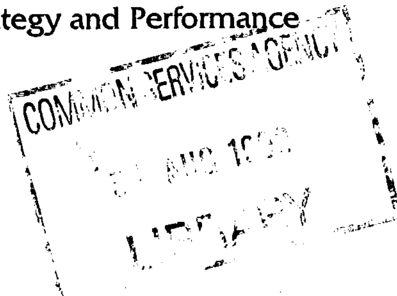
NHS
MEL(1999)64

SCOTTISH EXECUTIVE

Health Department
Directorate of Strategy and Performance
Management

NHS Management Executive
St Andrew's House
Regent Road
Edinburgh EH1 3DG



30th August 1999.

Addressees

For action:
General Managers, Health Boards
Chief Executives, NHS Trusts
General Manager, Common Services Agency
General Manager, State Hospitals Board for Scotland

For information:
(Epitomes only)
Chief Executive, Health Education Board for Scotland
Executive Director, Scottish Council for Postgraduate Medical and Dental Education
Chief Officers/Secretaries, Local Health Councils
Deans of Medical Faculties
Chief Executive, Clinical Standards Board for Scotland

Enquiries to:

Miss Laura Ross
Health Gain Division
Room 52
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 2378
Fax: 0131-244 2372
laura.ross@scotland.gov.uk

Dear Colleague

REPORTS OF THE HEALTH SERVICE COMMISSIONER AND THE SELECT COMMITTEE ON PUBLIC ADMINISTRATION

Summary

1. This letter covers a number of important reports by the Health Service Commissioner, and the report of the Select Committee on Public Administration covering the Annual Report of the Health Service Commissioner for 1997-98. They should be distributed widely and used by all Health Boards and NHS Trusts to review performance and take remedial action as required.

Action

2. Enclosed are:

2.1 the Health Service Commissioner's annual report for 1998/99;

2.2 his report on 17 selected cases drawn from those he investigated during the period October 1998 to March 1999, together with a report of one other about optical issues completed in April 1999;

2.3 epitomes of the selected cases;

2.4 his special report of March 1999 of his investigation of a complaint about treatment by deputising doctors;

SCOTTISH HEALTH SERVICE
COMMON SERVICES AGENCY
TRINITY PARK HOUSE LIBRARY
CLASS Ref
ACC. R/A: 106430
Date Price

INVESTOR IN PEOPLE

ENE04507

ISBN 0 7480 9100 9

2.5 another special report of April 1999 of his investigation of certain aspects of the operation of the NHS complaints procedure;

2.6 the second report of the Select Committee on Public Administration reviewing the work of the Health Service Commissioner during the year 1997-98.

3. Board General Managers and Trust Chief Executives are asked to:

3.1 circulate the reports as widely as possible; particularly drawing them to the attention of staff involved in administering the complaints procedure. The Health Service Commissioner's reports are also available on the Internet at http://www.ombudsman.org.uk ;

3.2 check performance against the findings in the reports and provide a note of action taken to improve procedures as a consequence of the failings which the Commissioner has highlighted and the recommendations made by the Select Committee. This information will be used by the Chief Executive in the event of him being called before a Committee of the Scottish Parliament. It should be sent to Moira Milligen, Health Gain Division, Room 51, St Andrew's House by **15 October 1999.**

4. Annex A attached brings to your attention issues which the Commissioner and the Select Committee thought of particular importance.

Yours sincerely

KEVIN WOODS
Director of Strategy and Performance Management

- poor independent review panel administration means that complaints are made to the Commissioner about a lack of thoroughness of investigation, an inappropriate confrontational style, the 'reasonableness' of the panel's conclusions and delays. As the panel is a sub-committee of the Health Board or Trust, technically these failings are the responsibility of the Health Board or Trust. However the Commissioner is aware that a balance must be struck between taking action on criticism of a panel's actions and prejudicing the crucial independence of the panel.

1.9 The Commissioner has increasingly been asked to investigate the quality of clinical care and there has been significant developments in the field of clinical governance. The Commissioner's office have been developing relations with other bodies in that area as the Commissioner considers it important for all organisations involved to define their roles clearly to prevent duplication and confusion.

1.10 The Commissioner feels that clinical negligence causing serious damage is appropriate for legal action through the courts, however in lesser cases he hopes that it will, in future, be made easier to seek financial redress through the NHS complaints procedure and has suggested that the Health Department's review this matter.

1.10 The Commissioner will give priority in 1999-2000 to establishing contact with the Scottish Parliament and with the new representative bodies.

