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COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES

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NATIONAL HEALTH SERVICE

COMPLAINTS PROCEDURES

A REVIEW BY THE

ASSOCIATION OF COMMUNITY HEALTH

COUNCILS FOR ENGLAND AND WALES

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Chapter 1: Introduction

> **"There needs, therefore, to be a simple and well understood mechanism through which people who use the National Health Service can suggest how it can be improved and complain when things go wrong."**
>
> (Royal Commission on the NHS 1979, Para 11.13)

1.1 Community Health Councils since their inception in 1974 have been instrumental in helping users of the National Health Service and their relatives and carers, to get the best possible service from the NHS. This has included advice and information about the availability of local services, campaigning for services tailored to meet the needs of individuals and helping to get the right sort of care for people with special needs. It has also included acting as 'Patients' Friend' - explaining health service procedures and assisting at the interface between health service providers and users.

1.2 This role, which has grown up over time and now occupies a significant part of most CHCs' work, is particularly important when health services' users wish to express some dissatisfaction or grievance with some aspect of the health service they have or have not received. Community Health Councils do not investigate complaints; however, they can assist anyone wishing to make a complaint. This assistance will vary depending on the nature of the complaint but could include listening sympathetically to someone who may be very upset and offering practical advice such as explaining how the different procedures work, advising on the best way forward, helping to construct a written formal complaint, making sure that the complaint is followed up by the appropriate people, and accompanying or even representing complainants at official hearings.

1.3 Helping complainants does not form one of the statutory duties of CHCs and they do not receive any extra resources for undertaking this work. However, most CHCs have recognised the importance of supporting users and their relatives in this way and have built up considerable experience in helping complainants. The experience of fifteen years assisting complainants has also allowed CHCs to reach a judgement on the effectiveness of the various NHS complaints systems in relation to how far they meet the needs of those who use them.

1.4 Formal complaints about NHS services have never numbered more than a tiny fraction of the total number of patient/health service encounters. For example, in 1988, Family Practitioner

Committees investigated 1162 formal complaints about GPs, 436 formal complaints about dentists and 150 formal complaints about other family practitioners. Additionally, hospitals received 29,956 complaints and community services 5,030.

1.5 Nevertheless, 15 years experience of helping complainants has led to CHCs making a number of serious criticisms about the way that the NHS deals with those who are dissatisfied with the service. Not least, it is held that the relatively small number of formal complaints obscures a much greater level of patient discontent which is hidden by a reluctance to criticise the health service. It is also suggested that the small number of complaints is evidence of the reluctance of the NHS to encourage criticism - many users of the health service have no idea how they can complain. Most importantly, the procedures have been criticised for failing to provide satisfaction for complainants and failing to meet their practical, emotional and financial needs.

1.6 CHCs are by no means a lone voice in their criticism of the complaints procedures. Other patients' organisations, such as the Patients' Association, consumer bodies such as the National Consumer Council and the Consumers' Association and independent research bodies such as the Kings' Fund have all, over the years, studied the procedures and found them wanting. Even statutory bodies such as the Council on Tribunals, whose function is to report to Government on the workings of tribunals against the criteria of openness, fairness and impartiality, have urged the Government to "take a fresh and unfettered look at this complaints procedure which we believe is still weighted too greatly in favour of the practitioner". (Council on Tribunals, Annual Report 1988/89)

1.7 In October 1988 the Association of Community Health Councils for England and Wales held a one day conference on complaints procedures. The aim was twofold. Firstly, the current procedures were examined in detail to determine the nature and extent of their inadequacies and secondly, the conference provided a forum for CHCs to exchange information and learn from the experiences of others. A detailed report of that conference was published by ACHCEW in October 1989 and is available. A summary of the conference is attached - see annex i.

1.8 The consensus view which emerged from the conference was that in terms of making complaints and seeking redress, current NHS procedures fail to address adequately the needs of users or their relatives or carers. The processes for airing grievances, investigating complaints and providing explanations when things go wrong are considered by those who use them to be long-winded, cumbersome, bureaucratic and strongly weighted in favour of the medical profession.

1.9 This review re-states the importance of a credible and effective complaints mechanism for the NHS, examines the issues which have led CHCs to reject current procedures as ineffective and proposes a completely new approach to dealing with the complaints of NHS users.

Chapter 2: Why are complaints so important?

(a) Complaints and Individuals:

2.1 When things go seriously wrong in the NHS it is often difficult to repair the damage: an unnecessarily performed operation cannot always be undone, a lost relative can never be replaced. When things do go wrong, it should be the responsibility of providers to ensure that everything possible is done to help individuals overcome their trauma and to meet their emotional, practical and financial needs.

2.2 It is the experience of CHCs that when a patient or relative complains they are usually seeking an **explanation**, an **apology**, a **reassurance that the incident will not be repeated**, and sometimes also **compensation**. Until all these needs have been met satisfactorily, it is unlikely that complainants will begin to forget and perhaps recover from their traumatic experience. It is important for service providers to understand why people complain, if they are going to be able to resolve problems satisfactorily and improve services to prevent recurrence.

(b) Complaints and the nature of health services

2.3 Like other welfare services, health care tends to be monopoly provided. If users are unhappy with the service they receive from their GP, hospital or community unit it is very difficult to change. This is particularly so because health service use tends to be sporadic, related only to episodes of illness. Thus, normal consumer methods of expressing dissatisfaction such as changing to another brand or supplier do not apply. It is, therefore, imperative that services work as effectively as possible. One major way in which health services can remain credible with users is to ensure that grievances - both minor and major - are dealt with in a professional, just and sympathetic manner.

(c) Complaints and the relationship between health care users and providers:

2.4 Since its inception in 1948 the National Health Service has often appeared to be organised for the convenience of the providers, with a paternalistic "professional-knows-best" attitude to users. Doctors, dentists nurses etc **do** things **for** their clients. This is a very unequal relationship in which users are rarely asked to make decisions concerning their own health care, let alone make an input into service planning or design.

2.5 At this time the tremendous impact of universal, comprehensive health care was received so gratefully that the way it was provided was hardly considered. Since then, the attitudes of health care users have changed. Users are no longer happy to be patronised or condescended to by professionals and want to be more

actively involved in the management of their lives. The growing concept of "consumerism" in public services has had much to do with this.

2.6 As yet, providers of services and professionals have done little to acknowledge this shift. As "consumer organisations", CHCs have argued that providers must learn to be receptive to criticism and challenges from users - users have a right to express their views on the way services are provided. Just because a service is free-at-the-point-of-use does not mean that users are not paying for it. NHS users are also financial contributors and have a legitimate right to be involved in discussions relating to their own care and the development of services.

2.7 This is part of a concept of **partnership** in care. Encouraging and responding positively to complaints is one way providers of services can demonstrate that they are genuine about valuing the input of users.

