverse range of organisations and individuals and over 1000 people attended roadshows and conferences. Sixty representatives were invited from organisations with an interest in responding to people's experiences of health and social care services. A full list of those able to attend can be found in Annex A.

The Department's response to the consultation was published in February 2008.

[Making Experiences Count : a new approach to responding to complaints](#). This acknowledged the feedback that had been provided and fed into the legislative framework that was published in December 2008. [Reform of health and social care complaints: Proposed changes to the legislative framework : Department of Health - Consultations](#)

The Department has also solicited further additional feedback on the framework and received over 190 responses. These responses are currently under consideration.

Existing good practice

94 NHS and LA organisations in England took part in the programme to support the development of the new approach to handling complaints. The EAs have been working since May 2008, gathering information and case studies about areas of good practice within their organisations which compliment the concept of introducing a single, unified approach to handling NHS and social care complaints.

As EA sites try out different styles and approaches, they have been reporting back on what works well, and what doesn't. This intelligence has been fed into a central pool of resources on a website, and into draft guidance which will be developed and refined in time for the national rollout. These resources will show how effective the EAs have been in locally collaborating to develop co-ordinated ways of working and applying the principles of the new approach.

What the evidence shows – key facts

NHS received 131,022 formal complaints in 2007/8. (DH figures)

23,000 complaints received by the Healthcare Commission over past three years

26% of complaints referred to the Healthcare Commission are referred back to the service provider for further work.

20% of complaints received by the Healthcare Commission are upheld.

DISABILITY

Patients/service users who have a disability may need specific support in order to use a complaints system (eg information/support in braille, easy read/big pictures, signing etc. There is evidence (especially the Mencap report 'Death by Indifference') that learning disability does place some complainants at a disadvantage. Additionally users with long-term mental health difficulties may also need specific/specialist support or representation throughout the process. Speech/communication difficulties may also lead to a reluctance to complain.

RELIGION AND BELIEF

Anecdotal evidence shows that where the complaint is of a sensitive or intimate nature complainants/service users may express a need or preference to work with either a male or female advocate in order to progress their complaint. Cultural customs or religious codes of behaviour may lead to difficulties in pursuing a complaint. For example, women of South Asian heritage may be unwilling to discuss sensitive or intimate issues with male staff; this can be compounded if they cannot speak English and the interpreter is male.

RACE

Service users may need information/translation services in their own language. People newly arrived in this country may be unaware of their right to complain.

AGE

Children or disadvantaged groups may need access to an independent person when raising a complaint.

Elderly people, particularly if in care/nursing homes or with no family or close friends, can find it difficult to raise concerns or make their voices heard.

SEXUAL ORIENTATION

Some gay people find it difficult to disclose their sexuality to health and care professionals.

Challenges and opportunities

"I want to feel that I'm being listened to by someone who is interested and can do something about the problem. And when they come back to me with an answer, I want to be able to trust what I am being told. I don't want to have to fight the system - I just want things sorted out". This quote exemplifies the problems encountered under the current arrangements. The new approach, developed by the Making Experiences Count project and refined and implemented by the Early Adopters, has been successful in responding to complaints in a more personal way and resolving them more quickly, supporting organisational learning in the process.

More than 10,000 complaints have been approached in this way and in health, the Department is not aware of any those complaints being escalated to the Healthcare Commission because of dissatisfaction with the process at a local level. Staff report that making a personal approach, usually by telephone as soon as the complaint is received, working with the complainant to fully understand all of the issues, agree a plan of resolution and keeping complainants informed throughout greatly increases rates of satisfaction in the process and the end result.

Indicate the policy's potential to reduce and remove existing inequalities:

By simplifying the process all complainants including those from vulnerable and seldom heard groups will find it easier to make their voices heard.

The emphasis would be placed upon resolving a complaint to the satisfaction of the complainant, who would be involved throughout the process. In other words, the organisation would identify at outset why the complaint has been made, and what the complainant is seeking in making the complaint, and handle the case accordingly. Case handling would depend upon the individual needs of the case and complainant, not a set process laid down centrally by the Department of Health. Local organisations would be able to resolve complaints efficiently and effectively. By adopting a more personal approach, providers would find that people who use services, whatever their background or circumstances, would find it easier to make a complaint.

Resolution of complaints is important and helpful to both the complainant and the organisation. However, information from complaints also provides useful feedback to enable organisations to improve services. The Department's proposals include a requirement for a 'responsible person' to be nominated within each organisation to have responsibility not only for the operation of an effective complaints handling process, but also for ensuring that any appropriate action identified as a result of a complaint is taken forward. This person will be a senior person; this could include for example, the Chief Executive in an NHS or LA body and a partner, director or owner of other responsible bodies. Where such action is identified, we intend to place an obligation on the organisation to inform the complainant, in the response to the complaint, of that action and what is proposed to take it forward. Each organisation will be required to produce an annual report which, amongst other things, will indicate in a general manner lessons learned by the organisation as a result of complaints it has received. Complaints data will be used to support continuous learning within health and care organisations. This represents a shift in the approach to complaints handling in which the aim of the complaints process is not just to resolve a complaint but also to prevent future harm, reduce risks and improve service delivery.

A good complaints system results in greater user confidence in the organisation, with 'customers' happy to continue dealing with that organisation. This has a positive impact upon reputation – an important aspect as greater choice is offered for delivery of health and social care services. Organisations that are able to demonstrate user-friendly complaints handling in their annual reports will potentially attract service users.