2. ISSUES ARISING FROM THE REPORT OF THE SELECT COMMITTEE ON PUBLIC ADMINISTRATION ON THE WORK OF THE COMMISSIONER FOR 1997-98

2.1 1997-98 was the first year in which the extension of the Commissioner's jurisdiction to cover investigations of the actions of family health service practitioners had significant effect. In drawing conclusions from some of the cases he has investigated, the Commissioner has taken the view that as providers of public services GPs implicitly accept an obligation to adhere to certain standards. The Committee took evidence from 2 GPs whose actions were considered to have fallen far short of these standards.

2.2 The Committee also took evidence from patient representative bodies and organisations of widespread lack of confidence in the convening and independent review stages of the complaints procedure.

2.3 The Committee's Report also considered the Government's proposals for clinical governance and their effect on the role of the Commissioner.

2.4 Your attention is drawn to Annex B tabulating recommendations made in the Committee's Report with a request that you check and confirm your Trust/Health Board's compliance with these recommendations.

1. ISSUES ARISING FROM THE HEALTH SERVICE COMMISSIONER'S REPORTS

1.1 The Health Service Commissioner's Office received a record number of 2,869 complaints in 1998/99 - an 8% increase on 1997/98. Of these, 217 (7.6%) were from Scotland.

1.2 The Reports provide the Commissioner's first comments on cases involving dentistry, pharmacy and optical services arising from the 1996 extension of his jurisdiction to complaints about the actions of practitioners in these family health services.

1.3 The Commissioner is of the view that some FHS practitioners have not developed an understanding and acceptance of the application of the NHS complaints procedure to their work despite the constructive approach taken by their professional organisations.

1.4 The Commissioner has decided that, except in particularly serious cases or cases of 'repeat offences', he will not name GPs in his published reports, only the Health Board area in which they practice. However, where a complaint against a GP is upheld and the recommendations rejected, the Commissioner thinks it reasonable that the practitioner should be named. Similarly, where a GP has removed a patient from their list for no other reason than that they have complained to the Commissioner he will publish their name.

1.5 While the majority of investigations now involve clinical matters, the same general concerns over the importance of communication and record-keeping continue to arise. Poor complaints handling continues to add to the concerns of complainants.

1.6 The need for adequate record-keeping was brought into focus in the Commissioner's first investigation of a complaint about dental services where a patient may see different practitioners and be referred elsewhere for specialist procedures. Adequate explanation of the cost of additional 'private' dental treatment must also be given to patients.

1.7 In the Commissioner's first ever investigation of pharmaceutical and optical cases the issue of communication proved foremost.

1.8 Despite encouraging progress since the introduction of the new procedure in 1996:

- poor communication means complaints are made to the Commissioner which should have been resolved at an early stage at local level. All NHS staff must develop the skill to handle complaints sensitively;

ANNEX B

RECOMMENDTIONS MADE BY THE SELECT COMMITTEE ON PUBLIC ADMINISTRATION REVIEWING THE WORK OF THE HEALTH SERVICE COMMISSIONER DURING THE YEAR 1997-98

CLINICAL ASSESSORS

1. It is certainly right for the Ombudsman to use clinical assessors who are practising clinicians, and who therefore are likely to take longer to complete reports. However, we would assume that when choosing clinical assessors, he will choose those who are able to meet reasonably tight deadlines, and will seek to ensure that those deadlines are met. More broadly, if there are serious difficulties in achieving further reductions in the time taken to conduct investigations, we would expect the Ombudsman's Office to specify more clearly what those difficulties are. Cases still take far too long to be completed, particularly when many of them have already been through the full gamut of the NHS complaints procedure before reaching the Ombudsman. As we have said before, if the delays can be resolved through additional resources, we believe the Ombudsman should request, and be given them.

ISSUES COVERED

2. We accept the Ombudsman's explanation of the loss of the table analysing grievances investigated; but we recommend that in future Reports, a fuller analysis of the issues covered is included identifying any trends in the complaints reaching the Ombudsman and comparing them with previous years. We agree that Trusts should be named in the extracts included within the Annual Report, as this would obviate any suspicion that information is being hidden or not available.

THE OPERATION OF THE NHS COMPLAINTS PROCEDURE

Training for Conveners

3. It is clear that in too many cases conveners are making some fairly elementary mistakes. We comment below on the adequacy of training for conveners, but here we note that although the Department of Health, England said in its response to our Report more than a year ago that a "good practice guide for conveners is being developed which will be circulated to the NHS later this year", no guidance has as yet been published. We hope that this will soon be remedied. We also comment below on conveners' independence of the NHS institutions they deal with. [This guidance was issued to Health Boards in July 1999.]

