HEALTH NEWS BRIEFING

ASSOCIATION OF COMMUNITY HEALTH
COUNCILS FOR ENGLAND AND WALES

The NHS Complaints procedure

ACHCEW's Memorandum to the Public Administration Committee

June 1999

SUMMARY

The Association for Community Health Councils was invited to give evidence to the House of Commons Select Committee on Public Administration about the NHS Complaints procedure. Written evidence was submitted, followed by oral evidence in November 1998.

In the written evidence the procedure is assessed using the five criteria of visibility, accessibility; speed; impartiality; and effectiveness. ACHCEW's evidence concludes that whilst the procedure, introduced in 1996, appears better than the procedures it replaced, there is still room for improvement.

The Select Committee report[1] was published on 27th April 1999 and ACHCEW is now able to make its evidence available in the form of a Health News Briefing. ACHCEW's oral evidence is available in the Select Committee's report.

[1] Select Committee on Public Administration. Annual Report of the Health Service Ombudsman for 1997-8 27th April 1999.

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1. Introduction

In April 1996 the existing NHS complaints procedure was replaced by a new system intended to provide a single, simple, speedy and accessible means of making a complaint for patients dissatisfied with NHS treatment or care.

Making a complaint about NHS services or treatment is rarely a comfortable experience for patients, their relatives or carers. Doctors, nurses and other NHS staff are respected and held in high regard by the general public and as such many people feel uneasy about pursuing a complaint. Furthermore the general public are often either unaware of or confused by the complaints procedure.

Many complainants turn for help to their local Community Health Council (CHC). Although it is not explicitly part of CHCs' statutory functions, CHC staff spend a considerable amount of time helping people pursue complaints through the NHS complaints procedure. It is estimated that each year CHCs assist complainants with some 30,000 complaints[1].

With this considerable contact with complainants, CHCs have become aware of the complaints procedure's strengths and weaknesses. This memorandum provides a broad overview of the roles performed by CHCs; looks at how well ACHCEW believes the procedure is working; and assesses the procedure by the Association's criteria of visibility, accessibility, speed, impartiality and effectiveness.

The memorandum concludes that the post 1996 NHS complaints procedure, whilst an improvement on the old procedures, still has room for improvement. In particular monitoring, the role of the convenors, its true independence and the speed of the process all require careful consideration.

The NHS Executive is currently embarking on a comprehensive review of the procedure[2] and the Association will be putting our concerns into that process.

We welcome the opportunity to put our concerns about the NHS complaints procedure to the House of Commons Select Committee on Public Administration.

2. Community Health Councils and the NHS complaints procedure.

There are 206 CHCs in England and Wales (16 Health Councils in Scotland and 4 Health and Social Services Councils in Northern Ireland perform similar functions). Each CHC has around 16 to 30 members: half local authority nominees; a third elected by the local voluntary sector; and a sixth appointed either by the Secretary of State for Health or the Secretary of State for Wales.

CHCs are funded from a national budget held by the NHS Executive, but are independent of the NHS management structure, each other and the Association of Community Health Councils for England and Wales (ACHCEW). The average budget for each CHC in England is £116,000 and in Wales £56,000. The total cost of CHCs is less than 0.1% of the total NHS budget.[3]

Health Authorities are required to consult formally with CHCs on substantial variations in service provision, provide information required by the CHC in carrying out its public duties and arrange a meeting between the authority and the CHC members once a year.

The main roles performed by CHCs include:

- monitoring local service delivery including the inspection of NHS premises.
- representing the public and putting their communities' views during consultative exercises.
- offering advice and assistance to individuals including offering advice and assistance when individuals wish to complain.

A survey of CHCs found that they assist complainants with some 30,000 complaints each year; an average of 145 complaints per CHC per annum. However this figure can vary between CHCs with one CHC stating that they handled 11 complaints and another 642.[4]

A survey of CHCs in London found that most Chief Officers spent more than half their time on complaints.[5] Whilst these surveys do not relate to the new complaints procedure a more recent survey by ACHCEW found that almost half of CHCs feel that the new procedure had increased their workload, 37% felt that their workload had remained the same and only 15% found that the workload had decreased. ACHCEW is currently planning a new survey which will look at the effectiveness of the complaints procedure and the role performed by CHCs.

3. The Association of Community Health Councils for England and Wales.

The Association of Community Health Councils for England and Wales (ACHCEW) was set up in 1977, under provisions of the NHS (Reorganisation) Act 1977, to provide a forum for member CHCs; to provide information and advisory services to CHCs; and to represent the user of health services at a national level.