There will also be an increased emphasis on performance management by commissioners of services, with annual reports on complaints handling, including

action taken as a result of its handling of complaints going to the Primary Care Trust. This will enable them to have a major role in making the new approach work effectively, allowing them to monitor the performance of complaints handling within those organisations commissioned to provide services in their local area. Where performance does not meet expected standards, the commissioning body will take appropriate action. Within the wider scope of 'World Class Commissioning', PCTs will be expected to use patient experience data to determine its commissioning decisions – one aspect of which will be information from complaints.

What measures does, or could, the policy include to address existing patterns of discrimination, harassment or inequality?

The Department knows that socially excluded people also experience difficulty in raising complaints and this may be linked to factors associated with age, disability and race, in particular.

This may be the case amongst particular groups and individuals (such as recipients of means-tested benefits, low income families, people residing in poor housing, homeless people and rough sleepers, the unemployed/educationally excluded, former offenders, people living alone and people that are more likely to have difficulty accessing public services; for instance refugees and asylum seekers). According to the January 2007 report 'The Multi-dimensional Analysis of Social Exclusion', one of the outcomes of social deprivation is poor health.

The Department is also aware that patients/service users who have a disability may need specific support in order to use a complaints system (eg. information/support in braille, easy read/big pictures, signing, etc.). Users with learning disabilities or long-term mental health difficulties may also need specific or specialist support and representation throughout the process. Speech and other communication difficulties may also lead to a reluctance to complain.

The Department seeks to promote equality amongst all patients, service users and their representatives who wish to progress a formal complaint about health and social care services by placing the patient/service user at the centre of the system. The policy aims to ensure that access to the new arrangements is designed to be inclusive to all groups and that specialist, high quality support, or information on where to obtain such support, is available as necessary.

The benefits of this proposal will include better feedback, including more systematic recording of complaints, feeding into organisational learning through other policies such as clinical governance and the evaluation/strategic planning stage in the commissioning cycle.

What impact will the policy have on promoting good relations and wider community cohesion.

The Department believes that by increasing the role of the complainant in the complaints procedure, providers will become more responsive to the needs and preferences of service users. If organisations focus on complainant satisfaction this will lead to higher levels of satisfaction and an increase in their reputation with the people they serve.

Information about how providers respond to complaints about their services would be routinely used when making decisions about how services should be commissioned. Organisations that do not have efficient effective arrangements in place to respond to complaints would be at a disadvantage, as they would not be able to show, for example, how the views of people using the services have been used to improve those services.

What will be done to improve access to, and take-up of, services or understanding of the policy?

Equality impact assessment

An adverse impact is unlikely and, on the contrary, the policy has the clear potential to have a positive impact by reducing and removing barriers that currently exist. The proposed regulations, by reducing the complexity of the complaints process and by improving the quality of local resolution, should facilitate complainants of all backgrounds pursuing a complaint to its conclusion.

Next steps

Data on the Early Adopters' experiences will be used to inform a good practice guide.

Regulations will be laid in February before implementation in April 2009.

A national event for 250 high level leaders in the NHS and social care took place early February. It promoted the importance of an effective complaints process with those most likely to be able to ensure effective complaints handling and public/patient experience are considered important priorities.

The national launch will be supported by a series of promotional regional networking events aimed at spreading good practice developed by the early adopters.

The Department will also communicate the changes to patients users and the general public by publicising the new systems and its benefits for users through various channels including through Department of Health and stakeholder websites and asking providers and commissioners to cascade to their service users in appropriate formats.

An implementation field team, supported by Early Adopters, is working with local groups of health and social care organisations to provide support as they prepare for new regulations from 1st April. A national conference for 'very senior' managers and four regional 'market place' events are planned which will allow DH to ensure:

- Chief Executives and Directors of Social Care are briefed on the final regulations and have an opportunity to hear about the experiences of the Early Adopter sites.
- complaints professionals have an opportunity to talk to Early Adopters from their own region, to hear about their experiences and discuss with colleagues locally how they will work together to implement the new arrangements.
- complaints professionals have an opportunity to talk with other key stakeholders including Ombudsmen, about their role locally.

The Department believes it is important to evaluate the impact of the new arrangements, in meeting their policy aims. A formal evaluation will be undertaken three years into the new arrangements, when we would expect there to be real benefits accruing to local organisations and service users.

Annex A

A wide range of representative organisations have been involved in the consultation process. Below is a list of those organisations attending the stakeholder event.

Representative Organisations

- Age Concern
- Anchor Trust
- Barnardo's
- Benendon Healthcare Society Limited
- Citizen's Advice Bureaux
- Commission for Patient & Public Involvement in Health
- Consumers Association/Which?
- Council for Healthcare Regulatory Excellence
- English Community Care Association
- Family Welfare Association
- Foundation Trust Network
- Health Advocacy Partnership
- Help the Aged
- HINT (BASE 51)
- Independent Healthcare Advisory Services
- Independent Healthcare Association
- Independent Healthcare Forum
- MIND
- Monitor
- NHS Direct
- Office of PHSO
- Patient Opinion
- Relatives & Residents Association
- Richmond Fellowship
- Social Care Institute for Excellence
- Social Enterprise Coalition
- UK Home Care Association
- Unison