

REVIEW

The NHS complaints system

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This paper reviews the methods by which complaints are currently handled within the NHS.

The NHS Complaints Procedure was set up in response to "Being Heard". This followed the report of a review committee, which had been chaired by Professor Alan Wilson in 1993. Its purpose had been to review how complaints were dealt with in the face of growing criticism of outdated procedures. With the introduction of "The Patient's Charter" and the purchaser provider split in the provision of healthcare there was a new consumer oriented approach in the health service. In an unpublished study of hospital complaints Sally Lloyd-Bostock and Linda Mulcahy had found that the main issues related to medical care, communication, and the behaviour and attitude of medical and nursing staff.¹ There were also concerns about the quality of hotel services provided to patients. In 1995 the government put forward a programme in response to these proposals in the form of "acting on complaints" together with "interim guidance". This meant that the right given under The Patient's Charter to a comprehensive and timely written response from the chief executive of a trust to a complainant could be met with uniformity across the NHS.

The objectives of this policy against which any success can be judged included:

- Making it easy for people to complain.
- Making the process simple and common across the NHS.
- Separating complaints from disciplinary procedures.
- Collecting data centrally on complaints and using this to improve patient services.
- Making the procedures equally fair for patients and staff.
- Speedy and transparent processes.
- An up-front attitude characterised by honesty and thoroughness leading to complainant satisfaction and where appropriate an apology.

The key to success was seen to lie with *local resolution*. In order to achieve this a three stage procedure was set up. Stage 1 is administered by the service provider and includes any informal activities. When this is unsuccessful an independent review panel is convened and this forms stage 2. If this fails and the complainant remains dissatisfied stage 3 is implemented and he or she may ask the Health Service Commissioner (or Ombudsman) to investigate the case.

STAGE 1 OF THE COMPLAINTS PROCEDURE OR "LOCAL RESOLUTION"

Trusts, health authorities, and family practitioners must have a local resolution process. In this process complaints are dealt with "quickly and, where possible, by those on the spot".²

It is not intended that this process should be legalistic or bureaucratic but rather flexible and conciliatory. It is for this reason that front-line staff are now encouraged to deal with complaints on the spot. However, this is not always appropriate with more serious problems and in such cases the complainant should be referred to the complaints manager. Clearly staff will need local guidelines on when to make such decisions. This will be particularly true for oral complaints as written ones must go directly to the complaints manager. Such guidance may include:

- Finding out what the complainant wants.
- Explaining to the complainant the procedure and actions that will be undertaken to resolve the complaint.³

The complainant may not wish to deal with the front-line staff responsible for his or her care and can complain directly to the complaints manager. If there is a suggestion of litigation or disciplinary proceedings the complaints manager must be involved from the beginning of the complaint. Complaints may be made by a patient or anyone who has their agreement, including a relative or even a close friend. However, there is a time limit and complaints must be made within six months or within six months of the complainant becoming aware of there being something to complain about, provided that this is not more than 12 months after the event. These time limits can be waived if there are good reasons.

Once a complaint is made there must be an initial response within 48 hours in the case of hospital trusts or three working days for family practitioners. Within hospitals complaints must be investigated and resolved within four weeks or 20 working days. In the case of general practitioners, dentists, pharmacists, and opticians this must be within 10 working days.⁴ In the case of written complaints there must be a written response from the chief executive of a trust or health authority which should contain an explanation, measures to be taken to prevent similar incidents, and if appropriate an apology. In this reply it is important that the complainant is notified of their right to request an independent review within 28 days, if they are dissatisfied with the outcome of the local resolution.

STAGE 2 OF THE COMPLAINTS PROCEDURE OR INDEPENDENT REVIEW

A dissatisfied complainant can request a further assessment through independent review. This can

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be made orally or in writing to the convener who must then: "obtain a statement signed by the complainant setting out their remaining grievances and why they are dissatisfied with the outcome of local resolution".²

The convener is a non-executive board member of the trust in which the complaint was made. However, he or she is expected to act impartially and must decide whether an independent review is justified or whether there should be further attempts at local resolution. If a decision against an independent review is made the complainant must be informed of their right to approach the Health Service Commissioner.

