The NHS complaints procedure.

Perceptions of a recent convener

Sylvia R Limerick

ABSTRACT – The purpose of the NHS complaints procedure is to investigate complaints in a way that is satisfactory to the complainant, while being fair to staff and learning any lesson for service improvement. The current complaints procedure was implemented on 1 April 1996. It covers complaints about primary care practices as well as hospital and community health services, and includes matters arising from clinical judgement. An evaluation of its effectiveness is being undertaken by the London School of Hygiene and Tropical Medicine, York University (York Health Economics Consortium) and Public Attitude Surveys, and a report is due after the end of 2000. This personal view of the complaints procedure, from the perspective of a trust convener, discusses recent proposals for reform from the House of Commons Health Committee and their relevance to the hospital physician.

'The purpose of the NHS Complaints Procedure ... is to investigate the complaint with the aim of satisfying the complainant while being scrupulously fair to staff and to learn any lesson for improvement through service delivery.'

NHS Executive

The current NHS complaints procedure was implemented on 1 April 1996, less than a month after the secretary of state issued the relevant statutory directions. This left little time for training in its intricacies.

Two major innovations were that the Health Service Commissioner (HSC)/Ombudsman's jurisdiction and the complaints procedure should cover complaints about primary care (GP) practices as well as hospital and community health services, and should be extended to include matters arising from clinical judgement.

There were 88,757 written complaints about hospital and community services in 1997/8, while complaints to the HSC in the 1990s increased by 12–15% a year. Yet it is estimated that less than 1% of patients make a formal complaint.

Patients, relatives and carers, hereafter referred to as complainants, have high expectations of the NHS based on trust, but they are in a position of dependency and can feel anxious and vulnerable when they voice criticism or dissatisfaction, or suggest an improvement. Complainants may have one or more objectives: most want an explanation, apology for a mistake, or expression of regret for a misunderstanding, and assurance that the problem will not recur. Clinicians and other staff may also feel worried, hurt and vulnerable when a complaint is made against them or is badly handled.

In November 1998, the NHS Executive (NHSE) announced that the Department of Health was to commission a two-year, UK-wide evaluation of the effectiveness of the complaints procedure, and commented 'This is an evaluation, not a review, and should not be taken as an indication that the NHS Executive is dissatisfied with arrangements'.

Surveys have, however, revealed discontent amongst complainants and those handling complaints about the current procedure's independence, conduct and fairness. They identify concern with the varied quality of initial investigation; the doubtful independence of conveners; uncertainty about the roles of conveners and independent review panel (IRP) chairs; inconsistency between different trusts/health authorities; the lack of training for complaints managers; and inadequate external monitoring. But clinicians, too, have an interest, since they may be the subject of a complaint or nominated as the complaints lead in primary care practices. They may also be asked to give clinical advice to a convener, to assess clinical aspects of complaints for IRPs, or they may hold responsibility for quality and clinical governance in NHS trusts. Clinicians, therefore, are equally interested in seeing that the system should function easily, fairly and effectively.

The complaints procedure in England

The first stage of the 1996 complaints procedure is local resolution (LR), which comprises an acknowledgement, investigation and response from the NHS organisation responsible. Complainants who are not satisfied with the response may request a second stage – an IRP – to reconsider the complaint. The decision whether or not to hold an IRP rests with the convener, who is usually a non-executive director (NED) of the relevant trust or health authority, in consultation with an independent lay chairperson who is nominated by the regional office of the NHSE. If not satisfied with the convener's decision or the outcome of the IRP, complainants are entitled to complain to the HSC, as are NHS staff if they feel unfairly treated by the procedure.
Convener’s experience

I was appointed convener for a large trust for the initial 18 months of the new procedure, and continued as associate convener to complete cases in hand. I received 30 requests for IRPs in 18 months, compared with the average convener’s 9 IRP requests over 2 years. Twenty-eight (93%) of my cases concerned clinical matters; 13 (43%) of the complainants were single persons (12 men). These cases highlight the importance of giving attention to the social and emotional vulnerability and support needs of patients living alone who are meeting serious illness for the first time. Seven complainants were bereaved relatives whose needs included sympathetic, honest and full explanation; three were single mothers, one of whom was apparently hoping for financial compensation although her complaint was not serious. Four, sadly, were vexatious complainants who were abusive and aggressive towards staff, or unwilling to accept documented evidence as factual, or persistent that responses were inadequate despite voluminous correspondence specifically answering their questions.