CHCs are not obliged to be members of ACHCEW but the overwhelming majority are. CHCs pay an annual subscription based on their own annual budgets and ACHCEW's Annual General Meeting decides national CHC policy. Currently 205, out of a total of 206 CHCs, are members.

ACHCEW's statutory duties are to:

- advise CHCs with respect to the performance of their functions
- assist CHCs in the performance of their functions
- represent those interests in the health service which CHCs are bound to represent.

ACHCEW provides a comprehensive information service to its members. As part of this service, ACHCEW advises CHCs about the workings of the complaints procedure and in turn gathers information about how well it is working from the patients' perspective. ACHCEW publishes a variety of leaflets aimed at the general public explaining what their rights are in the NHS and how they can make a complaint if things go wrong[6].

The Association also represents the interests of CHCs and patients at meetings with the Department of Health, the NHS Executive and the Health Service Ombudsman.

ACHCEW staff are also involved in presenting lectures and workshops to NHS staff and other interested bodies about the complaints procedure as part of our remit to represent the interests of patients.

4. Problems with local resolution.

The new procedure stresses the importance of informal "on the spot" resolution of complaints and the guidance accompanying the complaints procedure[7] places great emphasis on staff dealing with complaints swiftly at the local resolution stage.

The Association believes that at the local resolution stage there are problems with regard to: lack of knowledge about the procedure; monitoring the procedure and; patients being uneasy about going back to the GP practice to complain (sometimes fearing being 'struck off' their doctor's list).

Lack of knowledge of the procedure.

Whilst practices are required to "publicise" the procedure there is no detailed guidance of how this should be done. Some practices insert a few sentences in their practice leaflet while others have a small poster somewhere on the already crowded waiting room notice board - neither are particularly satisfactory.

Community Health Councils often tell ACHCEW of the failure of GPs to make themselves aware of the complaints procedure let alone their patients. Indeed it is not unknown for doctors to ring ACHCEW organisation to find out about the procedure.

Monitoring.

One of the difficulties of local resolution is that complainants may access practice based systems without recourse to the health authority or their local Community Health Council and therefore neither agency is involved in monitoring progress of the complaint.

ACHCEW is concerned that monitoring is not as effective as it could be and practices can exert pressure (albeit unconsciously) on patients not to take their complaint further without any one being aware that this is happening.

Patients' unease at making complaints about family health services.

A survey conducted by the Association found that only 27% of Community Health Councils felt that local resolution was working in GP practices[8].

Patients are often not happy about having to go back to the GP practice they wish to complain about to make their complaint - a problem not so apparent in hospitals as they will usually have a separate department that deals with complaints.

For example one Community Health Council in the survey replied that

"a lot of people are put off by having to go to the practice - I can think of one practice where the practice manager, who deals with complaints, is the spouse of the GP and refused to hear any criticism of their partner".

5. Problems with Convenors and Independent Review Panels.

The Association has identified a number of concerns about the role of convenors and Independent Review Panels. ACHCEW believes that there are problems regarding convenors attempting to solve the complaint themselves; delays in setting up Independent Review Panels and; the impartiality (or perceived impartiality) of the convenors.

Convenors attempting to solve complaints themselves.

Some convenors appear to be attempting to resolve complaints on their own which is clearly outside their remit as the role of the convenor is only to decide whether or not the complaint requires investigation by an Independent Review Panel. The Association has heard anecdotal evidence of convenors being reluctant to set up Panels due to the costs involved.

Delays in setting up Independent Review Panels.

One Community Health Council commenting on the lack of Review Panels being set up said that:

"Independent reviews are very costly - very difficult to set up, and get the correct panel of experts etc., within extremely tight deadlines. Because of this, patients are being pushed to go back again and again for further local resolution in the hope that this will eliminate the need for independent review".[9]

Perhaps even more worrying are the problems associated with finding suitable Review Panel members. The Association has come across anecdotal evidence of concern being expressed of the variable quality of Panel members and the problem of Regional offices of the NHS Executive supplying panel members. Indeed one CHC recently assisted a complainant who has been told that they were number 32 on the 'waiting list' for an Independent Review Panel due to the Regional Office experiencing difficulties in supplying Trusts with Lay Chairs. Whilst we understand that the situation in this region has recently improved it does illustrate the problems of finding Lay Chairs.

Such delays lead to frustration and distress for complainants. When the complainants are relatives of a deceased patient this delay can be particularly distressing as resolution of the complaint can be part of the grieving process.