The purpose of the independent review is to investigate the facts of the case, take into account the views of both sides, draw conclusions, and make suggestions which are included in a written report. The panel must convene within 20 days of a request by a complainant and complete its work within 12 weeks of its creation. The review is conducted by a panel of three members. They are:

- An independent lay chairman nominated by the Secretary State for Health, but in practice chosen by the regional office. He or she is appointed by the trust or health authority so that they may be indemnified for any advice given.
- The convener, who is a non-executive member of the trust or health authority.
- A lay representative of the purchaser or another independent person appointed by the Secretary of State.

When the complaint has a clinical element the convener is expected to call on at least two independent clinical assessors. They must have no links with the case and may need to be drawn from a different health authority. Suitable professional assessors will again be nominated by the regional office.

It is the convener's responsibility to ensure that the complaint is clearly stated and the reasons for failure of local resolution detailed. If the complainant has difficulties in explaining his or her problems then the convener should help them to produce a written statement or direct them towards organisations that can help. This could include the community health council.²

Although it is a committee of the trust or health authority each panel will decide on its own procedures, but these are subject to the chairman's view. The proceedings, however, must be in private and both parties must have an opportunity to express their views about the complaint. Although either side can be supported by a person of their choosing a legally qualified person cannot act as their advocate. The convener will explain to the complainant any elements that will be excluded from the review. This is particularly so if they are the subject of disciplinary investigation.

In its conclusions the panel is not allowed to suggest disciplinary action or referral to professional regulatory bodies. However, clinical assessors may subsequently have that responsibility or even obligation.

At the conclusion of its work the independent review panel must produce a written report. A draft copy of the report *may* be made available to the complainant and anyone complained against before the final version is prepared. This is to allow them to check its factual accuracy. Once finalised the report, together with any assessors' reports, will be sent to the parties involved, clinical assessors, regional directors of public health, chairmen, and chief executives of *both* the provider *and* the purchasing health authority. Although the report is confidential it may be shown to other interested parties such as trust board members or representatives of the community health council.

"Following receipt of the panel's report, the chief executive must write to the complainant informing any action the trust/health authority is taking as a result of the panel's deliberations and of the right of the complainant to take their grievance to the Ombudsman if they remain dissatisfied".²

These procedures must usually be exhausted before the Ombudsman is prepared to become involved in the case. From the first request for an independent review to the letter from the chief executive to the complainant should take no more than six months.

STAGE 3: INVESTIGATION BY THE HEALTH SERVICE COMMISSIONER

For complainants who are dissatisfied with the outcome of both local resolution and independent review appeal can be made to the Health Service Commissioner. Complaints investigated by the commissioner have to be the cause of: "hardship or injustice."

This can have quite a minor origin but the outcome must cause significant problems. His role is to be an investigator and interrogator. However, investigations of complaints are dealt with privately and the procedures adopted may vary from case to case. There is a general preference for informality in these proceedings. However, people can be represented and the commissioner has similar powers to those of a High Court judge, being able to call witnesses and request documents. A report of this investigation is sent to the complainant and the person or organisation complained about. An annual report summarises the outcome of these assessments and identifies areas of poor practice. Indeed since 1996 the commissioner has been able to draw the attention of professional regulatory bodies and employers to these areas of poor practice and this could result in disciplinary action against the perpetrator. With the involvement of the commissioner in assessment of the merits of clinical judgment there is likely to be further exposure of doctors, nurses, and other health staff to such disciplinary measures. Although this additional responsibility was given to the commissioner in 1996, he is still unable to investigate the merits of administrative decisions, such as the provision of expensive new drugs for patients. Linked with this is his inability to investigate government departments, such as the NHS Executive or the Department of Health.

Limits to the powers of the commissioner include a one year jurisdiction. This can be extended to longer periods, if the complainant was unaware of the problem at the time of the incident. However, this extended power is rarely used. A more significant limitation is when the complainant can seek: "a remedy by way of proceedings in any court of law"² in which case the commissioner cannot conduct an investigation. Equally when there is a question of professional discipline the case cannot be investigated by him.

The commissioner's main sanction is to recommend an apology and to suggest improvements in the delivery of care and the handling of complaints. He cannot award compensation, although *ex gratia* payments to cover out-of-pocket expenses can be recommended. The amount of these payments is not cost limited and so could become significant in the future. However, there is an additional component to the commissioner's recommendations, which was first used in January 1999. When a doctor failed to apologise after a complaint about his clinical judgment was upheld, he was named and required to appear before a Commons Public Administration Select Committee.