The convener’s task is to review the complaint and LR response and, with the complainant’s permission, the relevant medical records for clinical complaints. After ensuring the complainant is not intending to make a legal claim, and after taking clinical advice on any clinical matters, the convener decides, in consultation with an independent lay chairperson, on four possible courses of action:

- passing the complaint to the chief executive for consideration of disciplinary proceedings
- referring back to the organisation for further action
- investigating the complaint through an IRP
- no further action.

The convener has to give the complainant reasons for any decision to refuse a panel.

I referred back 14 (47%) requests, most of which were resolved by further action by the trust. An additional three complaints (10%) were referred back for the trust to arrange clinical care, which, it became apparent, was the complainants’ prime concern. Two other requests were dropped by complainants when asked to clarify outstanding grievances and reasons for their dissatisfaction with LR. Another was deferred owing to serious illness. In seven requests (23%) an IRP was refused on the grounds that the trust had already taken all practical action and therefore establishing a panel would add no further value to the process. Four of these complainants took their complaint to the HSC, who decided none warranted investigation. In three cases (10%) an IRP was held. One complaint was resolved at IRP, the complainant being satisfied by the opportunity to discuss his grievance with the panel members and the clinicians complained against, and talk to the independent clinical assessors. The other two took their concerns unsuccessfully to the HSC. One then consulted lawyers, who received the IRP report amongst the records and discontinued the claim.

Although, as convener, I had to pass to the trust chief executive any complaint in which it appeared that there was a prima facie case for the trust to consider initiating disciplinary proceedings and to cease the complaints procedure in that respect, it was not easy to discern any not already passed at LR until the complaint had been investigated by an IRP and clinical assessors. In the event, no disciplinary irregularity was ascertained. If it had been, the complainant would have had no right to hear the outcome of internal disciplinary cases, which is clearly unsatisfactory.

Possible reform of the complaints procedure

Recent proposals for reform from the House of Commons Health Committee, which considered survey findings and other evidence, focus on three main areas: local resolution (LR), the review process, and mechanisms for improving quality of service through monitoring complaints. My comments will address aspects relevant to doctors on the basis of my convening experience.

- Quality of local resolution

Most complaints are resolved at LR. In the small proportion (under 3%10) where an IRP is requested, conveners refer on average half back for further action at LR. The initial investigation report must be comprehensive and accurate: minor misrepresentations upset both complainants and those complained against. The NHS guidance advises ‘that any response given to a complainant which refers to matters of clinical judgement is agreed by the clinician concerned and, in the case of medical care, by the consultant responsible for the care of the patient’. One reform proposal is that the report from investigations relating to (potential) adverse clinical incidents must be robust enough to be used by other bodies such as the GMC and UKCC, NHS disciplinary committees or the courts, and contain a recommendation for further action.

Flexibility in the choice of procedure at LR is valuable. Most cases I referred back were resolved by a meeting between the complainant, the relevant clinicians and management representatives. Two were resolved by a conciliator, and a further two through the complainant meeting with another consultant in the same specialty who was able to offer the necessary explanation and reassurance. Another proposal is that the complaints manager sift complaints to ensure those which may contain serious allegations about staff performance and which could endanger future patient care are dealt with speedily and passed to an appropriate authority where necessary. This already happens in practice, but investigation by the trust is essential to establish whether the allegations are justified.
The independence and powers of the review procedure

The impartiality and independence of the convener are frequently questioned because, as an NED, he/she is a member of the organisation that is the subject of the complaint. The convener, however, plays no part in LR. Independence can thus be interpreted in two ways. While it is possible and crucial for the convener to act with complete impartiality, despite sometimes knowing the staff complained against, nevertheless the complainant’s perception that the convener is not independent of the organisation should be taken seriously. The Wilson Report

in whose principles the 1996 procedure is based, recommended that the stage two response (currently IRP) be made by an external body. One proposal is that the convener’s current role be abolished. Screening, however, even if undertaken by an external screening officer, is important because experience shows that many complaints are resolved through referral back to the trust for a second attempt at LR.

In clinical complaints, it is recommended that the convener take clinical advice from the trust’s medical or nurse director. In practice, because of the medical director’s huge workload, I sometimes sought clinical advice from a deputy medical director or a senior clinician in the relevant specialty who had not been involved with the patient’s complaint or care. The clinicians were prompt and helpful with advice, including an indication of issues requiring further attention. Since most had to go through lengthy medical records as well as the complaint correspondence and LR response, the task imposed a time-consuming, extra burden for which they received no remuneration. However, some complainants do not regard advice to the convener from inside the trust as sufficiently independent. Some conveners seek external professional advice from another trust, although this informal arrangement can add delay.

