HEALTHWATCH AND PUBLIC INVOLVMENT ASSOCIATION

Malcolm Alexander, HAPIA

ATKINS, Martyn, Health Committee, House of Commons, SW1P 3JA
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Dear Martyn,

we would like to make the following submission to the Health Committee's inquiry into the handling of complaints from patients and the public, and concerns raised by staff.

1) **Handling of complaints made by patients and families about care received in the health and care sectors, including both primary and secondary care providers.**

Based on the information received from our members across England we would like to comment on the following aspects of complaints investigation.

With respect to secondary care complaints, the language used is often confusing, e.g. the word complaints is often avoided and the public is often confused by words such as 'concerns' and 'comments', which some bodies use instead of the term 'complaint'. This is confusing because the complainant is often unsure what process they have initiated. If a complainant says they want to raise a concern not a complaint, there is often no way of ensuring a proper response, that would be consistent with high quality complaints investigation, and there is often no process of responding appropriately to 'concerns'.

The quality of response letters to complaints is generally improving, but the outcome of complaints in terms of what has been learnt by staff, how the organisation has changed the way it does things and how this is demonstrated to the complainant continues to be weak. Complainants usually want to see organisational change, improved services, changes the ways that staff respond to them, better information etc, but in practice these changes often do not occur once the investigation is complete, or if they do happen they are not visible to the complainant. It would be of immense value if after six month of the complaint having been submitted, the

complainant is advised of what has been done as a result of the complaint, what has changed and some evidence provided that the changes are enduring. Most people who make complaints do so either when they are extremely angry or because on reflection they really want to see change occur in the organisation. The best hospitals value complaints, demonstrate a good sensitive inclusive investigation process; carry out the investigation quickly; meet with the complainant if appropriate and ensure that the response is provided within a reasonable time frame. In practice this is rare. Good practice provides an opportunity for the person complained about to meet with the complainant so that, if necessary, a sincere apology can be given face to face - this approach can have a profound impact on the complainant, transform relationships between patients, clinicians and the hospital, and can help transform the culture of the hospital.

With respect to primary care complaints the confusion created by the changes to primary care commissioning have created a complete and utter mess. NHS England is taking no responsibility for the disgraceful situation it has created. In the present system if a complaint is made to a GP, dentists, optician or pharmacist and the complainant is unhappy with the response, the only appeal is to the Health Service Ombudsman, who is in practice is unlikely to do very much. If the complainant writes to the GP Commissioner – NHS England - to appeal, NHS England will refuse to examine the complaint, even though they commission the service. If however the complaint is sent first to NHS England, they will deal with it and investigate. Members of the public have no way of knowing about this perverse way of running a complaints system. The investigation of primary care complaints has now moved as far as it possibly can away from responding appropriately and adequately to complaints. A comparison with the use of Service Committees in the 1990s for primary complaints would be a valuable.

- **Support for patients, the public and staff who wish to make complaints or raise concerns;**
- **Openness about complaints and concerns, and accessibility of information;**

The model originally designed for Healthwatch of a public facing body that could provide support for patients and the public who wish to make complaints or raise concerns was unfortunately abandoned by the Department of Health. Local Healthwatch does not have a specific role with respect to complaints advocacy, except where the local authority has decided to include the Independency Advocacy Service (IAS) within the remit of Local Healthwatch. In most cases the IAS role is run separately from the Local Healthwatch. The only statutory activity available to Local Healthwatch with respect to IAS, is the role of signposting people to IAS. As LHW is virtually unknown to the public and is rarely visible to the public, it is

extremely unlikely that many people wanting to make complaints would be signposted by LHW.

The separation of LHW from the IAS is in our view irrational. Over the past 12 years the separation of public involvement from complaints advocacy has left the public involvement organisations (Patients' Forum and Local Involvement Networks-LINks) with no information about the most serious complaints submitted to NHS bodies. Community Health Councils literally had masses of data about complaints and could use complaints as a means of rapid intervention. E.g. if a complaint was made to a CHC about poor care on a ward, the CHC could inspect the ward on the same day, talk to the Chief Executive and produce a report on their findings the next day.

