ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES

HEALTH NEWS BRIEFING

NHS COMPLAINTS PROCEDURES

A Submission to the Complaints Review Committee

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INTRODUCTION

1.1 At the Association's Annual General Meeting in July this year, the following Resolution was passed:

> *This AGM welcomes the announcement by the Secretary of State for Health that there is to be a wide-ranging review of NHS complaints arrangements.*
>
> *This AGM notes that CHCs have had nearly twenty years experience of advising and assisting complainants and that this experience suggests that the existing arrangements are deeply flawed as far as patients are concerned.*
>
> *This AGM urges the Secretary of State to appoint people to the review team who can reflect the wide experience of CHCs in handling complaints.*
>
> *This AGM further calls on the Standing Committee to:*
>
> *a) Collect information on a common basis from CHCs about the complaints they handle; and*
>
> *b)submit evidence to the review team that calls for a new NHS complaints system that is user-centred and accepts the emotional and practical needs of complainants, by being speedy, impartial and unified (so that all complaints can be accessed through one door), but also meets the needs of the NHS in being a part of effective quality assurance."*

1.2 We welcome the inclusion on the Review Team of an individual closely associated with Community Health Council complaints work. We consider the perspective which this offers to be of key importance in any attempt to satisfy the requirements of patients complaining to the NHS.

1.3 The following comments are based as closely as possible on the current views of ACHCEW's member CHCs and on the wealth of information drawn from past experiences of dealing directly with complainants and various health bodies.

CHC EXPERIENCE

2.1 Health care is an emotive issue: never more so than when things go wrong.

2.2 Although it is true that some mistakes are merely the source of irritation and general dissatisfaction, other, more serious, mistakes can leave patients feeling isolated and helpless following a traumatic experience. In some cases it is difficult - if not impossible - to repair any damage which may have resulted from mistakes possibly leading to injury, illness or the death of a relative or close friend.

2.3 Community Health Councils have recognised the importance of providing information and assistance to patients wishing to make a complaint about their health care. Although complaints work does not form one of CHC's statutory duties and they do not receive any additional resources for undertaking this work, since their inception nearly twenty years ago, they have been continually involved in dealing with patient complaints and the systems through which they may be satisfied. Their involvement with the time-consuming and often complex work of assisting and counselling complainants has meant that CHCs and ACHCEW have built up considerable experience and expertise leading to them possessing the most informed overview of the complaints system from the perspective of the patient.

The Type of Help Offered by CHCs

2.4 Both the type and extent of assistance offered by CHCs to complainants does vary considerably. Although not necessarily typical, the following examples are indicative of the sort of work usually conducted:

> *"In dealing with complaints, the CHC advises people on the available procedures and their possible outcomes and assists them with what can be a long and frustrating process. We may attend hearings or meetings to discuss complaints and chase up responses when there are delays in the system.*
>
> *It is important also for us to be aware of the causes for complaints , as if there are a number about one aspect of care, it may warrant further investigation. We also try to ensure that where individual complaints suggest that changes to a service are necessary, this is done.*
>
> *We do not however have the power to enforce action, nor do we have the power to investigate complaints, which can be a source of frustration to some complainants." (North Birmingham CHC)*
>
> *"We provide three levels of assistance to people wishing to make complaints about the NHS. These are:*
>
> * *information and advice about complaints procedures and further information or advice as the complaint proceeds. We do not always hold casework at this level of assistance. Copy correspondence may be held in case of further developments.*
>
> * *empowering/supporting someone to make their own complaint where the individual signs all correspondence. Case work held by the CHC.*

* *complaint taken up by the CHC in full consultation with complainant. Case work held by the CHC. (Parkside CHC)*

Are patients satisfied with the system currently in place?

2.5 A survey aimed at revealing the level of satisfaction complainants experience with the complaints process was conducted between July 1992 and February 1993 by Leeds CHC[1]. This found that over half the clients advised by the CHC were dissatisfied with the result of making their complaint, the majority of these being "very dissatisfied". The Leeds CHC survey also found that around three quarters of complainants thought the procedures were easily understandable but that the main difficulty (expressed by nearly half the complainants) related to the *scope* of the system; they did not believe the procedures could adequately deal with their complaint.

2.7 North Birmingham CHC[2] revealed considerable frustration in their survey of complaints during 1992:

> *"Over half the respondents felt that it took too long to receive a response from the official body dealing with their complaint. Half said that they did not feel they had an adequate opportunity to voice their concerns".*

2.8 A survey by Southend CHC[3] found that, although most patients felt confident asking for information, 76% said they would like clearer guidance and better information about complaints because it was reassuring to know that a proper system was in existence.

How Well are Complaints Being Handled?

2.9 According to a recent ACHCEW survey[4] the majority of CHCs are satisfied with the overall manner in which complaints are handled by the relevant Chief Executive or General Manager. The major problems referred to were caused by time delays and patients becoming frustrated with bland or patronising responses and a lack of any assurance that action would be taken to rectify the situation.

2.10 There seems to be a far greater degree of dissatisfaction in the system itself than the way in which the system is operated by health service staff. One problem which has been expressed time and again, both by CHCs and NHS staff, relates to the division drawn between so called clinical and non-clinical complaints.

The Confusion of Clinical and Non-Clinical Complaints

2.11 The current system of dealing with complex complaints in the Health Service relies heavily on the assumption that, where necessary, each individual complaint can be separated out into its constituent elements and dealt with through the appropriate channels. In most cases this is possible if not necessarily desirable; in some cases it is impossible and this is one (of many) ways in which the complaint can end up being dealt with unsatisfactorily.

2.12 Possibly the most common cause of confusion amongst complainants (and professionals) is the distinction which is made between clinical and non-clinical complaints:

> *"An elderly gentleman made a complaint about the death of his wife. He claimed his wife had died while awaiting a heart operation and believed the administration system at the hospital concerned had denied his wife the operation.*
>
> *A meeting was arranged between the complainant, the consultant, the specialty manager and a CHC representative at which a number of separate concerns were raised. The complainant made it quite clear through subsequent correspondence that he did not want to pursue a complaint about the consultant but instead wanted to complain about the delay in receiving treatment, which the complainant believed had contributed to his wife's death.*
>
> *Despite these concerns, it was agreed that an Independent Professional Review was the best way forward. The IPR was duly held but when the complainant received the report, he was unsatisfied and felt that he had been unfairly treated.*
>
> *The complaint was complicated and covered a number of discrete areas (waiting times, the consultant, administrative errors, catering issues and concerns about the quality of nursing), although when the complainant tried to appeal he was, of course, told that the IPR process was out of the Ombudsman's jurisdiction and the Regional Medical Officer made it quite clear that this was the final port of call." (North Tyneside CHC)*

2.13 In practice, both clinical and non-clinical issues often appear together in even relatively simple complaints and the two are often inextricably linked. An example of this quoted by the General Medical Services Committee of the BMA[5] can be found in a common complaint made against General Practitioners about their failure to visit a patient at home: how does one separate the element of clinical judgement made by a GP and his or her contractual obligation? This distinction is, of course, largely irrelevant to the complainant until he or she discovers that it affects the manner in which the complaint is dealt and, possibly, its chance of yielding a satisfactory outcome.

2.14 We would welcome a system which did not rely so heavily on this distinction but, rather, focussed on the addressing the specific concerns raised by the complainant.

THE CONSUMER VIEW

Achieving the Correct Perspective

3.1 When attempting to analyse any consumer complaints system, it is important first to look at what the consumers want and expect of their service. It is even more important to know the prime concerns of those who believe there to be something at fault with that service.

3.2 Individual patients' general expectations of the NHS vary tremendously. However, it is the experience of ACHCEW[6] that, when some aspect of an individual's care or treatment is perceived to be unsatisfactory, the five major concerns of that person are to know:

* what happened;
* why it happened;
* whether anyone is to blame;
* if so, what action will be taken against that person/institution;
* what action is going to be taken within the system to try to ensure that it does not happen again.