(d) Complaints and providers of care:

2.8 For providers, complaints are a good way of finding out some of the things that are going wrong with the service and some of the things that may be going right. It is widely recognised in manufacturing that every complaint received actually represents substantially more dissatisfaction which has not been articulated. Therefore, each complaint is important in pointing to areas of probable user dissatisfaction with service provision.

Chapter 3: What is wrong with the complaints procedures?

3.1 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. 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. The evidence of CHCs is that few Health Authorities are taking seriously their responsibilities under the Hospital Complaints Procedures Act 1985 to produce publicity material about their complaints procedures.

- see recommendations 5.3, 5.3.1, 5.3.2

3.2 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. Fig.1 lists the range of complaints procedures currently in operation.

Figure 1:

FAMILY PRACTITIONER COMMITTEE (FORMAL)

FAMILY PRACTITIONER COMMITTEE (INFORMAL)

PROFESSIONAL CONDUCT REVIEW*

HOSPITAL: ADMINISTRATIVE REVIEW

HOSPITAL: CLINICAL COMPLAINTS PROCEDURE

HEALTH SERVICES COMMISSIONER (OMBUDSMAN)

CIVIL COURTS

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* The professional bodies set standards of conduct and have the power to discipline practitioners and 'strike them off'. The **General Medical Council** will investigate allegations of Serious Professional Misconduct by Doctors. Similiar functions are undertaken by **United Kingdom Central Council** for nurses, **General Dental Council** for dentists, **General Optical Council** for opticians and **British Pharmaceutical Council** for pharmacists.

3.3 A list of current DoH Health Circulars relating to complaints is attached, see appendix ii. From this it would appear that little attempt has been made in the past to integrate the different complaints mechanisms.

- see recommendations 5.2.5, 5.5, 5.6, 5.7, 5.10, 5.11

3.4 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 is the experience of CHCs that complaints can often take many months to process:

> "There are long delays by both the Health Authority and FPC in handling complaints. It can sometimes take over a year from the first letter to completion of enquiry and at the end the decision is not always acceptable to the complainant." (A CHC quoted in ACHCEW's Annual Report 1987/88)

Making a complaint and having it satisfactorily resolved 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.

- see recommendations 5.3.3, 5.3.4

3.5 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. Complainants encounter difficulty in obtaining access to information relevant to their complaint. In particular, access to medical records is usually withheld unless authorities are ordered to so provide by a Court. Many medical staff view complaints with hostility and are able in some procedures to refuse to co-operate at all. Many patients or carers feel inhibited about complaining because of a fear of retribution from those who will continue to provide care.

- see recommendations 5.4, 5.7

3.6 Effectiveness The outcomes of the different complaints procedures are unclear and often unsatisfactory. Most complainants are looking for an explanation, an apology where appropriate and a reassurance that a similiar incident will not happen again when they complain. 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.

- see recommendations 5.9, 5.10, 5.11

Chapter 4: The failings of existing procedures

4.1 Family Practitioner Committees: Formal Complaints

The scope for improving the complaints procedure of Family Practitioner Committees (FPCs), particularly the Service Committee hearings, was evident 20 years ago.

Council on Tribunals, Annual report 1988/89, Para 1.2

4.1.1 The operation of Family Practitioner Service Committee Hearings are laid down in the NHS (Service Committees & Tribunals) Regulations 1974. The procedure applies to all Family Practitioners: Family Doctors, Dentists, Pharmacists and Opticians working in the NHS and covers allegations made that practitioners have breached their 'terms of service', a type of contract.

4.1.2 Only allegations of breach of contract can be investigated formally by the Family Practitioner Committee. This means that whilst complaints relating to, for example, failure to respond to a request for an out-of-hours visit or failure to refer a patient to an appropriate specialist are covered; complaints relating to a practitioner's attitude are not. Practitioners who are rude, unsympathetic or uncommunicative cannot be investigated:

> "Many of the complaints which this CHC refers to the FPC are over GPs' attitudes and these are particularly difficult to resolve. In one case the widow of a man who has died from Alzheimer's disease felt that the GP had lacked understanding and sympathy. GPs should be reminded more often that they are providing a service to people who are entitled to be treated with understanding, tact and consideration."

> "Dentists are not giving proper estimates before commencing treatment - £100 for a course of NHS treatment may seem cheap to a dentist but it is a lot of money to the patient." (CHCs quoted in ACHCEW Annual reports 1987/88 and 1988/89)

4.1.3 In his remarks to ACHCEW's conference on complaints procedures, Dr David Williams, Chairman of the British Medical Associations Statutes and Regulations Sub-Committee made the following observation of the formal FPC procedure:

> "Once a complaint goes to a formal service committee, the patient is committed to a frustrating emotional marathon from which there rarely emerges any satisfaction, reparation, compensation or tangible contribution to service improvement. The patient meets his first hurdle on the middle of the first page of "Notes on Service Committee Procedures", where the following words are underlined: **"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."" (Our highlighting)

4.1.4 The Service Committee Procedure is perceived by many complainants as a mechanism for protecting practitioners. Its composition, 3 practitioners and 3 lay people, all of whom can question the complainant can often be very intimidating, especially as practitioners are usually accompanied by a representative of the Local Medical Committee. In addition, the Service Committee can only consider specific allegations of breach of contract and specific incidents rather than taking account of a history of bad practice.

4.1.5 Members of Service Committees receive no training and consequentially the effectiveness of Committees varies considerably. Much depends on the Chair's ability to recognise a breach of contract and his/her skill in questioning.

4.1.6 In the past many complainants have had to attend Service Committee Hearings without the support of the Community Health Council. Some FPC Chairmen have prevented CHC Secretaries from acting as Patients' Friend to give support and guidance to complainants. ACHCEW welcomes the Government's commitment in the White Paper "Promoting Better Health" to confirm the right of CHCs to adopt this role. However, CHC staff receive little formal training in the role of patients' friend and their own performance may vary.

4.1.7 Time limits can have the effect of making the complaints procedure inaccessible to many complainants. In April this year, the statutory time limit for receipt of complaints was extended from 8 to 13 weeks (6 months for dentists). This will remove a considerable obstacle to complainants. However, there are many circumstances in which it is unreasonable to expect a complainant to lodge formally a complaint within 13 weeks.

4.1.8 The Service Committee Procedure is often protracted, with complaints taking up to 18 months to reach a Hearing.

4.1.9 Appeals from the findings of a Service Committee Hearing are made to the Secretary of State for Health and both parties can appeal. However, whilst practitioners are likely to be represented at such appeals by barristers employed by the medical defence unions, complainants are not eligible for legal aid and, therefore, must meet the costs of any legal expenses themselves. The appeals panel consists of a legally qualified Chair and two doctors, there is no lay input at the appeals stage at all and complainants are liable to feel very isolated. Delays in the appeals procedure are also unacceptable; it is not uncommon for an appeal to be delayed by eighteen months to two years.