Neither the Department of Health (the commissioner) nor the ICAS (Independent Complaints Advocacy) organisations have shared useful qualitative data from complaints, outcomes from investigations or evidence of service improvements resulting from the investigation of complaints with Patients' Forum, LINks or LHW over the past 12 years. Only numerical data has sometimes been available, which was of no use to Patients' Forums or LINks. As these bodies had a duty to monitor services, depriving them of critical information from complaints prevented them from carrying out their roles effectively. This approach has moved forward into LHW. Some attempts are being made to bring bodies together to discuss complaints, e.g. in London, VoiceAbility has set up an Advisory Group for Pan London NHS Complaints Advocacy Service – but the terms of reference which follow, **do not include sharing information about complaints:**

The Advisory Group's Terms of Reference:

- Review service performance including the impact of networking and service promotion on demand for the service.
- Assist with ensuring VoiceAbility's service works successfully in partnership with Healthwatch, PHSO, NHSE, CQC, CCGs and CSUs to join services up for the benefit of complainants.
- Inform priority setting and action planning in accordance with addressing gaps identified in relation to under-represented: Trusts (and other providers); geographical areas; communities using VA's service.
- Assist with ensuring all commissioners and NHS service providers are engaged with promoting the service directly to people using services, their carers, families, partners and friends.

- Assist with informing and reviewing website, self-help and promotional materials range and accessibility.
- To feedback from the communities served about service accessibility, how the service is assisting people and any stumbling blocks the service needs to overcome.
- Make recommendations and connections in accordance with promoting the service, networking and reaching out further to communities.
- Attending as well as planning, organising and holding joint stakeholder and service awareness raising events, workshops and training.

Local authorities commission both LHW and IAS and it would be a simple matter from them to bring the bodies together into a single entity if they were so minded.

In addition the separation of health care from social care complaints makes no sense. In practice huge attempts are being made to integrate health and social care, but if a patient or family wish to make a complaint about both services they will need to make two complaints to different bodies and perhaps require two advocates from different organisations to support them.

In practice it would be valuable to create a consistent, easily understood system across the country, with common terminology so that Complaints and Concerns were defined and dealt with in consistent ways. A patient may raise a concern about the transport system used by a hospital and would like a letter saying what has been done, without this be described as a formal complaint. A patient may wish to make comments about a doctor for his or her appraisal and revalidation, which may be of immense value to the doctor in terms of improving practice, but is a valuable 'comment' not a complaint. Common terminology and clear approaches to dealing with issues would substantially improve and mature the system.

- **Handling of concerns raised by staff about care given in the health and care sectors;**

The Regulations currently do not enable staff members to make complaints about patient care. In a recent example, a nurse based in a hospice discovered that a patient had been denied transport to the hospice, because the ambulance service did not have the resources to transport the patient for urgent care, but did not tell the nurse in good time. She could therefore not arrange appropriate alternative care. She complained to the ambulance provider, and although her complaint was dealt with informally, she was advised that the Regulations did not allow health workers to submit complaints against providers. These Regulations clearly need changing.

- **Future plans for improvements in this area.**

We have made a request to the Health Committee to review the development of LHW. This is based on our concern that over the past 12 years we have had four models of public involvement in healthcare, and that in each case the model, though essentially the same in terms of role, has been weakened in terms of influence and capacity to represent the public and influence providers and commissioners. Lack of information described above about access to complaints data is central to our concern.

The current HW model has significant strengths in relation to its role in the Health and Wellbeing Board and the support of the national body Healthwatch England, but in many parts of the country it is not meeting local people's needs, because of inadequate funding, due to the consequences of the government's decision not to 'ring fence' LHW budgets and the separation of IAS and LHW functions.

The Health Committee will also be aware of the claim by HWE that £10m has 'disappeared' from the intended allocation for LHW. You may also be aware of our report on this issue: The Funding of Local Healthwatch 2013-2016 which demonstrates the massive cuts in funding for some local Healthwatch bodies.

http://www.nalm2010.org.uk/uploads/6/6/0/6/6606397/hapia-august_13-2013-final-v1-3.pdf

We believe that it is appropriate and timely for Health Committee to examine the following issues in relation to Local Healthwatch:

1) Absence of a role for LHW in relation to complaints advocacy
2) Funding of LHW
3) Independence and accountability of LHW
4) Significant variations in capacity and performance
5) Effectiveness in terms of influencing providers and commissioners of health and social care
6) Influence exercised by LHW in HWBBs
7) Impact of LHW in relation to the implementation of recommendations from the Francis and Berwick Reports.
8) Indemnity for LHW volunteers when inspecting health and social care services.

Healthwatch organisations must be an effective and powerful voice for their local communities. We believe an Inquiry would ensure that the strengths and weakness of LHW were examined in detail and appropriate recommendations made to government.

HEALTHWATCH AND PUBLIC INVOLVMENT ASSOCIATION

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