Review panels (IRPs)

At present, a trust panel is established and paid for as a committee of the trust. It is composed of an independent lay chairperson nominated by the NHS regional office, a representative of the health authority that purchased the care, and the convener. Clinical assessors, although nominated by the regional office, are also appointed by the trust. Although I always informed complainants in advance of the composition and status of a panel and consulted them about the terms of reference, and also kept the staff complained against fully informed, if the present procedure is maintained the title ‘independent review panel’ could be shortened to ‘review panel’ to avoid confusion over independence. Alternatively, it has been proposed that IRPs should not be connected with the trust or health authority subject to complaint, should have a majority of lay members, and be funded and accountable to the regional offices of the NHS Executive. Since these are civil service offices as part of the Department of Health, this major proposal would require legislative alteration to the powers of the HSC.

The conduct of a panel is currently decided upon by the chairman and the panel members. Although some proposals call for formalisation of the proceedings, to act as an adjudicatory body, with all parties present, and with power to summon witnesses and take evidence, my experience is that flexibility for the panel to choose how it conducts its proceedings should remain. It is sometimes advisable to interview the complainant and the complained against separately, and then bring them together. If, as proposed, a duty is imposed on staff to attend an IRP, flexibility in its conduct is especially important. In one IRP request, the complainant had a record of having physically attacked a consultant elsewhere because of disagreement over the cause of his condition. Similar disagreement formed part of the new complaint. While the relevant consultants in my trust were willing to attend a panel, they were not willing to meet the complainant again. Flexibility permitted arranging to interview the parties separately.

Some complaints are very complex, involving the attendance of five or more clinicians and other members of staff. It has been estimated that IRPs cost between £3,000 and £7,000 each. Because nurses and doctors-in-training move to new posts in different locations, the cost of time and travel from distant parts of the country to attend IRPs can be considerable. Conveners are required not to consider the cost in making decisions, but the panel needs to be timetabled by the chairman to minimise disruption of clinical work. ‘It is important that investment in complaint handling is not disproportionate to the resources available to improve services’.

The IRP report is accompanied by a separate report written by the two clinical assessors. Reform proposals suggest that the assessors’ report should be circulated in advance of the IRP. This would be unwise, since clinical assessors learn much from interviewing the parties to a complaint at a panel, and their report is more valuable thereafter.

The power of the panel at present is restricted to reporting its findings and making suggestions to the trust board and purchasing authority. A proposal is that the panel should be able to recommend that disciplinary action may be necessary. This would reverse the current prohibition on panels recommending disciplinary action. It would be fair for a judgement about referring disciplinary issues to management to be made by panel members and assessors at the end of an IRP, at which the accounts of both the complainant and the complained against have been heard. Important facts are sometimes only revealed at the IRP. The reason for separating the complaints procedure from the disciplinary procedure is to encourage staff to respond frankly and be willing to apologise in a non-threatening environment. The dual function of an IRP is to investigate the complaint within its terms of reference and to seek to resolve it; defensive attitudes must be avoided but an apology is not an admission of liability.
Learning from complaints

There is great potential for improving quality of service through monitoring the nature of complaints, and especially the recommendations in IRP reports, which contain valuable lessons. The introduction of clinical governance and health improvement programmes should facilitate this. It is mandatory to send the panel report to the complainant, those complained against, the trust and purchasing authorities and the secretary of state. It is proposed that trusts and health authorities make a formal response to panel recommendations. Chief executives already write formally to the complainant detailing action taken by the trust. Quarterly reports to the board and annual publication of a report on complaints are already compulsory.

At trust level, greater use of the nature of complaints could be made by departmental clinical audit meetings, and use of databases may help, but it is vital to have qualitative as well as quantitative measurements.

There is no formal interface between the convener and a trust’s clinical claims committee or risk management department, although it is evident that patients are being advised by solicitors to use the complaints procedure and request an IRP, thereby gaining a free clinical assessment with a view to using the reports for considering whether to initiate legal proceedings.

There is at present no formal interface between the NHS complaints procedure and professional self-regulatory bodies, except through the obligation of trusts and health authorities to report concerns about the performance of clinicians. If a particular clinician has been the subject of repeated complaints, consideration may need to be given to passing such information on to the relevant regulatory body. It is important, however, to be scrupulously fair and to be aware that a small number of people may abuse the complaints procedure. The authenticity of complaints submitted by persons outside the patient’s family needs to be checked at LR. Some complaints are unfounded, and there are published examples of ostensible misuse of the system through concerted campaigns to levy complaints against selected individuals, for example against those involved in the protection of children. There is a need for balance within the legitimate use of the system for alerting authorities to poor care.