4.2 Family Practitioner Committees: Informal Complaints

4.2.1 To meet criticism that the formal complaints procedure is too adverserial, the Department of Health has instructed all FPCs to establish an informal procedure for resolving disputes. FPCs may also extend the informal procedure to encompass complaints which fall outside of the practitioner's terms of service, such as rudeness, unsympathetic manner or other communication breakdowns. The procedure involves a lay conciliator attempting to resolve amicably any dispute between practitioner and complainant. However, the success of this procedure depends totally on the calibre of the lay conciliator, few of whom have been trained specifically for this role.

4.2.2 To date there has been no central guidance on the operation of the informal procedure and consequently practice procedures vary across the country.

4.2.3 Because of the conciliatory nature of the informal procedure, its outcomes are often vague and unclear. No formal action can be taken against a practitioner in consequence of an informal investigation and there is no guarantee that issues will be satisfactorily resolved.

4.3 Professional Conduct: The General Medical Council

4.3.1 All medical practitioners must be registered if they are to work within the National Health Service. Registration is performed by professional bodies which also set standards of conduct and have the power to discipline practitioners. The ultimate sanction that these bodies possess is the power to remove a practitioner from the register and, therefore, effectively prevent him/her from practising. This function is carried out for doctors by the General Medical Council, for nurses by the United Kingdom Central Council, for dentists by the General Dental Council, for opticians by the General Optical Council and for pharmacists by the British Pharmaceutical Council. In the case of the General Medical Council, a practitioner can only be removed from the register if an allegation of **Serious Professional Misconduct** is proven. Professional Misconduct covers issues such as disregard of responsibility to patients, dishonesty, misuse of drugs, improper emotional or sexual relations with patients, indecency and advertising. However, the GMC will only investigate cases of "serious" professional misconduct and the standard of this may be so high as to preclude investigation of allegations which suggest doctors may be a danger to the public.

4.3.2 It is the Preliminary Screener who decides whether complaints constitute Serious Professional Misconduct and currently a very high number of complaints are rejected at this stage. The Preliminary Screener does not have to give reasons for his decisions, and there is no appeal; since the Preliminary Screener may also be the President of the GMC there is no higher authority. No breakdown is published on the subject or source of

rejected complaints. The proposed addition of a lay screener, as suggested by the GMC, will not remedy these defects.

4.3.3 The GMC is often extremely reluctant to accept complaints directly from the public. Complaints which are received are usually referred back to complainants for investigation by either the FPC or hospital first. There is some concern amongst CHCs that the GMC may inappropriately refer complainants to another route and thereby delay investigation.

4.3.4 The GMC itself is dominated by professionals. Its few lay members do not adequately represent the wider community and include few women or people from minority ethnic communities.

4.4 Hospital Care: Internal Investigations

4.4.1 There is no single statutory procedure for dealing with complaints about the organisation of services in hospitals, although there is general guidance [HM(66)15 and HC(88)37] which Health Authorities are also advised to make applicable to community health services.

4.4.2 The procedures for investigating failures in service lack independence, in that complaints are investigated by those responsible for providing services.

4.4.3 It is the experience of CHCs that few health authorities are meeting fully their obligations under the Hospital Complaints Act 1985 to publicise their complaints procedures. Instead of producing specific leaflets on how to complain, many health authorities are relying on the standard in-patient information leaflets. This means that not only is the information less accessible but also that many patients - those using out-patients and accident and emergency, those admitted via A&E and long stay patients do not receive this important information.

4.5 Hospital Care: Complaints relating to Treatment

4.5.1 The lengthy procedures for investigating complaints relating to the clinical judgement of medical staff are perhaps the most cumbersome and unsatisfactory of all the NHS complaints procedures. The procedures which currently operate were in fact designed by the medical profession to prevent the Health Services Commissioner from taking responsibility for clinical complaints. Their evolution provides a graphic example of the enormous power that the medical profession is able to wield, when it is suggested that those other than doctors should have a role in regulating the profession. A summary of the historical development of these procedures, starting from the Davies Report of 1973, is attached. See appendix iii.

4.5.2 The clinical complaints procedure is entirely voluntary and consultants may refuse to take part in it. This can

effectively prevent any investigation of a complaint.

4.5.3 The first stage of the procedure involves the complainant and the professional complained of meeting to attempt to resolve the problem. For many complainants this can be a very traumatic experience.

4.5.4 The second stage involves the Regional Medical Officer (Medical Officer in Wales), considering whether the complaint warrants investigation at the third stage - the Independent Professional review. Complainants do not have a right to progress to the third stage.

4.5.5 The third stage is not truly independent, rather it is a mechanism whereby a consultant's clinical judgement is assessed by his/her peers. Complainants rarely receive a full report of the consultants' findings or any indication of any management or disciplinary action which might have resulted from the investigation. There is no appeal from decisions made at the third stage.

4.5.6 The guidelines for the operation of the clinical complaints system make it clear that complaints which may develop into legal action are not to be accepted for Independent Professional Review. CHCs have encountered health authorities which try and prevent complainants from suing by asking them to sign a disclaimer before agreeing to process their complaint. Such a disclaimer does not have any legal value but can be extremely intimidating for complainants. It has also been argued by CHCs that some health authorities appear to use the clinical complaints system to prevent those with serious complaints from going to law. There is currently a three year time limit for commencing legal action, if the clinical complaints system progresses very slowly, dissatisfied complainants may be ruled out-of-time for going to Court.

4.6 Health Service Commissioner (Ombudsman)

4.6.1 The Ombudsman can investigate complaints about the way health services are run, including the administration of complaints procedures. This makes the Ombudsman a valuable appeals mechanism for complainants who feel that their grievance has not been dealt with adequately. However, the Ombudsman's powers are severely limited, which means that he cannot investigate matters directly involving medical treatment or clinical judgement. Investigations by the Ombudsman are currently subject to lengthy delays because of inadequate resources; in his last Annual Report the Ombudsman reported delays of 60 weeks.

4.7 Compensation For Medical Accidents/Negligence

4.7.1 The only way to obtain financial compensation for loss, damage or discomfort as the result of medical treatment is to

take legal action in the Civil Courts. To win, a complainant must prove that a consultant or health authority acted negligently in providing care. Negligence is extremely difficult to prove and few solicitors are expert in medical law.

4.7.2 Legal costs tend to be substantial and few people qualify for Legal Aid, making suing an enormous financial gamble for the majority of complainants.

4.7.3 Legal action tends to take a long time and it is not uncommon for cases to take years to settle. Not only does this add to the expense of legal action it is also traumatic for complainants.

4.7.4 The threat of legal action can make medical staff very hostile and this often results in a reluctance to pass on information to complainants. Without full access to all relevant information, complainants and their legal advisors are often in a poor position to judge whether a complaint is valid.