The Single Front Door

3.3 No one with anything more than a passing experience of it would deny that the complaints system is complex. To some extent, this is inevitable when dealing with more serious grievances - particularly considering the range of services the system must cover. One of the main problems with the complexities of the current system that can and should be avoided, is that it appears confusing, and therefore inaccessible, to patients.

3.4 In some instances, these complexities (particularly the increasing separation of individual responsibilities brought about by the recent reforms) and the lack of a single coherent structure mean that even those patients who overcome the initial confusion still cannot gain access to the system:

> *"A lady had moved around the country with her husband for work reasons. Throughout the time she was receiving infertility treatment. She finally discovered four regions later that at some point she had a fallopian tube removed during one of the investigative operations. It was quite impossible unless she wanted to start four clinical reviews to find out at which hospital this had happened. No one region was willing to take responsibility.*
>
> *In the end she sued as that was the only way to get all the records together to find out which hospital was responsible." (Ealing CHC)*

3.5 Although there may be, in reality, a multitude of individuals who can legitimately advise and act as a contact for complainants, in order to avoid this confusing image, there needs to be one simple and obvious point of entry which can be used by all patients irrespective of their complaint.

3.6 To some extent, as long as patients perceive there to be a single point of entry, it becomes less important that there is more than one fixed procedure for dealing with complaints. It is, however, important that each procedure relies on similar rules and conventions - the various time limits discussed in 7.1.1 are an example of how different conventions can make the system confusing.

A model system

3.7 There have been many attempts to define the requirements of a "model" complaints system which would be suitable to all concerned. Some of these models have been developed and offered as an alternative package to the current arrangements and most have been based upon the assumption that the health service has the possibility of starting again "from scratch". We believe that, in order to truly satisfy patient needs, the health service must do just this: to start planning a complaints (or "patient satisfaction") system as if starting with a blank sheet of paper.

3.8 ACHCEW looked at the requirements of such a system[7] based on the prime concerns of the patient as stated above. Our proposals calling for an independent Health Standards Inspectorate have been widely circulated, and copies have already been made available to all members of the Complaints Review Team).

3.9 This proposal was based on a considerable amount of research looking into the needs of health service users. In 1988, delegates at an ACHCEW conference looking at NHS complaints[8] considered how a set of criteria originally devised by the National Consumer Council could be developed to determine the major requirements of procedures in the NHS. These criteria were further considered in an ACHCEW publication two years later,[6] in relation to the system presently in place:

VISIBILITY: Complaints mechanisms must be publicised both within health care units and within the wider community if potential complainants are to know that the systems exist. Current procedures are extremely poorly advertised and users are not encouraged to raise their grievances.

ACCESSIBILITY: Those with a grievance should be able to lodge it with someone in authority with minimum difficulty. The current NHS procedures are not only extremely complex but are also fragmented. Different procedures apply to different professional staff depending on where they work and the nature of the complaint. These procedures are administered by different bodies which do not appear to be able to co-ordinate action when a complaint raises more than one issue.

SPEED: A speedy resolution to complaints is in the interests of not only the complainant but also those against whom the complaint is made. However, it can often take many months or even years to process. The satisfactory resolution of a complaint is, for many people, part of the healing process which follows a traumatic or upsetting incident. If this procedure is protracted, it is more difficult for complainants to begin to recover from their experience.

IMPARTIALITY: It is the view of many who have been through them that

the existing complaints procedures are beholden to the medical profession. Serious allegations are investigated and judged by other medical professionals, often by those working in close proximity with those against whom the complaint has been made. Many patients or carers feel inhibited about complaining because of a fear of retribution from those who will continue to provide care.

EFFECTIVENESS: The outcomes of the different complaint procedures are unclear and often unsatisfactory. Most complainants are looking for an explanation, an apology where appropriate and a reassurance that a similar incident will not happen again. Few seek compensation, although many are driven to seeking justice in the civil courts by the unsatisfactory nature of the procedures. Complainants rarely receive a full explanation of what went wrong, apologies are often cursory and phrased in bureaucratic jargon and little indication is given as to what changes or improvements have been made following the complaint.

3.10 The Health Standards Inspectorate complaints system was based on these major requirements which were themselves, the result of assessing the true needs of patients (as identified by CHCs). It stressed that these concerns were inextricably linked and could not be dealt with satisfactorily in a piecemeal fashion ie that the existing procedures would have to be entirely replaced.

3.11 The principle advantage of such a system lies in its truly independent status and because of this ACHCEW proposed it as an effective way of satisfying patient needs. At the same time, we do not underestimate the scale of the proposals and realise that it may be some time before they can be adequately implemented. It is essential, in the meantime, that existing complaints arrangements are - and are seen to be - impartial, and that the option is available at an early stage for dissatisfied complainants to seek help from an external body.

3.12 We remain committed to the need for fundamental change and believe that *any* alterations should be aimed in the direction of the following principles for a consumer oriented system:

* straightforward one door access
* improved publicity and communication
* speedy procedures with firmly fixed response times
* impartiality and lay input
* the right to appeal irrespective of type of complaint
* positive use of complaints in monitoring quality
* transparent, simplified procedures
* full explanation of all outcomes to complainants

3.13 It is for the reasons above that we are submitting additional detailed comments which relate specifically to the current procedures and how they may be improved.

COMPLAINTS ABOUT HOSPITALS AND OTHER PROVIDER UNITS

4.1 ADMINISTRATIVE COMPLAINTS

4.1.1 Although we welcome the designation of a Complaints Officer for each hospital (and similar arrangements for Community Health Services) we remain concerned at the clear lack of independence inherent in a system which relies on this Officer to investigate all non-clinical complaints. In the words of one CHC:

> *"There is a fundamental contradiction between NHS management themselves investigating complaints and the need for a complaints system to be seen as impartial" (Salford CHC)*

4.1.2 Not only is the Complaints Officer employed by (and therefore ultimately answerable to) the provider unit, he or she can be placed in the difficult, and possibly compromising situation, of having to investigate complaints made about more senior members of staff.

4.1.3 We believe that a named *senior* member of staff should take *overall responsibility* for the handling of complaints. The term *overall responsibility* needs to be defined as including direct involvement with individual complaints and close supervision of both staff and procedures on a day-to-day basis. Seniority is an essential requirement but it should also be stressed that, whilst it is welcomed, direct accountability to the Chief Executive or General Manager does not, in itself, imply seniority.

4.1.4 The operational responsibility for complaints work should be the responsibility of staff from a "Quality Assurance" background and should be fully aware of the positive role complaints can play in achieving a quality service.

4.1.5 The possible use of conciliation is as important in relation to provider unit complaints as it is in relation to FHS complaints (see 5.1) and it is equally important that the designated complaints officer should have a background in counselling or at least receive proper training once in post.

4.2 COMPLAINTS ABOUT CLINICAL ISSUES

4.2.1 As with the administrative procedures, the three-stage clinical arrangements suffer from a lack of independence - particularly the third and final stage (after this, there is no right of referral to the Ombudsman) which, despite its title of Independent Professional Review, is a far cry from a truly independent process.

4.2.2 From the first stage, a patient whose complaint relates to clinical judgement often faces a traumatic experience. The designated Complaints Officer will usually arrange a meeting between the complainant and respondent (usually a consultant) in order that the opportunity is provided for a full explanation to be given about any treatment or decisions. This can be a daunting first step for many complainants and its success often relies on the expertise of the Complaints Officer

4.2.3 The second stage currently involves an examination of the complaint by the Regional Medical Officer in order to decide whether it is appropriate to proceed to the final stage. Commissioning bodies *and CHCs* should have the power to request the use of an independent review - where this is not already planned by the Regional Medical Officer - if they have reasonable cause to do so.