Other difficulties experienced as a convener

Should private care be brought within the scope of a complaints procedure? Private medical care provided by a consultant outside his NHS contract is excluded from the remit of the NHS complaints procedure. Three requests for an IRP came from complainants where the patient had initially been seen privately by consultants who for legitimate reasons arranged the patient’s transfer to the NHS for clinical tests, surgical treatment and intensive care respectively. Two of these complaints were investigated by an IRP and, although the terms of reference drawn up by the convener had to exclude the private care element, in practice it was necessary to discuss this in order to assess the NHS care in its proper context and to try to resolve the complainants’ grievances.

One IRP was held to investigate a complaint from a patient who suffered complications and permanent damage from surgical treatment that incurred a recognised 2% risk of this outcome, but where there was no evidence of clinical incompetence. In addition to the importance of giving patients advance written information to warn them of the risks as well as the benefits of any intervention to supplement face-to-face advice, this kind of unfortunate event, an unexpectedly poor outcome to treatment, deserves redress from a no-fault compensation scheme. There is a suggestion that panels should be able to make recommendations for compensation.

The convener’s work is operational and time consuming. I was handling five to seven requests for IRPs at any one time. A separate lay chairman was assigned for each request, whose experience, availability and criteria for holding an IRP varied widely. It was seldom possible to meet response times for a variety of reasons. For example, one desperate patient submitted as evidence for his complaint the transcripts of eight consultations secretly recorded. Checking these transcripts against the original tapes for accuracy and informing the consultants concerned, some of whom were upset by the deceit, caused delay.

Has the time come to make the complaints procedure less informal and more rigorous, to externalise the review panel stage and to link parts of the procedure to the disciplinary, professional regulatory and legal processes? The views of clinicians on these proposals for reform are sought.

References

1. NHS Executive. Complaints: listening … acting … improving. Guidance on implementation of the NHS complaints procedure. London: DoH, March 1996.
2. Secretary of State for Health. Directions to NHS trusts, health authorities and special health authorities on hospital complaints procedures. March 1996.
3. Health Service Commissioners (Amendment) Act 1996. London: HMSO, 1996.
4. Procedures related to adverse clinical incidents and outcomes in medical care. House of Commons Health Committee, Sixth report, Vol I. London: HMSO, Oct 1999.
5. The Associate (The Newsletter of the National Association of Complaints Personnel, Health). Vol 1.3, 1997.
6. NHS Executive. Director of planning announces NHS complaints evaluation project. Press release, 25 Nov 1998.
7. National Consumer Council. NHS complaints procedures: the first year. Report of NCC, Sept 1997.
8. Wallace H, Mulcahy L. Cause for complaint? An evaluation of the effectiveness of the NHS complaints procedure. London: The Public Law Project, 1999.
9. The Associate (The Newsletter of the National Association of Complaints Personnel, Health). Vol 1.2, 1997.
10. Buckley M. Industrious Resolution. Health Service J 1997; 107(5558):32-3.
11. Personal communication from Convenor’s Trust.
12. Department of Health. Being heard: the report of a review committee.
MEASUREMENT OF CLINICAL OUTCOMES

Practical approaches to monitoring care in acute myocardial infarction

Thursday 28 September 2000

To be held at the Royal College of Physicians

A one day conference jointly sponsored by the Clinical Effectiveness and Evaluation unit (CEEu) of the Royal College of Physicians and the Faculty of Public Health Medicine.

The conference aims to stimulate interest and promote discussion of major issues relating to the quality of care and its measurement. Dame Deirdre Hine, a keynote speaker at the conference, will discuss the relationship of quality measurement to the functions of the Commission for Health Improvement (CHI).

The National Service Framework (NSF) for Coronary Heart Disease sets standards for monitoring the quality of care for acute myocardial infarction. The conference will report on the Myocardial Infarction National Audit Project, which has been developed by the CEEu to monitor the NSF standards for acute myocardial infarction.

The conference will also feature a discussion session that invites cardiologists, public health planners and health care managers to contribute ideas and comments about the utilisation of the audit project and the role of quality measurement within the health service.

Conference fee £100

For an application form and further details please contact

Andrew Georgiou, Outcomes Programme Co-ordinator
Royal College of Physicians, 11 St Andrews Place, London NW1 4LE
Tel: (020) 7935 1174 ext 334 Fax: (020) 7487 3988
E-mail: andrew.georgiou@rcplondon.ac.uk