The Health Service Commissioners (Amendment) Bill [Bill 10 of 1995/96]

Research Paper 95/126

8 December 1995

The *Health Service Commissioners (Amendment) Bill*, which aims to extend the powers of the Health Service Ombudsman, was presented in the Commons on 30 November 1995 and is due to have its Second Reading on 12 December 1995. Part I of this paper looks at the background to the decision to amend the Ombudsman's powers and includes a brief description of the Department of Health's general review of complaints procedures in the NHS. Part II examines the Bill clause by clause and Part III briefly summarises responses to the Bill from Opposition parties, patients' groups and professional bodies.

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I Background

A. The Health Service Commissioner

The Health Service Commissioner, generally known as the Health Service "Ombudsman", could be described as the apex of the NHS complaints system. The Ombudsman's powers date back to 1973 and are now consolidated in the *Health Service Commissioners Act 1993*.[1] The Act provides for a Health Service Commissioner for England, a Health Service Commissioner for Wales and a Health Service Commissioner for Scotland but, in practice, all three posts have always been held by the same person, currently William Reid. The comparable role in Northern Ireland is filled (under separate legislation) by the Commissioner for Complaints, who combines the post of the Health Service Commissioner and the Parliamentary Commissioner for Administration in one office. In general terms, the Ombudsman is able to investigate complaints about alleged failures in service by Regional or District Health Authorities, Scottish Health Boards, Family Health Service Authorities, NHS trusts and a number of other bodies such as the Dental Practice Board. Individuals may approach the Ombudsman directly in order to ask him to investigate a complaint (there is no requirement to approach him through a Member, for example), but before a complaint can be considered, the Ombudsman must be satisfied that all appropriate local procedures have been exhausted. It should also be noted that the Ombudsman cannot investigate the *merits* of a decision, but only whether it has been taken properly. Cases considered by the Ombudsman, then, consist of those where the patient remains dissatisfied after the local NHS trust or health authority has considered their complaint and no further local remedies are available. They may also include complaints over the way in which the authority concerned handled the patient's original complaint. The Ombudsman is appointed by the Crown, and is therefore independent of both Parliament and the NHS.

At present, there are certain matters which the Ombudsman cannot investigate. Although he can consider complaints about alleged failures in service or maladministration in NHS trusts and health authorities, the provisions of the 1993 Act prevent him from considering similar complaints about primary care practitioners: GPs, dentists, pharmacists and opticians. Nor is he permitted to look into complaints about the *clinical* judgement of a doctor or any other health professional. It is these two exclusions from the Ombudsman's powers that the proposed legislation intends to remove. Other matters which the Ombudsman does not have the power to investigate, such as most cases for which there could be a legal remedy or cases involving disciplinary or other personnel matters, are not affected by the Bill and will remain excluded from the Ombudsman's jurisdiction. For a fuller description of the Ombudsman's role, see the Appendix, where an article by William Reid is reproduced.

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B. Proposals for change

In 1993, the Department of Health announced that it intended to set up an independent review of complaints procedures in the NHS under Professor Alan Wilson. The proposal to extend the powers of the Ombudsman emerged both from this review (known generally as the Wilson review) and from two reports by the Select Committee on the Parliamentary Commissioner for Administration, one published before the Wilson report and the other commenting on Wilson's recommendations. In March 1995, following these three reports, the Department of Health published its proposals for new complaints procedures and an extended role for the Ombudsman in the document "*Acting on complaints*". Each of these reports is discussed in more detail below. Members interested in details of how the current complaints procedures in the NHS operate are referred to an earlier Library paper, Research Note 91/61.

1. First Report of 1993/94 of the Select Committee on the Parliamentary Commissioner for Administration

In November 1993 the Select Committee on the Parliamentary Commissioner for Administration published its first report of 1993/94, "*The powers, work and jurisdiction of the Ombudsman*"[2] looking at the remit of both the Parliamentary Ombudsman and the Health Service Ombudsman. In the context of the Citizen's Charter initiative, the increase in the number of "ombudsmen", both in the UK and throughout the world, and the development of the use of tribunals and judicial review since the first Ombudsman (the Parliamentary Ombudsman) was established in the UK, the committee felt it was an appropriate time to consider what reforms might be necessary to ensure that the Parliamentary and Health Service Ombudsmen continued to operate effectively.