The impartiality of Convenors.

There is concern amongst complainants and CHCs about the impartiality of the convenors who are non-executive directors of the hospital or health authority that is the subject of the complaint.

One CHC stated that

"Convenors [are] attempting to resolve Independent Review requests personally"; and *"[We have] suspicion as to the role of the convenor and his/her independence".*[10]

Complainants are often surprised to receive correspondence from the convenor on the Trust or health authority headed note paper about whom they are complaining. Complainants are left wondering just how independent the Independent Review Panel really is. Even when the convenor is acting completely impartially (there is no reason to believe that in most cases they are not) there is still a perception by many patients that the convenor will naturally tend to be on the side of the Trust or health authority.

ACHCEW has called for a right for complainants who are unhappy with the initial response to be able to put their complaint to a genuinely independent panel[11]. The Association believes that this independent panel would mean that not only would patients be more reassured of a fair hearing, but it could also cut down on the number of referrals to the Health Service Ombudsman.

6. Problems with time limits and the costs of making a complaint.

Time limits.

Patients are also upset by the time limits in which they are required to make a complaint. It is expected that a complaint should be made within six months from the incident that caused the problem or within six months of the date of discovering the problem, provided that this is within twelve months of the incident.

The association is concerned that the imposition of specific timescales may deter some patients from pursuing their complaint. For example a wife whose husband has died may be so grief stricken that it takes her more than the six or twelve months before she is able to take up a complaint.

In the Patients' Agenda ACHCEW has called for "*a right to make a complaint about any aspect of care or treatment without the constraint of an imposed time limit*"[12] .

Whilst the patient is expected to make his or her complaint within these time scales it appears that hospitals, health authorities and GPs are regularly not adhering to the timescales that *they* are supposed to keep to and Community Health Councils regularly hear reports of patients not receiving replies within the times recommended by the guidelines.

Costs.

A further problem with the complaints procedure is the cost of making a complaint. The guidelines allow for expenses to be paid to the members of the Review Panels but there is no mention of expenses for the patient. Clearly some complainants may be put off pursuing their complaint if they fear that they may have to take time off work or incur travelling costs or other expenses.

When pursuing a complaint, complainants will often find it necessary to obtain copies of their health records. The Access to Health Records Act allows a charge to be made for copies of records. A recent survey conducted by the Association[13] found that one in three CHCs find that clients have faced charges of over 10 pence per page and charges of 20 to 25 pence per page commonplace. The survey found one patient being charged £159.00 to have their relevant records copied.

This Act will largely be superseded by the Data Protection Act 1998. The charging regime for the new Act is not yet clear but ACHCEW fears that patients may find it even more expensive to access their own health records.

7. The Health Service Ombudsman.

It is only when a complaint reaches the desk of the Health Service Ombudsman that many complainants feel confident that their complaint is being dealt with by a truly independent body and the Association acknowledges the complex and sensitive work that the Health Service Ombudsman and his staff undertake. However the Association has some concerns about the Ombudsman's Annual Report 1997-98.

We are concerned that the number of complaints received by the Ombudsman in 1997/8 was 2,660 an increase of 20% over 1996/7 - the highest number of complaints ever received. Yet despite a record number of people complaining to the Ombudsman the number investigated reduced to 270 from 551 in the previous year.

Given that the Ombudsman is for the first time able to investigate complaints against GPs and complaints about clinical matters, the Association did expect the number of complaints being investigated to rise.

We are also concerned that the report stated that it would be the last report in which a separate account of screening and investigations would be given. The Association has found it useful to know the number of complaints that reach the Ombudsman's desk and would wish to see the presentation of screening statistics continue in the report.

Unlike previous years the report did not analyse the investigations completed by service areas and subjects. The Association has found investigations by service area and subject to be useful and would like to see such statistics in future reports.

Again unlike previous years the report does not name Trusts investigated. Whilst the Trusts are named in the separate reports of investigations completed, it is the Annual Report that receives most attention. To help the NHS complaints procedure have an effect on standards in service provision ACHCEW believes that it is important that Trusts investigated should be named in the Ombudsman's Annual Report.

At the time of the Ombudsman giving evidence to The Public Administration Committee about his 1997-98 Annual Report the Association wrote to members of the Committee expressing these concerns. We have since met with the Ombudsman[14], who we understand has agreed to consider these points with a view to making some changes to next year's Annual Report. We welcome this dialogue between ourselves and the Ombudsman.