4.7.5 Community Health Councils have long recognised the inadequacies of current legal proceedings for dealing with cases where people have suffered material, physical and emotional loss. In 1987 ACHCEW considered proposals for the introduction of a system of no-fault compensation, which would financially compensate the victims of medical accident without the necessity to prove negligence. A copy of a paper produced at that time is attached. See appendix iv.

Chapter 5: A Users' Model for a Complaints System

> **"Reform of health service complaints procedures is long overdue. We would urge the Government to come forward as a matter of urgency with proposals for reform."**
>
> Managed Competition: A New Approach to Health Care in Britain, King's Fund Institute, 1990

5.1 It is evident from the experience of Community Health Councils and the observation of many other independent and statutory bodies that the existing NHS complaints procedures offer little credibility to users and are complex to use. Set out below, ACHCEW has begun the process of defining a uniform complaints procedure which genuinely puts the needs of users first. This model has been the subject of a year of research and discussion. Appendix v lists those individuals and groups which contributed to the debate or commented on earlier drafts.

5.2 GENERAL STATEMENTS OF PRINCIPLE

5.2.1 The primary aim of any complaints procedure should be the satisfaction of the emotional, practical and financial needs of the complainant.

5.2.2 In addition, any complaints system should be used by Health Authorities and health care staff, as part of a commitment to Quality Assurance, as a means of reviewing the standard of services provided and as an opportunity to improve communications and/or service delivery.

5.2.3 Health services staff should always attempt to resolve complaints or grievances at the earliest opportunity. The role of Community Health Councils in acting as "Patients' Friend", offering independent advice and support to patients and in acting as 'conciliator' or 'broker' should be publicised, to encourage the resolution of complaints at the earliest possible stage.

5.2.4 A record of all complaints and grievances made by health service users should be kept for use as part of an authority's commitment to quality assurance.

5.2.5 There should be one uniform system for investigating all formal complaints relating to health services, encompassing hospital, family practitioner, community and possibly private provision. This system would also have the ability to co-operate actively other agencies, such as social services departments. Such a system should judge each complaint on its own merits and should deal with each complaint in its entirety, regardless of the different parts of the health service to which the complaint might relate.

5.2.6 A uniform system should address as appropriate any (i) managerial and/or (ii) disciplinary (see S5.11) and/or (iii) compensatory (see S5.10) issues which arise from a complaint.

5.2.7 The possibility of litigation should not preclude a full investigation of a complaint, including the identification of any failings or mistakes.

5.3 **Clear information shall be available to the public regarding the complaints procedures in the NHS. This information shall cover all aspects of health service provision and shall be provided in easily understandable form and in appropriate languages. This information shall include details of time limits for dealing with complaints.**

5.3.1 The Department of Health shall take responsibility for providing written information on how to complain, including a clear definition of how the procedure works and the role of Community Health Councils in providing independent information, advice and support.

5.3.2 The District Health Services Complaints Officer (DHSCO) (see S5.6) shall have a responsibility to explain the procedure to all complainants, including the availability of independent advice and support from the CHC (see S5.4).

5.3.3 There shall be no absolute time limits within which complaints should be made. However, information relating to the complaints system should emphasise the desirability of making a complaint as soon as is practically possible.

5.3.4 There shall be strict time limits for dealing with complaints:

(a) A complaint shall be acknowledged immediately by the District Health Services Complaints Officer.

(b) An initial investigation, including response to the complainant, shall normally be completed within 4 weeks.

(c) If a complaint is referred to a Complaints Investigation Panel this shall be convened and the complaint investigated and reported within a further 6 weeks.

(d) Any recommendations from the Panel to management shall be responded to within a further 2 weeks.

5.4 **All complainants shall have access to free, independent and confidential advice on how to complain and to support whilst processing a complaint.**

5.4.1 Community Health Councils shall be given a statutory responsibility to give advice and information and act as 'patients' friend', giving practical support to complainants.

This will necessitate additional support for staff to enable all CHCs to undertake this workload. Additional resources and training for staff and members will be essential.

5.4.2 CHCs shall have the right to act as advocate for any complainants unable or unwilling to represent themselves during all stages of the complaints procedure.

5.4.3 CHCs shall have a duty to record all complaints received from users of health services, this to include any matters resolved by the CHC without formal referral to the DHSCO. Innominate reports of the CHC's complaints work shall be forwarded to health authority management as a contribution to the authority's quality assurance strategy. These reports will be public documents.

5.5 **Whenever a patient, relative or carer is concerned at the standard of health services provided, they should be encouraged to raise the matter immediately with the service provider or officer in charge**

5.5.1 Minor grievances resolved satisfactorily at a unit level shall be recorded and monitored by management as part of a commitment to quality assurance.

5.5.2 If unit based staff are unable to resolve a grievance satisfactorily, they should encourage the complainant to consult the local CHC, which may be able to help resolve the grievance amicably without recourse to a formal complaint.

5.5.3 If informal attempts to resolve complaints fail, a formal complaint to the District Health Services Complaints Officer should be made.

5.6 **All complaints should begin with an initial investigation to determine whether either conciliation involving discussion and explanation or a full enquiry would be the more appropriate and desirable course of action for the complainant.**

5.6.1 The administration of the formal complaints procedure shall be the responsibility of a District Health Services Complaints Officer (DHSCO), appointed by the Regional Health Authority (Welsh Office in Wales). In cases where a complaint involves services from more than one DHA or FPC area, District Health Services Complaints Officers shall liaise.

5.6.2 Complainants shall have the right to make their complaint orally or in writing. Formal complaints not made directly to the DHSCO shall be passed to him/her for action.

5.6.3 The DHSCO shall have a responsibility to explain the

complaints procedure, including the role of the CHC, in giving independent advice and support to complainants before beginning an initial investigation. This will provide an opportunity to identify the nature of the complaint and to obtain any relevant information before offering a considered opinion on the course of action which might be taken.

5.6.4 The initial investigation may include an exchange of correspondence between the involved parties, or informal conciliation between the involved parties; or any other action necessary in order to provide an explanation to the complainant.

5.6.5 On completion of the initial investigation the DHSCO shall make a full report to the complainant, including explanation and any appropriate apology from the relevant authority.

5.6.6 If on receiving the report of the DHSCO's initial investigation the complainant is dissatisfied with the explanation, s/he shall have a right to refer the complaint to the Complaints Investigation Panel.

5.6.7 If on receipt of a complaint the DHSCO considers it to be of sufficient seriousness s/he may, after consultation with the complainant, refer the matter immediately to the Complaints Investigation Panel. This may be particularly appropriate if conciliation has already been attempted by, for example the complainant, the CHC or another party.

5.6.8 The DHSCO shall be obliged to produce an annual report to the DHA, FPC, RHA, Secretary of State and CHC containing innominate details of all complaints received, including outcomes and subsequent action. This shall be a public document.