The committee concluded that serious thought should be given to extending the Health Service Ombudsman's powers to include alleged maladministration by GPs. While acknowledging that complaints should be resolved locally if at all possible, the committee pointed out that "the Ombudsman is there because of the sad fact that such resolution is not always possible" and that "we find it difficult to see why such a fundamental part of NHS care should be deprived of the scrutiny of the Ombudsman". Accordingly, it recommended the following:

> "We believe that the Wilson Committee and the Government should consider seriously the extension of the Ombudsman's jurisdiction to maladministration on the part of GPs. The current exclusion deprives the public of a right

[2]HC 33 1993/94

> considered necessary in all other sections of the NHS. We believe that this should be changed."[3]

The committee also recommended that the Ombudsman should be allowed to investigate complaints about the way Family Health Services Authorities (Health Boards in Scotland) handle the formal proceedings against primary care practitioners. Unlike the hospital complaints system, the formal complaints procedures against GPs and other primary care practitioners are effectively disciplinary proceedings for breach of their terms of service, and the way in which they are handled has never been within the Ombudsman's remit. However, this recommendation has been overtaken by the changes to the NHS complaints procedures to be implemented from April 1996 (see below, page 10) which will separate complaints procedures from disciplinary procedures in the primary care sector, in the same way as they already are in the hospital sector.

On the question of clinical complaints, the committee considered that the present system of "independent professional reviews" of cases by two consultants not originally involved in the patient's care did not do enough to ensure impartiality in its procedures. It therefore recommended that a lay element should be introduced, but expressed some uncertainty as to whether this lay element should be the Ombudsman. Given appropriate professional advice, the committee had no doubt that the Ombudsman would be quite competent to consider such cases; it also felt that the unity brought to the complaints system by extending the Ombudsman's powers in this way would be advantageous. Nevertheless, considering the inevitable extra workload which such an extension of the Ombudsman's powers would entail, the committee concluded:

> "We recommend that clinical judgement remain outside the Health Service Ombudsman's jurisdiction under the existing arrangements, although we believe that the Health Service Ombudsman should be seen as the apex of any unified NHS complaints system that may be introduced."[4]

2. The Wilson review of NHS complaints procedures

The Review Committee on NHS complaints was set up on 18 June 1993 under the chairmanship of Professor Alan Wilson "to review the procedures for the making and handling of complaints by NHS patients and their families in the United Kingdom, and the costs and benefits of alternatives to current procedures, and to make recommendations to the Secretary of State for Health and other Health Ministers."[5] Currently, a number of different systems for

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[3]ibid para 119
[4]ibid para 110
[5]Department of Health press notice 94/228, 11 May 1994

handling complaints about NHS services exist, depending on whether they are about hospital or primary care, and whether they concern clinical judgement or administrative matters. This system has been criticised as being inaccessible and confusing, especially where a complaint extends across both primary and hospital care, or has both administrative and clinical elements.

The committee's report[6], published in June 1994, recommended that a single complaints system covering all parts of the National Health Service should replace the existing procedures, making it easier to understand and more accessible to patients. This system should also be quite distinct from any disciplinary procedures against staff. The committee proposed that the new system should consist of two broad stages:

- stage one, where an immediate first-line response could be followed where necessary first by investigation or conciliation and then by action by an officer of the relevant health authority; and

- stage two where those complaints which had not been resolved at stage one could be screened and, where appropriate, investigated by panels with a lay majority. Where the complaint concerned clinical judgement, the panel would include two members from the relevant profession, acting as independent assessors.

The committee made no specific recommendation as to who should appoint the stage two panels, although it outlined four possible options: the chief executive of the trust concerned (or, for GPs, the health authority holding their contract); purchasing authorities, or consortia of purchasing authorities; the regional offices of the NHS Executive; or a national Complaints Commission. As members of the committee had been unable to agree on which of these options would be the most appropriate, the report simply recommended that Health Ministers should consider all four.