8. ACHCEW's criteria to judge complaints procedures.

The Association has long used the following five criteria to judge complaints procedure models: visibility; accessibility; speed; impartiality and effectiveness.

Visibility.

Any complaints procedure must be widely publicised within hospitals and doctors' surgeries and within the wider community. Patients must know that they can complain and they need to know how they go about making a complaint.

Accessibility.

Patients with a complaint should be able to lodge their complaint with some one in authority with the minimum of difficulty. Any complaints procedure will need to have common steps regardless of what you are complaining about.

Indeed a criticism of the old NHS complaints system was that it was complex and fragmented, with different procedures applying to different professional staff. The new procedure at least has a simple "one door" point of access.

Speed.

A speedy resolution to complaints is in the interest of not only the complainant but also those who are being complained about.

Moreover, for some people the satisfactory resolution of a complaint is part of the healing process that follows a traumatic or upsetting event. If this process is protracted, it is more difficult for patients or relatives to recover from their experience. That is why speedy procedures with firmly fixed response times are important.

Impartiality.

Clearly if patients are to have any faith in a complaints procedure then it must be seen to be impartial. Patients may lose faith if a complaint is investigated by staff who work in close proximity to those who are subject of the complaint, or by non-executive directors of the Trust or health authority that is subject of the complaint.

Effectiveness.

To be effective from a patient's perspective any complaints procedure must address the three major concerns of patients. These are to find out:

- what happened;
- why it happened and;
- what action is going to be taken to try and ensure that whatever happened does not happen again.

Community Health Councils often find that any desire to blame, any desire for retribution and any desire for compensation fall some way behind the first three concerns.

What must be avoided by hospitals and GP surgeries are replies to patients that are cursory and bureaucratic with little indication as to what changes or improvements will be made a result of the complaint.

9. Does the NHS complaints procedure meet ACHCEW's criteria?

We are not convinced the new system is particularly **visible**. Community Health Councils regularly see patients who are unhappy with the service that they have received but do not realise that there is procedure in place for them to make a complaint.

The new system would appear to be reasonably **accessible** - it does at least provide a single procedure with "one door" access. However the time limits, the need to take time off work and lack of any expenses prevent some patients from making a complaint. Additionally some patients may fear being struck off their doctors list if they complain.

The new procedure is certainly not proving to be **speedy** - recent figures from the National Health Service Executive found that only 35% of the Independent Review Panels for hospital and community services were concluded within the performance target of six months whilst for family health services the number of Independent Review Panels concluded within the performance target of three months was only 11%.[15]

There has been a particular problem with complaints that require a dental assessor. Clinical assessors are in dispute with the NHS Executive, claiming that their payment is not adequate for locum cover whilst they are away from their practice. Lack of progress in this dispute has resulted in some complainants waiting indefinitely as Independent Review Panels are unable to find an assessor willing to undertake the required work. The Association feels that this is an unacceptable situation and very distressing for those complainants involved.

A former Deputy Health Service Commissioner observed that: *"The strict time limits in the national guidance for responding to complaints were frequently not being met, and the Ombudsman expressed concern that sometimes complainants were not told early enough of their right to request a Panel and that local resolution was being inappropriately dragged out."*[16]

Patients have also questioned the **impartiality** of the procedure, particularly as the convenors are non executive directors of the Trust or health authority being complained about. Again the Deputy Health Service Commissioner has observed that convenors need to pay particular attention to demonstrating their impartiality and distancing their role from that of the hospital.[17]

The new procedure has yet to fully demonstrate that it is **effective** from a patient perspective. Complainants often simply want to know what happened, why it happened and what is going to be done to prevent the same thing happening again. The NHS Executive leaflet for potential complainants states that: *"The aim* [of the Complaints Procedure] *will be to give you a quick, but thorough response which answers your concerns properly"*[18].

Unfortunately CHCs are aware of cases where the responses received by complainants have been unacceptably poor; with one CHC stating that a complainant received *"a one line reply from a GP saying 'I am sorry you are not happy with your care. I have always tried to do my best'"*[19].

The Department of Health will be conducting a review of the procedure later this year. The Association is in the process of preparing a consultation exercise with Community Health Councils so as to feed into this review..

10. Alternatives to the complaints procedure.

Alternatives to the complaints procedure are either to take legal action or where appropriate to pursue a complaint with one of the professional regulatory bodies such as the General Medical Council.

The Secretary of State for Health has made it clear that he wants to reduce the levels of litigation in the National Health Service. However the Association is concerned that discussions about litigation against health professionals can give the impression that patients are routinely taking legal action when things go wrong. In reality legal action is enormously complex, stressful, very expensive and often disappointing for patients.