5.6.9 In investigating a complaint it is often essential to refer to medical and other records. It shall be the legal responsibility of the DHSCO to obtain all relevant material and make it available to the complainant and, where appropriate, the Complaints Investigating Panel.

5.7 **Complainants shall have a right of access to an "independent complaints investigation service", which although drawing on the expertise of the health care professions would be under lay control.**

5.7.1 The Secretary of State shall be responsible for selecting on a Regional basis a list of members able to serve on a Complaints Investigation Panel (CIP). There shall be a Regional lay Chair, appointed on a fixed term basis, who shall receive appropriate training. The list (excluding the Chair) shall include lay members (who will also require training), and a cross section of the health care professions, including also administrators and legal representatives.

5.7.2 The DHSCO shall be responsible for the administration of the CIP.

5.7.3 On receipt of a complaint the Regional Chair will establish a Complaints Investigation Panel drawing on expertise from the list, depending on the nature of the complaint, with a lay Chair. Each CIP should be small enough to be manageable but large enough to reflect the different issues within the complaint. (Typically a CIP might consist of 2 professionals, 2 lay members and the lay Chair). CIP members would be paid on a fee for service basis.

5.7.4 The first task of the CIP shall be to evaluate whether or not there is any further action that can reasonably be taken in relation to the complaint. If it considers that the explanation given by the DHSCO at the initial investigation is sufficient, it can decide to take no further action. This decision should be reported to the complainant.

5.7.5 If the CIP agrees to further investigate a complaint, it shall instruct the DHSCO to undertake any further research or seek any additional evidence in relation to the complaint as necessary. The DHSCO shall then arrange a hearing to which all involved parties shall be invited to present their cases and to answer questions both from the other parties involved and from members of the Panel. Hearings shall be held in private with no legal representation for parties, although all parties to the complainant may nominate a 'friend' of his/her choice to provide support or act as an unpaid advocate if necessary. Parties to the complaint shall be permitted to call witnesses in presenting their evidence.

5.7.6 The CIP shall have the necessary powers to call witnesses.

5.7.7 The CIP shall have the necessary powers to investigate any issues of concern arising out of the complaint which did not form part of the original complaint.

5.7.8 After hearing the evidence of all parties and in considering any previous relevant cases, the CIP shall have the authority to make recommendations to the employing authority in respect of any management and related issues, to the appropriate professional bodies in respect of any disciplinary action and to the compensation agency in respect of any financial settlements which may be appropriate.

5.7.9 Appeals from the CIP may be made on two grounds. Complaints relating to the administration of the procedure should be addressed to the Parliamentary Commissioner (Ombudsman). Complaints relating to the outcome of the procedure should be addressed to the Secretary of State. He shall have the discretionary power to order a re-hearing by another Region's CIP. The Secretary of State's decision shall be final.

5.7.10 The DHSCO shall produce an annual report containing

innominate details of all cases referred to CIPs, for the HA, FPC and Secretary of State, including outcomes and subsequent action. This shall be a public document.

5.8 **It shall be a condition of the contract of all Family Practitioners, NHS contractors and other health care staff that they shall take part in these procedures as required.**

5.9 **Complainants shall receive a full explanation of the outcome of any enquiries.**

5.9.1 On completion of its investigation, the CIP should produce a full report of its findings and recommendations for the complainant and other involved parties, including the CHC, and the Secretary of State.

5.10 **If necessary, the complaint and the results of the investigation shall be referred to a Compensation Agency. This would not prejudice the complainants right of appeal to a Court if the compensation awarded was not satisfactory.**

5.10.1 The Secretary of State shall establish a Compensation Agency to administer a Compensation Fund for persons who have suffered as a result of a medical or other health care mishap.

5.10.2 The Compensation Agency shall consist of Regional Panels whose task shall be to assess whether patients experiencing unreasonable outcomes of health care should be compensated financially for distress, pain, suffering and physical and financial loss and, if so, the appropriate level of compensation and whether any compensation should be paid by means of a lump sum or an annual award subject to periodic review.

5.10.3 Assessment of eligibility shall be based on the circumstances giving rise to a loss or an injury rather than on proving negligence. Where there is a doubt concerning eligibility for compensation, the benefit of the doubt can be given to the injured party without any adverse reflection on anyone else.

5.10.4 The CIP shall refer to the Compensation Agency all complaints which are considered to merit an award of compensation.

5.10.5 The Compensation Agency shall have the necessary legal powers to evidence and witnesses.

5.11 **Where appropriate, the complaint and the results of the investigation shall be referred to the appropriate employing and/or professional body for possible disciplinary action. All parties to the complaint shall be informed if such a referral is made, have the right to make an independent complaint and be informed of the outcome of any disciplinary action.**

5.12 **Any new system should include mechanisms to ensure the accountability of those administering it.**

5.12.1 The DHSCO shall produce an annual report of all complaints received for the DHA, FPC and Secretary of State. This shall be a public document and shall contain innominate summaries of all cases including details of outcomes and subsequent action.

5.12.2 The Regional Chair of the Complaints Investigation Panels shall establish a special panel (reflecting the same balance of membership as the ordinary panels) to review a random sample of the complaints received by the DHSCOs in the region which were not subject to an investigation by a CIP.

5.12.3 The Health Service Commissioner (Ombudsman) shall retain powers to investigate complaints about the maladministration of the health service complaints procedure, including the activities of the CIP.

5.12.4 The Mental Health Act Commission will retain all of its powers relating to complaints and may be a more appropriate route for detained psychiatric patients with a complaint because of its specialist expertise.

APPENDIX i

ACHCEW CONFERENCE: NHS COMPLAINTS PROCEDURES

11 OCTOBER 1988: REGENTS COLLEGE, LONDON

S U M M A R Y

Introduction

The credibility of the NHS rests largely on patients having confidence that their grievances - both minor and major - will be dealt with in a professional, equitable, just and sympathetic manner. In other consumer sectors the simplest way to express dissatisfaction is by changing to another brand or supplier. The NHS is a near monopoly provider and for the majority of its users there is no alternative. Even where choice does exist, for example the right to change GPs, this is often a lengthy and over complicated procedure. It is therefore imperative that the NHS runs as effectively as possible, that GPs abide by their contracts and that "a simple and well understood mechanism (exists) through which people who use the National Health Service can suggest how it can be improved and complain when things go wrong". (Royal Commission on the NHS, Report, Paragraphs 11.12, 11.13)

On 11 October 1988, the Association of Community Health Councils for England and Wales - the national body representing users of the health service - held a one day conference on NHS complaints procedures.

The aim of the conference was two fold. Firstly, as part of a policy consultation exercise, the current procedures were examined to determine whether a consensus exists regarding defects and possible remedies. Secondly, the conference provided a forum for Community Health Councils to exchange information and learn from others' experiences in an attempt to ensure that current procedures are used as effectively as possible.