The Independent Professional Review

4.2.4 The Independent Professional Review is, essentially, an assessment by peer review of a consultant's clinical judgement. It does not involve lay participation and the final decision is not subject to any form of appeal (the Ombudsman can only look into failings relating to the way in which the system was administered, such as excessive and unnecessary delays). It was described by one CHC as an excellent idea whose operation is deeply flawed:

> *"A group of patients, upwards of 23 in all, who felt themselves 'victims' of one consultant formed a self-help group one of whose objectives was to stop this consultant practising. After many months on 'extended leave' he was allowed to take early retirement.*
>
> *During this period the Independent Professional Review procedure was invoked whereby the Regional Medical Officer arranged for two eminent consultants from elsewhere to examine the work of their colleague. It was only after meeting the CHC Chief Officer that the two made the concession to see anyone in addition to interviewing the consultant concerned and examining the consultant's case notes...As the major evidence examined in this IPR was the consultant's own notes it is not wholly surprising that the colleagues found the consultant competent. (Oxfordshire CHC)"*

4.2.5 Complaints procedures in most other professions (eg Law, Accountancy) ensure that there is adequate lay input when the professional behaviour of members is under investigation. Concerns were expressed at this failing of the IPR system at the Associations' last AGM and a Resolution was passed[9] which:

> *"Calls upon the Department of Health to make the necessary legislative changes to ensure that an independent Lay Assessor is part of the assessment team ie two professional consultants and one Lay person."*

4.2.6 Complainants should be entitled to the emotional support of a relative or friend *and* the professional support of a CHC officer at each stage of their complaint, including the Independent Professional Review.

4.2.7 Complainants should be entitled to a *full* report following the outcome of the Review and an explanation of any aspect about which they may be confused. The complainant's GP should only be informed of the outcome with the complainant's express consent.

4.2.8 Greater efforts need to be made to ensure that, following any recommendations made as a result of an Independent Professional Review, any required action is taken by the relevant Health Authority or Trust.

COMPLAINTS ABOUT FAMILY PRACTITIONERS

"Service Committee proceedings do not exist to remedy patients' personal grievances but to settle disputes about whether or not practitioners have fulfilled the terms of their contracts" (extract from first page of: "Notes on Service Committee Procedures").

"Patients see the (FHS) process as remedying the wrong done to them. Most are amazed to find that it is effectively a contract monitoring procedure for the FHSA involved. A number have great difficulty in understanding what is happening and are very aggrieved when they realise the limited powers the FHSA has if a practitioner is found in breach of his contract." (Ealing CHC)

5.1 INFORMAL FHS ARRANGEMENTS

5.1.1 There are clear benefits in establishing an effective informal procedure to resolve disputes at an early stage and avoid the unnecessary bureaucracy and delays associated with a formal enquiry. We believe such a system should be operated wherever possible as long as there is a reasonable chance that it will satisfy the complainant and address any concerns which have been raised; in the past, informal procedures have been particularly appropriate in dealing with breakdowns in patient/practitioner communication and complaints about staff attitude or conduct.

5.1.2 The success of the procedure depends largely on the expertise and experience of the lay conciliator whose job it is to resolve amicably any dispute between the complainant and the practitioner. Many CHCs are concerned that so few lay conciliators are trained specifically for this important role.

5.1.3 Operation of the informal procedure varies across the country. A common failing seems to be that its outcomes are often vague and unclear and there is no guarantee that issues raised will be satisfactorily resolved or that action will be taken to ensure future improvements.

5.1.4 We recommend that emphasis should be placed on the informal procedure as an opportunity to satisfy a complainant's concerns without delay. However, conciliation needs to be conducted within a framework of training and standards and those involved in the process should have experience (or receive training) in counselling.

5.1.5 The term "informal" can be misleading to patients whose complaints, although serious, would be most appropriately dealt with through this procedure. Where practice-based procedures are seen to work, patients are more likely to use this as a truly informal first stage in the complaints system.

5.2 FORMAL FHS ARRANGEMENTS

5.2.1 There is little doubt that the Service Committee procedure is seen by many complainants as both unwieldy and beholden to the medical profession - CHC experience shows that it is perceived by some simply as a mechanism

for protecting practitioners. It is essential that certain fundamental imbalances in the procedure must be corrected if it is to be seen to be fair to complainants.

5.2.2 We would welcome a move away from the adversarial nature of the Service Committee hearing which places the onus on the complainant to "prove the case" against the respondent(s). This can lead to *both* parties taking unnecessarily extreme stances in order to prove a point and can result in an intimidating environment, particularly for the complainant who usually has limited knowledge of the system and may also be emotionally distressed whilst the hearing is taking place. The adversarial nature of hearings can also present difficulties to CHC staff who, after presenting a case in opposition to a local practitioner, must try to retain positive links with that practitioner and his/her colleagues.

5.2.3 Practitioners are usually accompanied by a representative of the Local Medical Committee who is likely to be more experienced than a CHC member of staff (if present) who will receive little, if any, formal training in the role of a patient representative/friend at formal FHSA hearings. CHC Officers have expressed concern not only at the inequity of access to *legal* advice between complainant and respondent but also to the difficulties in obtaining independent *clinical* advice, without which a case can be substantially weakened.

5.2.4 An observer should be permitted to attend a Service Committee hearing if he or she is a close relative or friend of the complainant on the grounds that the complainant should be entitled to emotional, as well as professional, support.

The Operation of Service Committees

5.2.5 There needs to be greater consistency between Service Committee decisions and the local interpretation of the Committee's role, which can vary tremendously:

> *"A lady wished to make a complaint relating to the care of her late husband. It was a complicated complaint which rested largely on problems caused by the fact that the complainant lived on the border between two FHSAs. The GP who was involved was employed by both FHSAs to work with patients from that area.*
>
> *The lady first contacted the CHC which covered the area where the GP surgery was based and after discussions with the FHSA, it turned out that little could be done for her as many of the issues within the complaint were out-of-time.*
>
> *She then transferred to her local CHC where another FHSA is considering at least three of the six elements of the complaint at a Service Committee hearing." (North Tyneside CHC)*

This type of inconsistency and misinterpretation of Regulations can lead to even greater problems when it causes delays and complainants, through no fault of their own, find they have exceeded the overly-restrictive time limits which exist for formal complaints:

An elderly woman with Alzheimer's Disease was suddenly given written notification by her GP of his intention to strike her off his patient list after 20 years. The FHSA refused to accept a complaint relating to this incident on the grounds that the woman's son had actually made the complaint and that therefore there was no patient/doctor relationship. The fact that the woman was incapable of making a complaint in her own right and that the son had enduring Power of Attorney via the Court of Protection was rejected as sufficient grounds by the Chairman of the Medical Services Committee.

The son was advised by the FHSA to make a complaint, if he wished, to the GMC who also initially refused to take up the complaint. Subsequently, the GMC admitted that their decision was, by their rules, wrong. The FHSA also subsequently admitted that their view of the acceptability of the complaint was wrong but since more than 13 weeks had passed since they rejected the original complaint they claimed that there could be no Medical Services Committee hearing relating to this matter.

Finally, because there had been no hearing, the FHSA Appeals Unit refused to look into the matter." (Cornwall CHC)

5.2.6 The overall effectiveness of a Committee can vary depending on the Chair's ability to recognise a breach of contract, his/her skill in questioning, or the experience of individual Service Committee members. For this reason, we recommend that formal training should be developed which stresses the need for consistent treatment of all cases. Formal training should also be made available to CHC staff to enable them to provide an equivalent service to complainants as that which is currently available to medical practitioners.