Independent Review Panels

4. We are concerned about the lack of sufficient numbers of suitably qualified personnel available to serve on independent panels, and recommend that the department review the procedures for recruiting panel members, and for compensating them for their time. The problems need to be addressed quickly if the procedure is not to become bogged down with a backlog of complaints.

5. We agree that there should be some system by which the work of the independent panel can be monitored and reviewed, if it is seen as falling below acceptable standards. We recommend that provision be made for the Ombudsman to have the right to call for the establishment of a second panel to rehear a complaint. [Proposals are at present with Solicitor's Office to make such a change in the Directions.]

Training

6. We recommend that the NHS Executive, and its counterparts in Scotland and Wales, review the provision of training in the operation of the complaints procedure and consider whether more organised, if not prescriptive, training is required. We would expect this to include training in forensic skills, and in how to make the judgements required, and also training in the sort of skills necessary to ensure that complainants accept that the process gives them a genuine opportunity to have their case heard.

Independence

7. We believe that the independence of the complaints procedure is something that needs to be reaffirmed, and we recommend that the Department of Health should consider ways of signalling more clearly its independence, for example through including a person chosen by the Community Health Council on any panel, and nominating as conveners persons other than non-executive directors.

Conciliation

8. We would welcome greater use of conciliation within the complaints procedure where appropriate, and recommend that this is encouraged. But the complaints procedure will in our view need to have a strong element of formality in order to ensure a proper respect for it and to ensure that it is seen as fair and impartial.

Cross-Sector Complaints

9. We recommend that the Department of Health review arrangements for cross-sectoral complaints concurrently with the Cabinet Office review of public sector Ombudsman and consult appropriate with local government and others.

GPs in small communities handling complaints on behalf of each other

10 We recommend that groups of GP practices are encouraged to operate joint complaints-handling systems, and that the Department of Health consider how Primary Care Groups might establish within their member practices effective complaints mechanisms. In the longer term, we hope that the evaluation of the complaints procedure will pay particular attention to solving the problem of achieving impartiality in considering complaints against family health service practitioners, and we recommend that the Department of Health in the meantime seeks proposals for improvement in the procedure as it currently operates in primary care.

11. We find it disappointing that the profession is taking so long to accept the complaints procedure fully. It is now 3 years since the introduction of the new complaints procedure. There is no excuse for GPs or their practice staff not to be familiar with it. They should also publicise it in accordance with RCGP guidelines, and provide advice on how to obtain the assistance and support of the Community Health Council.

LITIGATION

12. We think the best hope for avoiding an ever increasing resort to litigation is the creation of a proper code of practice for the payment of financial redress in the NHS, as there is in other Government departments; and we recommend that the Government introduce such a code.

REMOVAL OF PATIENTS FROM GP LISTS

13. We agree that Health Authorities should be doing more to review removals from GP lists, and recommend that they make enquires whenever the number of patients removed rises above 4 a year.

14. We support the Ombudsman's willingness to identify doctors who do not respond to his findings, and recommend that the message that this will happen be widely disseminated throughout the NHS. In the longer term, we agree that the need for GPs to be educated in the importance of good communication is vital to the patient/doctor relationship, and we recommend that it be an important feature of the revalidated system currently under discussion by the GMC, designed to require specialists and GPs to demonstrate on a regular basis that they are keeping themselves up-to-date and remain fit to practice in their chosen field.

15. We believe that GPs should only be permitted to remove patients from their lists as a last resort, and that their powers to do so should be qualified by amendments to GPs' statutory terms of service. These should ensure that:

- information be provided to the Health Authority on the reasons for the removal of any patient not moving out of the area;

- in the event of a breakdown of the doctor/patient relationship, GPs should not be able to remove other members of the patient's family, or other people connected with the patient, unless they are able to show that a similar breakdown has occurred with them as well;

- the Health Authority agree to removal of any patient from a GP's list;

- an account be provided to the patient of the reasons for the removal; and

- there should be a right of appeal to the Health Authority or an independent panel by any patient believing himself to have been wrongly removed.

16. GPs should be prepared to justify the inconvenience and stigmatisation caused by removal, and Health Authorities should be prepared to provide better channels of communication between GPs and patients and institute clear and sensible removal mechanisms where conciliation has failed.

QUALITY

17. We believe that it will be vital to ensure that the various agencies involved in ensuring and monitoring quality in the NHS work together to provide an efficiency system for checking performance and following up failures in practice. We recommend that in advance of the evaluation of the complaints procedure, and of the establishment of the Commission for Health Improvement the Department of Health brief together a taskforce including the Ombudsman and representatives of the GMC, to consider how best this may be achieved.