Community Health Councils and patients' groups have long argued that within the National Health service there is very little in the way of consumer choice, the balance of power is strongly weighted in favour of the medical profession. With delegates from CHCs, FPCs and HAs present it was anticipated that the conference would provide an opportunity to debate how this imbalance might be redressed.

After a general overview on the role and nature of complaints by Mr. Maurice Healey, Director of the National Consumer Council, participants divided into five workshops to examine specific aspects of the complaints procedures: Professional Accountability: the General Medical Council; Professional Accountability: the Family Practitioner Service Committees; Complaints as Quality Assurance; Hospital Complaints and the Independent Professional Review; and the Role of the Professional

Advice Worker. The second session began with an account of how professionals view complaints by Dr. D. Williams, representing the British Medical Association. This was followed by a panel discussion chaired by Mr. Chris Ham of the King's Fund Institute, where issues arising from the workshops and the other session were developed.

Edited transcripts of the day's proceedings, including reports from each of the workshops and details of the participants follow this summary.

Issues Arising from the Conference

The first subject for discussion was the role and nature of "complaints" as a concept to which all providers of goods and services should address themselves. It is generally accepted that a good consumer service should have an accessible complaints procedure which is seen to be fair by complainants. The National Consumer Council has developed this principle into a set of criteria against which all complaints systems can be measured, including the current NHS procedures. Delegates considered how the following criteria for a successful complaints-handling mechanism reflected their experiences of NHS procedures:

- visibility: potential complainants must know that a system exists.
- accessibility: those with a grievance must be able to lodge it formally with someone in authority with minimum difficulty.
- speed: complaints should be acted upon without delay.
- impartiality & fairness: those responsible for acting on complaints must be seen to be independent.
- effective: complaints should be dealt with by those with the competence to judge and the authority to act to improve services for the future.

The strongest theme which emerged throughout the conference was the multi-faceted nature of complaints and the inability of current procedures to deal with complaints to the satisfaction of all concerned: the patients, the management and the profession. Speakers throughout the conference illustrated how the current procedures fail to meet the general criteria listed above and, in particular, how procedures appear not to be designed to meet patients' needs. Dr David Williams, representing the BMA, pointed out that the existing Family Practitioner Service Committee Hearing procedure is not a complaints procedure at all - rather it is a management device to investigate alleged breaches of contract. Jean Robinson, lay member on the GMC

argued that the General Medical Council is not concerned with patients' grievances unless they constitute a breach of the Council's own definition of "serious professional misconduct". In relation to hospital complaints, it was suggested that the Independent Professional Review is difficult to get established and is designed to reassure patients without critically examining faults in the service. It also fails to deal with multidisciplinary complaints.

There was some consensus that these failings arise mainly because the aim of existing complaints procedures is not clear to patients, management or the professional bodies. The need to identify the various facets of any complaints system was highlighted, for example:

- conciliation: many complaints can be resolved with conciliation and a frank discussion amongst all parties, leading to explanations and apologies where appropriate. In cases of major complaint and possible litigation, conciliation is equally important to restore patients' and relatives' confidence in health care workers.

- investigation: complaints need to be investigated and patients need to have confidence that such investigations will be impartial and fair; this is particularly important where facts are in dispute. The results of any investigations need to be made available to complainants.

- management, disciplinary or other action: where complaints are found to be justified, management or the professional organisations need to consider if and what disciplinary or other action should be taken. Again there is a strong case for keeping complainants informed of action taken.

- compensation: finally there are some cases where an explanation and apology are not sufficient and patients should be adequately compensated without having to go through the legal system.

Much of the discussion throughout the conference centered on how to disentangle the various aspects of what a complaints system should do. Whilst many participants agreed that the first and second points above could be pursued in tandem, it was generally agreed that there should be a distinct separation between investigation and explanation of a complaint and any subsequent managerial or disciplinary action. In practice, this would mean that all complaints should be investigated on their own terms and not in reference to some pre-determined managerial or professional standards of reasonable behaviour. Only after a full and proper investigation of the background and nature of the complaint, should management or professional bodies be asked to take appropriate disciplinary action.

APPENDIX ii

EXTANT DEPARTMENTAL CIRCULARS AND REGULATIONS RELATING TO COMPLAINTS AND DISCIPLINARY ACTION

HM(61)112: Disciplinary proceedings in cases relating to hospital medical and dental staff

HM(66)15: Methods of dealing with complaints by patients.
This early advice on dealing with patients' grievances is still in force. It gives Health Authorities the power to establish ad hoc committees of health authority members to investigate complaints, or in the most serious cases to establish independent investigations chaired by an independent lawyer.

NHS Reorganisation Act 1973 (Commencement Order No 2).
This establishes the office of the Health Service Commissioner for England and Wales.

SI 74/455 NHS (Service Committees and Tribunals) Regulations as amended by SI 74/907, 82/288, 85/39, 87/445
These regulations set out provisions relating to investigations, disputes, appeals and enquiries relating to family practitioners, that is, doctors, dentists, pharmacists and opticians.

HC(82)16: Supply of information about hospital patients in the context of civil legal proceedings

HC(88)37: Hospital Complaints Procedures Act 1985
This circular implements the Hospital Complaints Act 1985, which requires Health Authorities to designate a senior officer for each hospital or group of hospitals responsible for complaints. It also encourages Health Authorities to produce publicity material to improve the public perception of the complaints procedures. The circular contains guidance on the investigation of non-clinical complaints and confirms the existing arrangements for the investigation of clinical complaints (See HC(81)5). Complaints about Community Health Services do not come within the scope of the Hospital Complaints Procedures Act. However, Health Authorities have been asked to consider extending the procedures for the handling of hospital complaints to community services.

HC(81)5: Health Service Complaints Procedure
This circular introduces a memorandum of guidance upon which Health Authorities are advised to base their arrangements for dealing with suggestions and complaints other than those relating to family practitioner services. The circular itself is now cancelled, by HC(88)37. However, the appendix iii, which details the handling of complaints relating to the exercise of clinical judgement by hospital medical and dental staff remains in force.

APPENDIX iii

THE CLINICAL COMPLAINTS PROCEDURE - FROM THE DAVIES COMMITTEE TO THE INDEPENDENT PROFESSIONAL REVIEW

1. The Davies Committee was set up in 1972 largely in response to public concern at the failures of the existing complaints procedures. These had been graphically illustrated by the investigations into three serious cases of neglect and poor care at three hospitals: Ely, Farleigh and Wittingham. Not only had the incidents at these hospitals been the cause of public outcry, but there was also concern at the method of their eventual investigation which was long, cumbersome and did not inspire public confidence that the truth had been fully reached. The Committee heavily criticised the largely internal complaints system and the uneven way it had been allowed to develop. It reported in December 1973 and recognised the legitimate interest of patients in seeing that hospital management is accountable for the services it provides.