5.2.7 Service Committees are not currently permitted to consider complaints unless they are specifically related to the practitioner's terms of service. This means in practice that if problems relating to rudeness or the attitude of a practitioner cannot be dealt with informally, patients have no effective means of recourse available:

"Attitudes of GPs towards patients is often brusque, uninformative, dismissive or jocular. [The FHSA] does try to have a quiet word with 'persistent offenders' but there is little that can be done, unless people believe they have been put at risk. It is time that GPs were made to realise that their patients are human beings with fears, beliefs and intelligence and should be treated accordingly.

Complaints about GPs manners vary from straightforward rudeness to downright offensiveness. We try to get [the FHSA] to set up informal hearings...but the outcome is never really satisfactory because a GP's manner does not form part of his terms of service. (Extract from ACHCEW's 1988/89 Annual Report)"

In addition to Service Committees broadening their remit, we would welcome any further involvement of the various professional bodies in dealing with these problems, or discussions about extending the Primary Care Charter and building it explicitly into the terms of service of practitioners.

5.2.8 Unacceptable delays are commonly caused by difficulties in arranging regular Service Committee hearings:

> *"For the past 12 months, a situation has existed in Buckinghamshire whereby dental service complaints have not been heard because the Local Dental Committee has refused to nominate the required professional members in accordance with the regulations, because of the dispute with the Government over fees. Happily, because of the pressure and publicity generated by the three CHCs the Local Dental Committee has now agreed to resume taking part in hearings.*
>
> *Whilst this situation has been resolved, it remains, that for whatever reason, the Local Professional Committees can delay proceedings by withdrawing co-operation and preventing the rights of patients to have their complaints heard." (Aylesbury Vale CHC)*
>
> *"[The CHC has] concerns about the unacceptable waiting times for people who are pursuing a complaint against their GP through the FHSA procedure.*
>
> *The reason for the delay seems to be that the Local Medical Committee is unwilling to have its members participate in Medical Services Committee Hearings more than once a month.*
>
> *The FHSA currently has hearings booked until September this year [this refers to the situation in May] and a further 14 people are awaiting a hearing after that date. At the current rate of one hearing a month , it would be November 1994 before the current waiting list is cleared and 1995 before complaints currently under investigation could go to a hearing.*
>
> *I understand that the FHSA would convene two hearings a month if medical members were forthcoming. This would not only help them to comply with local charter standards but also avoid repeating the situation that occurred last week, when all parties at a Medical Services Committee Hearing had great difficulty in recalling events that had taken place some 26 months previously." (Manchester North CHC)*

These problems need to be addressed before any formal system can have the chance of meeting the needs of both patients and professionals. We recommend that the current Regulations are amended accordingly and that greater efforts are made to ensure that they are complied with. The general problem of delays within the complaints system is discussed more fully in Section 7 of this report.

5.2.9 It needs to be made quite clear that those respondents who fail to attend a Service Committee hearing should have no defence where their absence leads to difficulties in obtaining factual information relating to the incident in question.

PUBLICITY & INFORMATION

"The public need to be aware, not only how to complain, but also how to make comments and suggestions to improve the services in the knowledge that their views will be recorded and taken into account. It is essential that clear details are widely available of how to make a complaint, what can be expected and what action will be taken as a result of the complaint being upheld." (Stockport CHC)

6.1 There needs to be increased emphasis on publicity about NHS complaints, in a form which is easily understood by all members of the public. This should focus on:

* the patient's right to make a complaint should the need arise;
* clear guidance on how, why and where to do so;
* where to go for further advice about complaints;
* the importance of making an early representation about unsatisfactory treatment/care.

6.2 For several years, it has been the experience of CHCs that few health authorities are meeting fully their obligations under the Hospital Complaints Act 1985 (and subsequent guidance[10]) to publicise their complaints procedures. Instead of producing specific information such as leaflets on how to complain, many health authorities rely on the standard inpatient information leaflets. This means that not only is the information less accessible but also that many patients, such as those using outpatients and Accident & Emergency services, do not receive this important information.

6.3 This lack of awareness is not only limited to hospital-based care: A Survey by the Royal Institute for Public Administration and Social Community Planning Research showed that two thirds of the people registered with a GP said that they would not know how to make a complaint and of recent users of hospital services, only 5% claimed to have been given any information on how to complain.[11]

6.4 Clarification is required as to who is to take the lead responsibility for the provision and distribution of up-to-date information on complaints; ensuring that all publicity information is regularly reviewed and removing out-dated leaflets etc from circulation. We recommend that the Department of Health should issue further guidance on this issue, in consultation with (among others) CHCs and other patient representative bodies.

6.5 All publicity and information relating to NHS complaints should be presented in a 'user-friendly' format and should not exclude those people whose first language is not English, those who are illiterate, people who have physical, sensory or learning disabilities or people with mental health difficulties.

6.6 A speedy, if not immediate, acknowledgement should be provided in all situations where a patient makes a complaint. It is not, however, sufficient to assume that once an acknowledgement has been made that further

information does not have to be made available as the complaint progresses:

> *"One patient had occasion to complain about hospital care received by his wife and kept getting letters of acknowledgement. Eventually I phoned the manager involved and left a message with a secretary saying that the carer wanted a reply. The office was phoned in my absence by an intemperate manager on a mobile phone demanding what business it was of ours to stick our noses into the complaint." (Ealing CHC)*

(The content of complaint response letters is discussed in the section on quality assurance.)

THE TIME ALLOWED FOR COMPLAINTS

7.1 TIME LIMITS

7.1.1 The various time limits applied to different types of NHS complaints are an example of unnecessary complications which have resulted from uncoordinated developments in different parts of the system: if your complaint relates to the alleged breach of a practitioner's contract, you have **13 weeks** from the time of the incident (**8 weeks** before 1990) unless the practitioner is a dentist, in which case you have **6 months** from the end of the treatment which caused the complaint or **13 weeks**, not from the time of the incident but from when the cause of the complaint came to your notice; you may complain about hospital care without fear of being ruled "out-of-time" (although guidance expects complaints to be made within **3 months** of the incident giving rise to the complaint) but you should remember that, should you be unsatisfied with the manner in which your complaint is handled by administrative staff, the Ombudsman will only normally consider your case within **one year** of the date on which the matter first came to your notice. It is little wonder that not only patients but also staff have become confused about time limits.

7.1.2 Whereas unnecessary delays can have the effect of making the complaints procedure **ineffective**, time limits can have the effect of making the procedure **inaccessible** to many complainants. Where patients have suffered an emotional trauma through, for example, a recent bereavement or personal problem, they may not be in a position to logically consider their next step without first dealing with their own immediate concerns or grief. While they are doing this, most patients are unaware of the detailed requirements of making a complaint:

> *"The main problem is that despite efforts to publicise them, most people will not be aware of time limits until they actually want to complain, when they may already be out of time. Our experience of non-FHSA complaints is that they work satisfactorily even if out of time". (Winchester & Central Hampshire CHC)*

7.1.3 The current time limit of 13 weeks for FHS complaints is often seen as a particularly unnecessary hurdle for patients, preventing ease of access for, amongst others, those overcoming emotional traumas which may have arisen from the circumstances of the complaint. Even the comparatively generous time limits allowed for dental complaints can prevent seemingly legitimate concerns from being investigated:

> *"A dental patient was unhappy with four crowns fitted in 1991 but accepted the dentists assurances. Ill health, leading to surgery, and the trauma of her experience with the dentist meant she put off further dental check-ups. In 1992 she began to suffer severe discomfort in her jaw and her GP diagnosed a dental problem. She saw a different dentist ... who informed her that the problems were entirely due to the ill-fitting crowns supplied previously. Only then did she realise her earlier concerns were justified and she had legitimate grounds for complaint.*
>
> *The FHSA received the complaint within 13 weeks of the grounds becoming known but did not accept a reasonable cause for delay and refused to investigate. This was upheld by the FHS Appeal Unit in 1993. In all this time, the lady was advised against remedial work in case a hearing was held and examination of the dentist's work required ... The*

*complaint raises the question of what **would** be accepted for a late complaint - ill health and fear of dentistry are obviously not enough." (Clwyd South CHC)*

7.1.4 The hospital complaints procedure does not rely on these time limits and there is no reason to believe that improvements would result were it to do so. Furthermore, it could be argued that such a restrictive time limit negates the Patient's Charter right for patients *"to have any complaint about NHS services investigated"*.