THE SUCCESS OF THE NHS COMPLAINTS PROCEDURE

The present complaints procedure was set up in response to the Wilson Report, which identified a significant level of complaints about medical care, communications, behaviour, and attitude of clinical staff as well as problems with the hotel facilities.⁵ Despite these findings there was a general concern that patients had difficulties raising complaints and there was a lack of uniformity about the ways in which they were considered. As a result of the reforms that have been introduced in 1996–97 more than 93 000 complaints about hospital and

community health services were reported, with the number falling to about 88 000 in the next year. During this period there were about 37 000 and 38 000 complaints about family health services.⁶ On average more than 100 000 complaints were made each year about care within the NHS and of these about 98% were completed through local resolution. Of the 2% that requested independent review in only one in five cases was a referral made to the panel by the convenor. During the same time the Health Services Commissioner appears to deal with about 30 cases.⁷ The question must be asked as to whether such a system adequately addresses the disquiet of a significant number of people who never progress beyond the local resolution stage. The convener clearly limits the number of cases referred to independent review and these data must raise questions as to the actual independence of non-executive directors of trusts, who hold this position. Equally the prominence given to advertisements in hospitals and family practices throughout the NHS about how and to whom patients should make complaints is likely to foster a culture of "blame". Equal prominence is not given to methods by which patients can praise the service.

HOW EFFECTIVE IS LOCAL RESOLUTION?

At first appearances local resolution seems to satisfy 98% of complainants. About 30% of cases concern clinical treatment⁶ and approximately 20% are about the attitude of staff or problems with clinical communications. However recent reports show a huge variation in the number of complaints between trusts of comparable size and in the professional groups who are the subject of complaint.⁶ Some of this lack of detail may reflect the fact that: "detailed information on local resolution will not be required".²

This must raise questions as to the accuracy of the returns made by the reporting trusts. Longley in his review of the reforms suspected this was the case and felt that: "in reality there has not been as great a change to complaints procedures as was first heralded and that the systemic flaws remain".⁸ These include the fact that complaints are still dealt with largely as an internal matter and that the principles are inconsistently applied. The increase in medical litigation reported by Frank Dobson on 29 April 1998 in a press release would support the view that it is likely that many of the 98% of patients for whom resolution appeared to be successful at a local level were in fact dissatisfied and sought remedy in the courts.

HOW EFFECTIVE IS INDEPENDENT REVIEW?

About 2% of cases request independent review and this is granted by the convener in about 0.4% of cases.⁶ One in four of these cases, however, fail to be concluded within the performance target of six months from the request by the complainant. On occasions this may reflect the difficulties arising from multiagency complaints, where other groups will be involved in any investigations. The panel is a committee of the trust or health authority and is covered by their indemnity

policy. The convener, at least, will be a local person. Their impartiality must therefore be questioned and the low number of cases accepted would lend some support to this view.

HOW EFFECTIVE IS THE HEALTH SERVICE COMMISSIONER?

The types of complaint the commissioner can investigate are limited and exclude problems which initially involve a disciplinary element or are the subject of legal remedy. Although he is unable to investigate failures by a health body to provide services, policy matters such as the prescription of Viagra are excluded. The existence of differences in prescribing according to "post code" are therefore outside his jurisdiction.

The commissioner has expressed his hope that his reports will be used to better train staff and so limit complaints, thus meeting some of the objectives of the procedure. The question must be asked as to how can this be successfully implemented in the clinical setting, which is the source of the vast majority of complaints.⁶ There may be some hope in the small fall in complaints between 1996–97 and 1997–98 of about 3%.⁶ However, this fails to take account of the possibility that these are now being directed into litigation instead. The future possibility of the use of "no win no fee" approach may accelerate such changes and further encourage the use of the complaints procedure as a mere "fishing" expedition.

In summary to quote from Longley⁸:

"The most fundamental shortcoming of the British health complaints system is that it is not grounded in legislation or a statutory code of rights, there is therefore nothing tangible enough for the complaints process to bite on. General principles are fine, those put forward by the Wilson Committee are exemplary, but the important question is how these are upheld and able to be encashed and there is little support from the Patient's Charter which is light-weight, not in its aspirations, but in its punch".

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