2. The first major premise of Davies was that the initial investigation and satisfaction of complaints should be primarily a management function. To assist this the Committee recommended a detailed Code of Practice, staff training and more information for patients and relatives. To ensure effectiveness and accountability, Davies recommended a system of rigourous external checking. Although at the time of writing neither CHCs nor the Health Service Commissioner had been established, Davies saw their role as crucial:

> "If the HSC, CHCs and HAS do not flourish or if they do not effectively carry out their functions as providers of external checks there is at least some risk, some would say a real possibility, of a future Ely, Farleigh or Whittingham."

3. The two principal recommendations of the Davies Committee, were supported by patients groups, and were:

(i) There should be a national Code of Practice for dealing with suggestions and complaints about hospital services, uniformally applied to all Health Authorities and in all hospitals.

(ii) Investigating Panels composed of professionally qualified and lay members under a senior lawyer as Chairman should be established to assist in the investigation of any complaint that could result in litigation. The Panels should accept complaints referred by Health Authorities and by complainants who are dissatisfied with a Health Authority investigation, if the chairman is satisfied that they do not intend to go to law.

4. The first recommendation was accepted by the Government and in 1976 the DHSS produced for consultation the first draft Code of Practice. Indeed, Barbara Castle as Secretary of State for Social Services, proposed that the code should be extended to cover the handling of complaints outside of hospitals and those relating to family practitioner services. Implementation of the code was delayed by protracted consultation, primarily with the professional interests and not until 1981 was a circular on the handling of non-clinical complaints and guidance issued by the Department (see HC(81)5). However, by this stage the proposal of a detailed Code had been dropped in favour of "simple, easily understood, basic procedures".

5. The second proposal was criticised, particularly by the medical profession, on a number of grounds; a particular aspect of concern was the danger of possible overlapping of functions between the Panels and Health Service Commissioners and consequent confusion to the public.

6. The Secretary of State, therefore, asked the Select Committee on the Parliamentary Commissioner for Administration to undertake a review of the existing jurisdiction of the Health Services Commissioners affecting the hospital services, having regard to the recommendations of the Davies Committee about Investigating Panels. CHCs were asked to give evidence to the Social Services Committee and expressed support for independent investigatory panels. The Select Committee reported the outcome of its review in its First Report for 1977/78; it confirmed Davies' view that the existing means by which hospital complaints were dealt with was slow, fragmented and in need of replacement by a simple straightforward and speedy alternative method. It acknowledged the need for independent investigation of complaints and recommended that the role of the Health Services Commissioner be extended to cover clinical complaints.

7. This proposal was the subject of further consultation with RHA Chairman and the medical and dental professions. It was strongly opposed by the BMA who co-ordinated a successful lobbying campaign to discredit the proposals. The Joint Consultants Committee, in a desperate attempt to resist the extension of the Ombudsman's role, produced its own report on the handling of clinical complaints. This recommended a three tier structure for handling clinical complaints, the final stage being the so-called "Independent Professional Review" which consists of a system of peer review rather than any recognisably independent enquiry. Indeed, at no time in the JCC's procedure would complaints be investigated by anyone other than doctors or administrators.

8. In 1981 Dr Gerard Vaughan, then Minister of Health, accepted the JCC's recommendations, and these were speedily incorporated in a health circular HC(81)5. Mr Patrick Jenkin in introducing

the new guidance said that the possibilities for independent investigation of complaints had in the past been extremely limited and that the JCC's procedures were a significant advance. The new procedure was introduced in December 1981 on a trial basis and was reviewed by the Department of Health in 1983. It was further consolidated by the 1985 Complaints Act and the 1988 circular implementing that Act.

Davies Committee: Independent Investigation & Formal Enquiries

Davies' principal recommendation was that those complainants not satisfied with the health authority investigation would be able to take complaints falling outside the jurisdiction of the Health Services Commissioner to an **Investigating Panel.** Investigating Panels would serve for isolated incidents or limited (serious) failures of service, whilst for major failures of service a Formal Inquiry would be constituted akin to the provisions of S70 of the 1946 NHS Act.

The role, structure and remit of the Panels would be as follows:

(i) RHAs would appoint one or more Investigating Panels for the region. Panels would have to be able to sit in any part of the region.

(ii) The Panel would have a permanent part-time Chairman who should be a senior barrister or solicitor. It would include professional members representing all clinical specialities and lay members appointed after consultation with the CHC.

(iii) An investigation would be by the Chairman and two to four other members, at least one of whom would be a lay member.

(iv) The Panel would have to decide whether to conduct the investigation by a hearing or by correspondence, written statements etc. Hearings would always be in private, the complainant, persons complained against and representatives of the HA would be present and could call witnesses.

(v) Hearings would usually be informal and representation legal or otherwise, would not normally be allowed. Complaints would be entitled to bring a friend (CHC) to help who would not be allowed to address the panel without the permission of the Chairman.

(vi) In particularly complex or serious cases it might be necessary to convene a formal hearing with full legal representation of parties. The RMO would be asked to constitute the Panel as a formal Inquiry and the investigation would follow the procedures for such as laid down in the Code of Practice.

(vii) RHAs would provide administrative support to the Investigating Panel. The services of the RHA legal advisor would also be made available.

(viii) The Investigating Panel would seek to establish the facts without expressing a judgement on possible negligence.

(ix) The Panel would report it's findings to all concerned in a written form.

(x) The HA concerned would report the action it proposed to take on the findings to all parties. The RHA would ensure that appropriate action was proposed and implemented.

WHEN THINGS GO WRONG IN THE NHS: COMPENSATION AND INVESTIGATION

1. In 1982 the Annual General Meeting of the Association of CHCs for England and Wales passed a resolution on medical accidents calling on the Secretary of State "to consider the financing of a No Fault Compensation Fund" for persons who had suffered as a result of a medical mishap.

2. Professional organisations have recently shown a revived interest in this matter. This is to be welcomed. A reason often quoted for introducing such a scheme in Britain is the increasing level of medical litigation and escalating legal costs. Far more important considerations, however, are the rights and needs of the injured patients themselves and the need to establish why something went wrong and what can be done to try to ensure that it does not happen again. In any discussions on this subject it is vital that the consumer interest be represented to make sure that these issues are accorded the highest priority.

3. In Britain at present financial compensation for medical mishaps - apart from occasional minor ex gratia payments - can be secured only by initiating legal action, under circumstances where there is a realistic prospect of proving negligence on the part of an individual or an authority.

4. There are some advantages in having cases tested in a court of law quite apart from the damages which may be awarded. In particular it provides a public forum for debating vital issues such as standards of care and the meaning of "informed consent". It is sometimes argued that litigation can lead to the practise of "defensive medicine" as though that is something to be deplored. If the publicity given to legal cases leads to greater care on the part of the health professions - even if it is designed partially to protect themselves - it is likely to be safer for the patients too and to lead to higher standards of care in future.