7.1.5 We agree it is in the best interests of everyone that complaints are dealt with when and where they arise, or at least at the earliest possible opportunity. We would like to see a system where patients are encouraged to complain as soon as they become aware of cause to do so, where most complaints are dealt with as soon as possible but at the same time, a system which does not discourage those with genuine concerns who may be late in making a complaint through no fault of their own.

7.1.6 Improvements could therefore be made by making patients more aware of the need for early complaints, stressing that they should be made straight away to ensure they have the desired effect, and publicity should state that this should be not more than some set period after the complainant first became aware of the matter. Complaints made after this date would not be automatically ruled 'out-of-time' but would require the complainant to explain the delay.

7.1.7 If any enforceable time limit is to be applied, it should certainly start from the time a complainant becomes aware of a problem rather than from the actual event giving rise to that problem. Furthermore, rigid enforcement of deadlines and 'blocking' of 'out-of-time' complaints by practitioners are clearly detrimental to the spirit of looking at complaints in a positive manner and would have to be prevented if the system was to be acceptable to patients.

7.1.8 It is in the nature of complaints that several different events over a course of time will all contribute towards a patient's dissatisfaction until a final precipitating point is reached and the complaint is made. It is therefore important that all contributory factors should be admissible as background evidence to a complaint even if, individually, they would have been considered 'out-of-time'.

7.2 DELAYS

7.2.1 In relation to NHS complaints, justice delayed is justice denied.

7.2.2 As previously discussed, it is clearly in the interests of all concerned that problems should be resolved without delay if at all possible. CHCs have reported that some complainants are discouraged from making complaints at all simply because of the reputation the system has for long delays. Needless to say, this further serves to limit the access of patients to the system.

7.2.3 Delaying a complaint almost invariably leads to a worsening of the overall situation. It can lead to dissatisfaction which affects both the complainant and respondent. It makes the facts more difficult to ascertain as memories fade and can restrict the possibility of further action (such as appeals or legal claims), which usually disadvantages the complainant. It also breaks down constructive approaches to resolving the complaint and can lead to suspicion about why the delays are occurring:

> *"The widow of an elderly gentleman who had died asked to meet the two consultants responsible for his care, in order that she could hear from them a description of the particular health problems and related matters which had eventually led to the death of her husband. The lady made it very clear that she was not concerned about the quality of clinical care but that, simply as part of the grieving process, she wanted a better understanding of what had happened. The hospital concerned took eight months to arrange a meeting and then with only one of the consultants. The widow understandably became irritated by the hospital's failure to make the necessary arrangements and the family began to suspect (unnecessarily) that the hospital had something to hide. The meeting with the second consultant will now not take place until ten months after the original request." (Cornwall CHC)*

> *"A man had difficulty with an orthopaedic operation. He complained with little result so applied to the region for a clinical review. After great dilatoriness this was agreed.*
>
> *To his amazement two months later he received a letter telling him that he should pursue the matter with the hospital and that a clinical review would not be undertaken." (Ealing CHC)*

Standard Response Timescales

7.2.4 Complaints must be a priority concern and mandatory, centrally-set response timescales should reflect this with regard to all complaints:

* an acknowledgement should be made immediately (ie within 24 hours)

* following investigation, a detailed reply and full explanation should be provided within 20 working days.

* if the complaint remains unresolved and a further inquiry is necessary, this should be conducted as soon as practically possible and, in any event, within a maximum period of three months.

* timescales for dealing with complaints should apply nationally and arrangements made for the *actual* response times to be published locally.

Delays in the Appeals System

7.2.5 There has been a certain amount of recent media coverage relating to GP concerns about delays in the complaints system and the possible effect of this on GP respondents who may be "under the shadow" of the impending verdict for several years. Whilst we appreciate this genuine problem faced by the medical profession as a result of delays, we are equally concerned that doctors accused of serious misconduct are still permitted to practise, sometimes for a matter of years, whilst an appeal is conducted. The recent case of a GP eventually removed from the NHS register highlights the

problems:

"The GP joined the local Health Centre on 1 September 1990. The FHSA received the first complaint a month later. Three cases of complaints by women patients concerning medical examination were brought before the Medical Service Committee in June 1991, and it was found in each case that the doctor had breached his Terms of Service.

The case was referred to an NHS Tribunal, but the FHSA had no power to suspend the doctor while further investigations took place. The case came before the Tribunal in July 1992 and a decision was issued in October 1992. The Tribunal found that the doctor should not practise as an NHS GP. The doctor appealed to the Secretary of State and as a result of [making] this appeal, could have continued practising as a GP. The doctor was eventually removed from the NHS Register on August 16 1993." (Lambeth CHC)

(Further implications of this case are discussed under the section on "The Right To Appeal")

7.2.6 Further efforts also need to be made to reduce the length of time of investigations conducted by the Health Service Commissioner's Office. Clearly, reductions in time should only be made where they will not adversely affect the thoroughness or level of detail of the investigation.

7.2.7 We are aware that the average length of time taken to complete investigations by the Ombudsman has already fallen. This trend should be maintained if at all possible all clients should receive notification of:

* the length of time their complaint is likely to take;

* the reason each complaint takes so long;

* the fact that efforts are being made to speed up the process.

Clients are then generally more willing to accept delays if it means that their complaint is investigated thoroughly and in sufficient detail.

7.2.8 Moreover, the Health Service Commissioner's office should inform complainants in writing every two months, of the progress made with their complaint. Many individuals feel isolated and forgotten if they are not kept in touch with the progress of their complaint; this can, in turn, lead to greater dissatisfaction.

THE RIGHT TO APPEAL

8.1 The NHSME recently reiterated[12] that Regulations should give any party to an investigation the right of appeal against ***any decision*** that was adverse to him or her. This, it was stated, reflects the Department of Health's long standing policy.

8.2 We believe the principle that all complainants should have a right of appeal to an independent body must be central to the NHS complaints system. It is regrettable that, in practice, so many patients with legitimate claims of unfair treatment are prevented from gaining access to any appeals system and are forced to consider legal action or more commonly, due to lack of funds, to giving up in exasperation.

8.3 By and large, where appeals systems are accessible and not subject to unreasonable delays, they are considered to operate well by many patients. We have received a large number of positive comments, particularly about the thoroughness of the Health Service Commissioner. Problems, however, do still occur:

8.4 THE APPEAL FUNCTION OF THE HEALTH SERVICE COMMISSIONER (OMBUDSMAN)

The Need for a Broader Remit

8.4.1 Under the Patient's Charter, all patients have the right *"to have any complaint about NHS services - whoever provides them - investigated and to receive a full and prompt written reply."* The Charter goes on to tell patients: *"If you are still unhappy with the way your complaint about the administration of an NHS service has been handled, you have the right to take the matter up with the Health Service Commissioner."* Nowhere in the Charter is it explained to patients that in a large number of cases, they will not qualify for this right because their complaint is concerned with areas beyond the "administration" of NHS services.

8.4.2 To patients who believe they have not been dealt with fairly, the category into which their complaint falls is largely immaterial; to many the distinction appears incomprehensible. The fact that certain types of complaints cannot be referred to the Ombudsman adds further confusion to an already over-complex system and unjustifiably deprives patients of the right to appeal. CHCs regularly receive complaints resulting from these difficulties:

> *"I have assisted two complainants in recent months who have felt that the Ombudsman's inability to assist them further was proof of an over-narrow remit or an over-narrow interpretation by the Ombudsman of his remit." (Preston CHC)*

> *"The problems we have experienced are difficulties in getting past the screener. It almost seems like unless all the right boxes are ticked they are rejected." (Basildon & Thurrock CHC)*

8.4.3 We do not suggest that it would be practical for *all* complaints to qualify for referral to the Ombudsman, for example: an issue which could more appropriately be dealt with in the courts should not necessarily qualify.