Likewise procedures of the professional regulatory bodies can also be lengthy and are often intimidating to the general public.

It is often the failings of the procedures of such bodies as the General Medical Council that drive patients to take their case through the courts. The Association believes that greater openness of the procedures of the professional regulatory bodies would go some way in improving the public's confidence.

We also believe that a genuinely independent complaints procedure would reduce the number of people seeking redress through the courts. That said, we believe that patients must always retain the right to seek redress through the courts, if they so choose: particularly as the legal route is the only one that allows the complainant to explicitly pursue financial compensation.

The NHS complaints procedure does allow the Independent Review Panel the option of recommending that a financial payment be made to the patient. However the Panel cannot suggest an amount, nor is the procedure designed to be an explicit mechanism for awarding financial damages to complainants.

We would welcome a more explicit mechanism in the NHS Complaints Procedure for financial compensation to be awarded. However we are wary of any moves towards "no fault compensation schemes" that fail properly to address the issue of accountability of doctors. Any system of financial compensation must be linked to ensuring that the actions of the medical professions are properly scrutinised so that appropriate action can be taken when things go wrong.

11. Conclusion.

The new NHS complaints procedure introduced in April 1996 was intended to provide a single, speedy and accessible means of making a complaints about NHS treatment or care. Responses to complainants are supposed to give a thorough response to their concerns.

The Association acknowledges that the new procedure is an improvement on the previous one. However we are not completely satisfied that the process fully meets our criteria of visibility, accessibility, speed, impartiality and effectiveness.

The NHS complaints procedure is for many complainants simply taking too long; not appearing to be completely impartial and; does not always effectively address their concerns.

For many people the Health Service Ombudsman represents the only truly independent part of the process. We have some concerns about the Ombudsman's Annual Report 1997-98 but we understand that he is considering the concerns we raised.

The alternatives to the complaints procedure (taking legal action or taking a complaint to the relevant professional body) are often more daunting, more time consuming and in the case of legal action more expensive for people to pursue. An improved NHS Complaints Procedure could prevent complainants taking inappropriate legal action or taking their complaint inappropriately to a professional regulatory body. However the Association is clear that individuals should be able to take these routes when it is appropriate.

ACHCEW is pleased that the Department of Health is embarking on a review of the complaints procedure and we shall be contributing to this process. We plan to undertake further work looking at the complaints procedure and the role of CHCs in this area. We will feed our findings into the work of the Department of Health and trust that our concerns will be taken into account when considering any modifications or changes.

We thank the House of Commons Select Committee for Public Administration for giving us the opportunity to set out our concerns about the NHS complaints procedure

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References

[1] Insight Management Consulting (1996) Resourcing and Performance management in Community Health Councils.

[2] The Department of Health's Research and Development Division in collaboration with the Quality and Consumers Branch of the NHS Executive are currently assessing tenders from organisations bidding to undertake a two year review of the NHS complaints procedure.

[3] ACHCEW (1997) CHCs Making a Difference.

[4] Insight Management Consulting (1996) Resourcing and Performance management in Community Health Councils.

[5] Christine Hogg (1992) Complaints about family practitioners - Community Health Councils and FHSA Complaints.

[6] ACHCEW (1998) Patients' Rights: ACHCEW (1996) Making a Complaint

[7] Department of Health (1996) Complaints. Listening..Acting..Improving: Guidance on the Implementation of the NHS Complaints Procedure.

[8] ACHCEW Annual Report 1996/7 "New Complaints System".

[9] ACHCEW Annual Report 1996/7 "New Complaints System".

[10] ACHCEW Annual Report 1996/7 "New Complaints System".

[11] ACHCEW (1996) The Patients' Agenda.

[12] ACHCEW (1996) The Patients' Agenda.

[13] ACHCEW (1998) Medical Records: restricted access, limited use.

[14] Meeting between Health Service Ombudsman and key patient/consumer organisations to discuss his 1997-98 Annual Report (22 October 1998).

[15] Department of Health (1998) Handling complaints: monitoring the NHS complaints procedure England 1996-97

[16] Deputy Health Service Commissioner in article for CHC News (September 1997).

[17] Deputy Health Service Commissioner in article for CHC News (September 1997).

[18] NHS leaflet (1996) "Complaints: Listening...Acting...Improving".

[19] ACHCEW Annual Report 1996/7 "New Complaints System".

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