5. However, only a small percentage of the cases where legal action is initiated actually reach a court. Many are settled out of court. When this is done the injured party receives some financial compensation, but the other advantages of the legal system - a thorough examination of what went wrong and public debate about the issues involved - are missing.

6. There are also a number of drawbacks to legal action. These include:

(a) Legal costs can often be very substantial. This means that the whole process is a financial gamble for injured parties (unless they qualify for legal aid when part or in some cases all of the costs are borne by the State). This can deter people with a good case from pursuing a claim.

(b) Legal action usually entails lengthy delays - often of several years duration - before a settlement is reached whereas there may often be an immediate financial need. This period may also be one of tremendous stress for the injured person and his/her family or for bereaved relatives, and this exacerbates the problems of adjusting to a physical impairment or those associated with grieving.

(c) Eligibility for compensation depends on proving negligence on the part of a health authority, a member of staff or a contractor. In cases of doubt, the benefit of that doubt must be given to those charged with negligence rather than to the injured party.

(d) The possible threat of legal action may increase the reluctance of professional staff and health authorities to offer full explanations to patients or to apologise if things have gone wrong. This hampers even further the development of harmonious relationships between the professional staff and patients.

(e) The system can highlight deviations below currently accepted standards but does not directly challenge current norms.

7. We therefore urge the establishment of a Patients' Compensation Scheme within the NHS analogous to the Patients' Insurance Scheme, which has been operating successfully in Sweden for the past 12 years. It must be emphasised however that this scheme must not extinguish the right to take legal action which should remain an option for any aggrieved party. We would also not wish the scheme to have as many exclusions as in Sweden, in particular brain-damaged children should be included.

8. In advocating this, we would want to make it clear that we believe that it is essential that patients retain the right to seek redress through the courts. This principle has been endorsed by the British Medical Association, in their own No Fault Compensation proposals. However, the evidence from Sweden is that very few people, if any, will exercise this right, and so any patients' compensation scheme must be introduced in parallel with some mechanism for inquiring into what went wrong and why, so that accountability can be established and lessons learned.

9. For those whose main concern is to secure financial compensation a Swedish-type system has several advantages. These include:

(a) There are no legal costs and the claimant is not therefore involved in any financial gamble.

(b) Compensation is paid out much more quickly - often within a few months in the case of lump sum payments.

(c) Assessment of eligibility is based on the circumstances giving rise to an injury rather than on proving negligence. Where there is a doubt concerning eligibility for compensation the benefit of that doubt can be given to the injured party without any adverse reflection on anyone else.

(d) The system may encourage more openness on the part of the professions - eg in Sweden doctors often assist in providing full information to back up a patient's claim for compensation, which leads to a better doctor/patient relationship.

(e) Periodic reviews can identify unsatisfactory outcomes of currently accepted good practices. This may help to raise norms rather than concentrate on deviations below them. This is vital if improved standards of medical care are to be achieved.

10. Such a compensation scheme is based on what happened to the patient rather than why it happened. It does not involve an enquiry into the standards of professional care provided. There is a danger therefore that on its own it could lead to a more lax approach by some professionals and a possible lowering of professional standards.

11. Many patients who are concerned at the level of care afforded have no desire for financial compensation. They want to know precisely what happened and why. They also want an assurance that if something did go wrong, every effort will be made to ensure that no-one else suffers in a similar fashion in future. If professional standards are queried or if there are bona fide allegations of professional negligence they must be investigated thoroughly. If such allegations are found warranted, appropriate action must be taken. Systems do currently exist for doing this in Britain - via Health Authorities, independent investigations, Independent Professional Reviews, Family Practitioner Committees, the General Medical Council and other professional bodies and the Secretary of State. Most of these procedures are difficult to activate and are not seen to be impartial by the patient. In practice, the pursuit of allegations of negligence often relies on individual patients initiating legal action for damages, eventhough their prime motivation may not be to secure financial compensation.

12. The most easily activated method of investigating complaints of clinical care afforded in hospital - The Independent Professional Review - is a voluntary rather than a statutory system. A statutory system already exists for querying the standards of care afforded by family practitioners and a statutory system of investigating complaints of a non- clinical nature with regard

to Health Authority services is being introduced. We believe it is essential that a statutory system should be established for investigating all complaints regarding clinical care afforded in hospital and by Health Authority community services, and that such a system must be much simpler and much easier to activate than those already in being. It must also be seen to be impartial by the complainant.

13. Such a system exists in Sweden run by a Medical Responsibility Board which is financed by the Government. This is entirely separate from the Patients' Insurance Scheme - eg no information provided for compensation purposes is forwarded to the Medical Responsibility Board (although the Board of course may secure similar information as a result of its own enquiries). The Board is of a multi-disciplinary nature and includes lay representation. It is charged with the task of identifying individual mistakes and unacceptable clinical practices and with taking appropriate action.

14. The 1982 Resolution to which reference was made at the start of this document also called on the Secretary of State to "review present procedures relating to the holding of inquiries into medical mishaps". In supporting the establishment of a Swedish-type compensation scheme in Britain, the Association wants it to be absolutely clear that Clinical Responsibility Boards, similar to the Swedish Medical Responsibility Board need to be established at the same time.

Patients' Compensation Working Group
Association of Community Health Councils for England and Wales.

June 1987.

APPENDIX V

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND AND WALES

COMPLAINTS WORKING PARTY 1988-90

Mrs W Pockett (ACHCEW Chair 1986-89) Hounslow & Spelthorne CHC

Mr H Wyn Jones (ACHCEW Chair 1989-) Ceredigion CHC

Mr R Thomson (ACHCEW Honorary Treasurer) Stockport CHC

Mrs R Lewis (ACHCEW Vice Chair from July 1989) Croydon CHC

Mrs J Robinson (Lay member GMC)

Mr E Roberts (Secretary) South Gwent CHC

Mr T Harris (Director ACHCEW)

Ms S Tyler (Development Officer ACHCEW)

ORGANISATIONS WHICH COMMENTED ON THE REVIEW

AGE CONCERN ENGLAND
ASSOCIATION FOR VICTIMS OF MEDICAL ACCIDENTS
BRITISH COLLEGE OF OPTOMETRISTS
BRITISH DENTAL ASSOCIATION
BRITISH MEDICAL ASSOCIATION
CENTRE FOR CRIMINAL AND SOCIO-LEGAL STUDIES, UNIVERSITY OF SHEFFIELD
CONSUMERS' ASSOCIATION
HEALTH EDUCATION AUTHORITY
KING'S FUND INSTITUTE
NATIONAL ASSOCIATION FOR WELFARE OF CHILDREN IN HOSPITAL
NATIONAL INSTITUTE OF SOCIAL WORK
PATIENTS' ASSOCIATION

ACHCEW also received detailed comments from many Community Health Councils. We are grateful to all those who contributed to this review.

ST/March 1990