Nevertheless, there are certain areas which could usefully and practically be included in the Commissioner's remit. These include:

* the administration and impartiality of formal investigations by FHSAs and the competence of Service Committees to perform their required role;

* those clinical decisions which are entwined with existing areas of the Commissioners' remits, and those in which the matter is not one of purely clinical judgement;

* decisions made by the Family Health Services Appeal Unit;

* complaints made about Community Health Councils

(NB With regard to the final point and following discussion at our last AGM,[13] the Association made this recommendation in recognition of the value of comments, complaints and suggestions within the process of improving NHS services, and in the belief that CHCs should be as accountable as possible to the local population which they serve.)

Public Awareness of the Ombudsman's Work

8.4.4 The level of public awareness of the Ombudsman's work is low. Although there have been increases in the number of individuals contacting his office,[14] these are generally attributed to a heightened awareness of patients' rights and of the overall NHS complaints system.

8.4.5 Individuals often only become aware of the Ombudsman when they are informed of his existence by a source such as a CHC or a complaints officer. Those approaching the Ombudsman with the assistance of the CHC at least receive an explanation about the procedures. Individuals making direct approaches are sometimes deterred by what seems to be yet another hurdle placed before them when they may be already distressed, having negotiated their way unsuccessfully through an uncoordinated, over-complex complaints system:

> *"There is almost an interrogation if someone, other than the recognised next of kin wants to place the complaint. For example, a woman cared for her sister-in-law for many years following her brother's death. All three had lived in the same house. There was no other blood relative. The sister-in-law died and a complaint was lodged eventually with the ombudsman. This poor woman and I had to go to great lengths to get them to recognise her as able to make the complaint. By the time she got [past] the first lot of obstructions ... she gave up." [Basildon & Thurrock CHC]*

8.4.6 Complainants are rarely told by the NHS bodies to which they complain, about the role of the Commissioner *during the early stages of their complaint*. Many of these will subsequently 'drop their complaint', possibly as a result of dissatisfaction with the way in which it was being handled, without any knowledge of the Ombudsman.

8.4.7 It is rare for hospitals or other relevant premises to display prominent publicity about the Ombudsman's role:

> *"I am aware of at least one hospital which was advised by the*

Commissioner's office not to place leaflets about the Commissioner on public display and just to hold them for when they were requested". (Salford CHC)

Although we appreciate the difficulties of large numbers of inappropriate referrals from members of the public, we do not believe that this practice of simply 'hiding the Commissioner from view' is an acceptable method of dealing with these difficulties.

8.4.8 We have evidence to suggest that some Health Authorities, NHS Trusts and even CHCs are uncertain about the Ombudsman's exact role, and when it is appropriate to forward complaints. This means that utilisation of the Ombudsman's services varies considerably throughout the country.

8.5 APPEALS ABOUT FHSA SERVICE COMMITTEE DECISIONS

8.5.1 We are concerned at the apparent autonomy and lack of sufficient accountability of the Family Health Appeals Unit. As recommended above, decisions made by the Unit should be brought within the remit of the Health Service Commissioner.

8.5.2 At the same time, the Appeal Unit's powers could usefully be strengthened in certain areas:

"In a recent case which has been handled through this office a complainant lodged a complaint with the FHSA in July 1991, a Service Committee hearing was held in January 1992, the FHSA overturned their report in February 1992, an appeal was lodged by the practitioner in March 1992 and an appeal tribunal organised for September 1992. Ten months later, in July this year a decision was reached by the Secretary of State that she did not have the jurisdiction to consider the doctor's appeal (even though the NHSME had already held a tribunal to do just that).

The letter from the NHSME to the doctor's solicitors stated that "the FHSA should now give consideration to the steps it should take to investigate the complaint."

In other words, even after holding their own tribunal the NHSME wishes to remit a two year old complaint back to the FHSA. From the complainant's perspective, this is a complete shambles of a system... The Regulations should be drafted in such a way that the Appeals Unit itself is empowered to act as the appropriate tier of recourse for a dissatisfied complainant." (Bromley CHC)

Restrictions on the Right of Appeal

8.5.3 ACHCEW has recently expressed concern at the mis-drafting of Regulations[12] which has denied the right of appeal to complainants about Family Health Service contractors where the complaint has been dismissed without reference to a Service Committee. CHCs are placed in the impossible situation due to this oversight, of explaining to complainants that, although they were previously informed by the FHSA that they had a right to appeal,this right has now been withdrawn and they must drop the complaint. We remain concerned that, although the Department of Health is introducing new Regulations for future complainants, no action is to be taken

retrospectively to help those who have had appeal rights refused (or who may have appeal decisions overturned).

8.5.4 Furthermore, there needs to be a right of appeal not only against the dismissal of a complaint without a hearing before a Service Committee, but against the decision itself not to so refer:

> *"Were this point to be accepted, an appeal on such a matter would be dealt with by a simple direction from the FHS Appeals Unit to the FHSA concerned to refer the case to the appropriate Service Committee for a formal investigation and hearing. As matters stand, there is only an appeal against the dismissal of the complaint. If the FHS Appeal Unit decides on an oral hearing, months elapse before this is held. This alternative might save all that time." (Southampton & South West Hampshire CHC)*

Access to Legal Advice

8.5.5 ACHCEW has already expressed concern[15] at the major problem of inequity of access to legal advice at appeals to the Secretary of State from FHSA Service Committees, where practitioners may be supported via their defence organisations and patients are largely denied this legal expertise. This situation is quite clearly inconsistent with the philosophy underpinning the Government's Patient's Charter initiatives.

8.5.6 We believe this situation needs to be reviewed with the aim of providing patients with equality of access to appropriate legal advice at these appeals.

Protection of Patients during Appeals

8.5.7 The recent case already referred to (paragraph 7.2.5) of a GP (now removed from the NHS Register) being permitted to practise for three years whilst complaints of serious misconduct were being investigated and considered by the NHS Tribunal, shows up disturbing inadequacies in the appeals system.

8.5.8 During the considerable length of time generally taken for decisions to be issued by the NHS Tribunal, Regulations do not give FHSAs the necessary powers to suspend a GP under investigation for alleged serious misconduct. We believe that legislation needs to be introduced as a matter of urgency to provide for the suspension of GPs in certain situations where patients may otherwise be at risk.

> *"The incapability of FHSAs and the NHS Tribunal to suspend GPs under gross misconduct allegations surely must be a priority on the Secretary of State's review of NHS complaints" (Lambeth CHC)*

8.5.9 This is even more important with regard to those professionals not working from a fixed address:

> *"The need to take prompt action to remove from patient care any member of staff under investigation for a serious complaint is important. This ought to cover the actions of locum medical staff who may move frequently from place to place and who, at present, may be difficult to trace." (Lancaster CHC)*

COMPLAINTS AND QUALITY ASSURANCE

"The ability of any organisation to deal with complaints about itself is a vital measure of the commitment of its staff to the provision of quality services." ('HealthWatch' - Burnley, Pendle & Rossendale CHC)

The Health Service Perspective

9.1 The NHS, in common with most other bodies which regularly receive complaints, has tended to accept that, although they are inevitable and must be dealt with, they should receive the minimum of attention and publicity - behind closed doors if at all possible. In the past, managers in the health service have sometimes considered there are more important concerns to which they must dedicate increasingly stretched time and resources.

9.2 Complaints are a fact of life in the NHS. A worthwhile complaints system takes up resources but so do the effects of ignoring the complaints. A good system not only deals with problems which arise, it provides information, through monitoring concerns and eliciting patient views, which can have the resultant effect of reducing problems in the future.