The report then addressed the question of the Ombudsman and proposed that his powers should be extended both to GPs and to clinical complaints:

> "We support the recommendations made by the Select Committee on the Parliamentary Commissioner for Administration to extend the Health Service Ombudsman's jurisdiction to GPs and to the operation by family health services authorities of the current service committee procedure. We also suggest that the Government should carefully examine whether the practical difficulties might be overcome which the Select Committee believes prevent the Ombudsman considering complaints about clinical judgement."[7]

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[6]Department of Health, *"Being Heard"*, May 1994
[7]ibid para 322

A further possible extension of the Ombudsman's powers concerned complaints about purchasing decisions and policy matters: for example complaints about the way a District Health Authority prioritised its spending. At present, the Ombudsman can only investigate such cases if the complainant has personally suffered injustice as a result of the purchasing authority's policies. The committee suggested that if a complaint about purchasing decisions could not be resolved at stage 1, complainants should ask the Ombudsman to investigate. Although the Ombudsman would not be able to substitute his own decision for that made by the authority, he would be able to investigate whether decision making processes were appropriate and whether they had been properly followed.[8]

3. Sixth Report of 1993/94 of the Select Committee on the Parliamentary Commissioner for Administration

In their sixth report of 1993/94[9], the Select Committee commented on the conclusions of the Wilson report. The recommendation to establish unified complaints procedures was welcomed as "remov[ing] much of the current obscurity and complexity"[10], although the committee expressed doubts about how stage 2 procedures might function in practice:

> "We retain, however, serious doubts as to the wisdom of the system proposed. We are concerned that the proposed procedures are long and cumbersome, often requiring the duplication of lay or expert advice. We believe that if implemented as proposed they would prove bureaucratic and an impediment to ready access to the Health Service Commissioner."[11]

As far as the powers of the Ombudsman himself were concerned, the committee welcomed the Wilson report's support for extending jurisdiction to GPs and other primary care practitioners. On the question of clinical complaints, the Ombudsman submitted a memorandum to the Committee stating that he "would not oppose in principle extension of the jurisdiction of HSC, but some fundamental questions need to be addressed first."[12] These concerns included the extent to which the Ombudsman himself would be able to be involved in every investigation because of the increased workload, together with the need for more staff and office accommodation and, possibly, the creation of regional offices. In its report, the committee accepted the idea of clinical complaints coming within the Ombudsman's remit, but reiterated concerns about workload and the need for appropriate staff and resources to be made available. It also recommended that the new procedures should apply to the clinical judgement of all staff, and not just doctors.[13]

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[8]ibid para 275
[9]"*Report of the Health Service Commissioner for 1992-93*", HC 42 1993/94
[10]ibid para 62
[11]ibid para 64
[12]ibid p.148
[13]ibid para 67

The committee also congratulated the review team on raising "a matter of genuine public concern": the question of how complaints about purchasing decisions could be made before an individual felt they had personally suffered injustice. The committee felt it was "clearly inadequate only to be able to complain once a decision has led to an individual suffering injustice". However, the committee did not recommend any changes in the Ombudsman's remit in this respect, both because of the practical problem of the impact on the Ombudsman's workload and because of the danger of his independence being compromised by becoming involved in "what are essentially local political arguments". Instead, the committee highlighted the statutory requirements which already exist for purchasers to consult on major changes in service[14] and recommended that the Government ensure that this procedure be widely publicised and easily accessible.[15]

4. The new complaints procedures

In March 1995, the Department of Health published its proposals for a new complaints system in the document "*Acting on Complaints"*. The proposals are closely modelled on the Wilson recommendations, with a few adjustments: for example any of the options listed in "stage 1" can be used immediately in order to give the most appropriate response, instead of their being taken in sequence. A summary of the two stages of the procedure is reproduced below:

"TWO STAGE NHS PROCEDURE

IV *We accept the recommendation of the Review Committee for a two stage complaints procedure within the NHS, overseen by the Health Service Commissioner (Ombudsman).*

STAGE I

V. In the first stage those providing services to patients should try to resolve the complaint as quickly as possible.

7 At Stage I the following options would be available for resolving the complaint:

an immediate, often oral, first line response;

investigation/conciliation;

action by an officer of the health authority for family health services or by the chief executive for trusts.

8 These would not be sequential procedures which a complainant had to go through in turn. The kind of response would depend on the nature of the complaint and the wishes of the complainant. There will need to be well publicised access for all complainants to a named person such as a complaints officer.