9.3 A lack of clear procedures or confusion about their operation can lead to greater and more costly problems for managers (as well as patients) in the long term when complaints are dealt with inappropriately:

"A woman gave blood and consequently suffered problems in her arm causing her to have considerable amounts of time off from her work. She sought help from her GP and the local hospital but there was no improvement in her condition. She was unhappy with the response she received at a donor session six months later and sought the CHC's help. We took up the complaint with the director of the National Blood Transfusion Service (locally) who referred the complaint straight to a solicitor with no "in-house" investigation. From that point, the NBTS has been unhelpful to the CHC, to say the least. The woman has now received a solicitor's letter denying liability for her claim (which she never made) and the report is seemingly at variance with the remarks made to her by the independent medical expert who examined her arm. It would appear that the NBTS has no complaints procedure made known to donors and it is worrying that costly legal advice was taken as a first rather than a last resort." (Clwyd South CHC)

Action Taken Following a Complaint

9.4 Whether the intention exists or not, there is little evidence to suggest that complainants are generally informed of any action taken as a result of their complaints (this is an area into which ACHCEW hopes to look in greater depth, in the near future). The relatively simple step of ensuring patients are kept informed would substantially improve satisfaction levels and bring greater attention to good practice, where this occurs.

The Ombudsman and Quality Assurance

9.5 Many CHCs note that the same type of complaints show up from time-to-time. The Health Service Commissioner has himself noted how often similar complaints and findings are made with regard to different authorities. It

would appear that, not only are patients not informed of outcomes, in many cases Health Authorities and NHS Trusts are not acting upon the findings highlighted in the Ombudsman's six-monthly and annual reports.

9.6 Where the Ombudsman upholds a complaint against a Health Authority or Trust, that body should make arrangements publicly to announce the finding and any action that will subsequently be taken to remedy the problem. An assurance should be given wherever possible to the local population that the problem will not reoccur.

9.7 If the Ombudsman recommends a particular course of action, his recommendations clearly need to be capable of being monitored. Consideration may be given to extending his powers to ensure that certain Health Authorities/Trusts report annually on what action has been taken in response to the original comments, until such a time that the Ombudsman is satisfied. This information would clearly also be of interest to CHCs in relation to their statutory duty of reviewing local health services.

9.8 We understand that the Ombudsman should avoid being prescriptive in suggesting remedies. However, it would be in-keeping with the general philosophy of the Patient's Charter if he were to issue a digest of recommended 'good practices', rather than simply expecting NHS bodies to learn lessons from the Ombudsman's reports in their current format. These 'good practices' could then be developed by the NHSME into standards or incorporated into charters.

Training And Standards

9.9 It is essential that detailed guidance on the operation of any complaints system needs to be issued centrally for those working with and within the NHS who are involved with complaints. Less detailed guidance on the existence of the system should be issued to those working with and within the NHS irrespective of their role.

9.10 It is inevitable that, even relying on well-drafted guidance, local interpretation and therefore local practices will vary. It is due to this that we believe there would be some benefit in extending, as suggested above, the regulatory role of the Ombudsman's office, focusing not only on individual cases but on trends.

9.11 Several CHCs have commented at the lack of standards in the way complaints are handled by FHSAs and designated Complaints Officers. One example of this relates to the drafting of letters of response to complainants, some of which do not contain even the most basic information about the way in which the complaint is being (or has been) dealt with. Another example, from Winchester and Central Hampshire CHC, relates to a badly worded initial letter drafted at a relatively junior level, to which approximately 40% of complainants do not reply. Lack of communication is not only the major cause for complaints, it also exacerbates the situation once the complaint has been made. We believe it is essential for complaints to be dealt with at a senior level from the start.

Persistent Complaints

9.12 One of the most important advantages of utilising complaints data is that persistent problems can be more easily identified and resolved. The information may be particularly useful as a tool in dealing with sensitive situations such as those relating to individual members of staff. This is a common problem area experienced by CHCs:

> *"Over the last three years I have had serious complaints about a specific unit within a hospital and about one specific doctor within the unit.*
>
> *A difficulty is that the doctor involved is a very good surgeon; it is style and interest that is the problem - some cases are well looked after, others abysmally. As a Chief Officer I am limited by libel laws in what I can say publicly. There is a real need for managers to grasp the nettle in areas like this." (Ealing CHC)*

COMPLAINTS IN THE NEW NHS

10.1 The recent major reorganisation of the health service has resulted in a certain amount of ambiguity as to how existing complaints arrangements should be applied.

GP Fundholding Practices

10.2 One particular concern which has been expressed relates to procedures to protect patients of GP Fundholding practices when private arrangements are made with consultants to undertake outpatient services on GP premises:

> *"The problem for understanding for patients and their right to redress was highlighted by a recent complaint where I assisted the patient. The complaint concerned the attitude of a consultant who had seen the patient at (the patient's) GP's surgery. The consultant had walked out leaving the patient without treatment or a consultation.*
>
> *Naturally, a complaint had been made to the local NHS Trust hospital who the patient saw as the consultant's employer. However, the complainant was surprised to receive a reply which denied any responsibility on the part of the Trust for investigating the complaint as the service received had been provided under a contract between the Practice and the consultant personally ie it was a private arrangement and as a result not subject to NHS complaints procedures. I made extensive enquiries locally regarding the right of redress of the complainant, the responsibility for discipline in respect of the consultant, and the position of the GP Fundholding Practice.*
>
> *There seemed to be no written guidance on the procedures to be followed, however I was advised that the North West Regional Health Authority had suggested that GP Fundholding Practices have their own complaints procedures in place to deal with similar situations. It was also confirmed that the consultant was acting in a private capacity and therefore outside NHS complaints procedures. Guidance was subsequently issued to Practices that they should ensure that patients were made aware of their rights under these arrangements" (Rochdale CHC)*

10.3 It is understood that the majority of contracts negotiated by GP Fundholders will be with Health Authorities or Trusts and will be covered by the usual NHS arrangements. However, where a contact is negotiated direct with a consultant, as in the above example, there is a strong possibility that no appropriate complaints procedures exist. Even where procedures are in place, they will still be unsatisfactory in that the maximum penalty that the Fundholding Practice can apply is through the cancellation of the contract.

NHS Trusts

10.4 The advent of NHS Trust status has also led to complications for complainants, often through difficulties in obtaining necessary information in relation to a complaint:

> *"A man wrote to an NHS Trust to express his concern about the confidentiality of medical records. This involved what, in the complainant's opinion, was the quite wrongful transfer of NHS information to a private hospital without the patient's knowledge. The*

response received from the Trust was inadequate. The complainant then asked for a copy of the written guidance used by the Trust and which complainants should follow.

After further letters of enquiry, he was told by the Chief Executive that no such procedure existed and that, if it had, it would not be made available to a member of the public. There was further correspondence, including letters to and from the Chairman of the Trust, none of which took the matter forward but which took over five months to reach a conclusion when the Trust eventually gave the man a copy of the written guidance." (Cornwall CHC)

Complaints Relating to Different Service Areas

10.5 Confusion and delays resulting from an unwillingness of different professionals to take overall responsibility for a complex complaint, are indicative of problems caused by merely 'tinkering' with the current system. Difficulties experienced by patients whose complaint covers different services have been reported time and again by member CHCs. Further consideration needs to be given to these difficulties and also a new range of problems resulting from the delivery of Care in the Community and the operation of many primary health care teams, both of which transcend traditional service boundaries.

10.6 The guiding principle should be that an NHS patient should not be made to suffer hardships due to inferior complaints mechanisms solely on the basis of where the treatment is provided. Complaints arrangements must therefore apply equally and fairly to *all* NHS-initiated care. It is not sufficient for 'similar' or 'comparable' systems to be in place and contracts should make this clear beyond any doubt.

10.7 Where the complaint relates partly to NHS-initiated care and partly to care provided by Social Services, the roles and responsibilities of both agencies must be clearly established from the start and communication should be continued until all required action has been taken. We recommend that the role of the CHC in complaints involving Social Services should be clarified and appropriate guidance issued.

Private Residential and Nursing Homes

10.8 The Association recently expressed concern[16] that Regulations implementing the Registered Homes Act 1984 for private nursing and residential homes made no reference to the provision of a procedure for residents and/or nearest relatives to make complaints about the care and services provided by an establishment, other than regarding matters concerned with a possible breach of the Regulations.

10.9 We believe that, in view of increased expectations by the public and the Government regarding the provision of opportunities to make complaints about services provided, the Regulations should be revised to:

* Extend a person's right to make a complaint, as set out in the Patient's Charter, to cover all residential and nursing homes in the private and public sectors.

* Require registration authorities to set out a model complaints procedure for use by homes within each registration area, including a formal appeal mechanism to be used where complaints cannot be resolved satisfactorily after reasonable discussion with the home.

Ministry of Defence Hospitals

10.10 Standard NHS complaints arrangements should apply to Ministry of Defence hospitals providing treatment to NHS patients rather than the current anomalous Home Office arrangements.

A System to Cover all NHS-initiated Care/Treatment

10.11 We believe in the basic principle that an NHS patient should not be made to suffer hardships due to inferior complaints mechanisms solely on the basis of where the treatment is provided. Complaints arrangements must therefore apply equally and fairly to *all* NHS-initiated care. It is not sufficient for 'similar' or 'comparable' systems to be in place and contracts should make this clear beyond any doubt.

10.12 It should also be made clear beyond any doubt when health-related services are provided outside of the NHS:

"I do feel that complaints about optical services must be clarified. The patient who is getting an NHS sight test and vouchers toward the costs feels that they are within the NHS." (Huntingdon CHC)

Or provided (as with some dental treatment) partly as NHS services and partly as private services.

THE ROLE OF THE COMMUNITY HEALTH COUNCIL

11.1 As previously discussed, CHCs are closely involved with nearly all aspects of NHS complaints work on a day-to-day basis; many CHCs describe this as *the* major part of their workload. A recent report shows that in most CHCs, chief officers spend more than half their time on complaints and that additional complaints work has been carried out at the expense of other activities in many CHCs.

11.2 Ministerial advice[17] has encouraged Councils to play an even more active role: *"to involve themselves in individual casework"*. It has, however, never been identified as a specific statutory role of the CHC.

The Increasing Level of Complaints

11.3 The level of complaints work has risen dramatically in recent years and, due to initiatives such as the Patient's Charter, is set to increase even further. An ACHCEW survey published earlier this year[4] shows that 86% of CHCs have seen an increase in complaints over the last year and that most of these considered it to be substantial.

11.4 A recent survey looking specifically at the Greater London CHCs' involvement in FHS complaints[18] reveals some disturbing statistics about the workload with which CHCs are faced:

> *"Most CHCs have two or three staff. Complaints and related enquiries made up a large part of the workload of CHCs. In most CHCs the Chief Officers spent more than half their time on complaints work ... for other staff, the time tended to be between 30% and 50% on complaints ... In all but three CHCs at least one member of staff spent half or more of the time on complaints.*
>
> *Additional complaints work has been carried out at the expense of other work in many CHCs. Many CHCs are concerned that other aspects of the work ... have lost priority."*

CHCs are experienced in complaints work: their staff are skilled and they are ideally placed to provide assistance. However, without additional resources to carry out this important work, either it will not be able to be continued or other, statutory duties, will have to be neglected. We do not believe these to be reasonable options and call for an urgent reassessment of CHC resourcing.

11.5 Communication arrangements need to be formalised in some areas to ensure that patients are made aware of the existence of the CHC and support that can be offered:

> *"A woman who had to wait over fourteen months for a Medical Service Committee hearing has written: "I was not advised by the FHSA until approximately two weeks before the hearing that there was a professional body (ie the Community Health Council) who could help me to prepare my case against the GP. This information was only given by chance in a telephone conversation with the FHSA and at no time prior*

to this was I advised either orally or in writing to contact (the) CHC. I found this very disturbing as never having made a complaint to the FHSA before I had no knowledge of the procedure or indeed how to prepare my case. By receiving this information when the hearing was imminent obviously did not leave much time to adequately prepare whilst thee respondent, who would have been far more familiar with the procedure than myself, had more than fourteen months to prepare. Fortunately the CHC was extremely helpful and invested a lot of time and effort at very short notice to advise and help me ... I am concerned that it was only by accident that I was pointed in their direction and that without their considerable help and advice with regard to the hearing procedure and preparation of evidence, I would have been at a great disadvantage at the hearing." (Parkside CHC)

Formal Training for CHCs

11.6 As mentioned in 5.2.5, it is important that both complainant and respondent are treated equitably and consistently wherever possible. In order for this principle to be realised, the appropriate formal training and resources must be made available to CHC staff to enable them to provide a similar service as that which is currently afforded to the medical profession.

11.7 We would particularly welcome joint training initiatives with CHCs and NHS staff. However, it is important that this should be initiated by, and have the full support of, management within the relevant NHS body.

THE PROFESSIONAL ASSOCIATIONS

12.1 The importance of attitude should not be overlooked as the initial cause of many disputes. This featured in the recommendations of a detailed analysis[19] conducted by the Yorkshire Regional Association of CHCs:

> *"Rudeness, arrogance, alleged dishonesty and apparent lack of concern are the root of many complaints or the reason for dissatisfaction of some clients at the outcome of investigations ... Unfavourable attitude is a recurrent issue in complaints against members of the medical profession at all levels. The importance of treating patients and staff with courtesy should be stated in professional standards of conduct."*

12.2 The attitude of patients can be improved through the increased and effective use of complaints publicity, as previously discussed. The attitude of health professionals, however, can be affected by their appropriate professional association. We support the principle of moves by the General Medical Council to discipline doctors with a persistently negative attitude but must also reiterate our previously expressed concern at the lack of lay involvement in developing these ideas and in the general functioning of the GMC.

12.3 We would welcome greater general openness and, specifically, a greater proportion of lay members on *all* professional bodies with a responsibility for health care standards.

LEGAL ACTION

13.1 Legal recourse through the civil courts is fraught with problems as far as complainants are concerned. Firstly, it is notoriously difficult to prove that a health professional/body acted negligently in providing care. Secondly, it takes an extremely long time even in comparison to the NHS procedures. Thirdly, it is almost always a traumatic experience, and finally (although probably most importantly) it is an enormous financial gamble for most complainants. In fact, due to the recent changes in eligibility criteria for Legal Aid, the option of litigation has become even less accessible. ACHCEW has previously expressed concern that, due to these changes, some cases that would have previously gone to law are now being channelled through the NHS procedures adding both to the complexity and number of complaints.

13.2 Despite these inherent difficulties, complainants are still forced into legal action; often as a last resort when the NHS procedures have failed to provide a reasonable, or impartial, response:

> *"Often the complainants are forced to pursue a claim of negligence through the courts in order to secure explanations in what is seen as an ultimate step for information. What all major [parties] must realise is that just about all people who have a complaint against the service want explanations and not compensation." (Brecknock & Radnor CHC)*

> *"A number of people who would have been happy to complain and leave matters there, take up litigation because they feel that the complaint system is without teeth." (Ealing CHC)*

13.3 ACHCEW has long recognised the serious difficulties and dangers in seeking financial compensation (or an admission of guilt) through legal proceedings. It was partly in recognition of these difficulties that the case for the Health Standards Inspectorate was originally developed.

13.4 Considering the nature and complexity of the subject, we believe it would be appropriate for the Government to establish a formal review to focus on the whole area of compensation in relation to health care.

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