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[14]as set out in section 19 of the *Community Health Councils Regulations* (SI 1985/304), as amended
[15]HC 42 1993/94 para 73

VI. The current Patient's Charter right to receive a full and prompt written reply from the chief executive to any formal complaint against a trust will be retained.

9 The Review Committee did not think it appropriate for chief executives to provide written replies to all complaints given the emphasis on a rapid first line response. The Select Committee on the Parliamentary Commissioner for Administration, however, felt* that it was important to retain this right. We agree with the Select Committee that the chief executive should continue to sign all written responses to complaints in order that he or she should maintain oversight over all complaints, while ensuring that complaints receive as quick a response as possible.

* *in their sixth report, 1993-94 session, HC 42, paragraph 63*

VII. Practice-based complaints procedures will be developed in all family health services.

10 We will be discussing with the professional representative organisations and others how to develop practice-based complaints procedures in family health services.

STAGE 11

VIII. If complaints cannot be resolved by service providers, complainants will have the option of asking for a further review which may include the establishment of a panel to reconsider the complaint. Such panels will have a lay chair and a majority of members totally independent from the provider of the service. Independent clinical assessors will provide advice in appropriate cases.

11 In relation to hospital services the decision on whether to convene a panel will be taken by a non-executive director of the relevant NHS trust (the "convener"). In relation to primary care services, the convener will be a non-executive member of the relevant health authority. In making this decision, the convener will act in consultation with the independent lay chairman who would chair the panel if one were to be convened. In England, the independent chairman will be drawn from a list maintained by the regional office of the NHS Executive.

12 In deciding whether to establish a panel, the convener and independent lay chairman will consider:

* whether the trust or practice can take any further action short of establishing a panel to satisfy the complainant;

* whether the trust or practice has already taken all practicable action and therefore establishing a panel would add no further value to the process.

13 If this consideration leads them to conclude that a panel should not be established, the complainant can, of course, put their case direct to the Health Service Commissioner (Ombudsman). This is an important safeguard.

Panels will be composed as follows:

* in relation to a non-clinical complaint about hospital services, the independent lay chairman, the convener and, in most cases, a non-executive from the relevant health authority. Where appropriate, the health authority would also consult the relevant GP fundholder to take their views. If the fundholder agrees, he or she might represent the purchaser interest on the panel;

* in relation to primary care complaints, the independent chairman, the convener and another independent lay person drawn from the regional list;

* panels wholly or partly related to clinical matters (whether in hospital or primary care cases) would also be advised by two independent clinical assessors.

* Reports by complaints panels will routinely be made available to the complainant and the relevant trust and purchaser or, in the case of family health services, the relevant health authority and family practitioner.

14 Detailed guidance on the criteria for convening panels, their membership, how best to ensure the input of independent professional advice in appropriate cases, and on their operation will be developed based on discussion with interested parties."[16]

The target date for the implementation of stage one and stage two procedures is April 1996. In October this year, the Department of Health issued interim guidance[17] on implementation, providing advice for those responsible for developing the practical details of the new system. The guidance also gives details of the legal framework for the new procedures: Directions will be issued to NHS trusts and health authorities under the *Hospital Complaints Procedure Act 1985* and the *National Health Service Act 1977*, and amendments will be made to the Regulations governing the terms and conditions of family health services practitioners.

The document also announced firm proposals on the future powers of the Ombudsman:

"21 Currently the Health Service Commissioner's jurisdiction covers hospital complaints (excluding those concerning the exercise of clinical judgement), and complaints against family health service authorities, but not against family health service practitioners. As recommended by the Review Committee and by the Select Committee on the Parliamentary Commissioner for Administration, we propose that his jurisdiction be extended to cover clinical complaints against all NHS staff and all complaints against family health service practitioners and their staff. The Commissioner will need access to appropriate professional advice in undertaking these new responsibilities. Complainants would not be able ordinarily to take the complaint to the Commissioner before they had exhausted the internal complaints system. The current exclusion from matters which the Commissioner can investigate, of action taken in respect of disciplinary or other personnel or contractual matters, shall continue.

22 We agree with the Select Committee on the Parliamentary Commissioner for Administration that there should be no change in the Commissioner's current jurisdiction over complaints against purchasing. He can and does investigate complaints where there appears to have been specific harm or injustice caused to an individual as a result of a decision by a purchaser."[18]

It is hoped that the Bill will receive Royal Assent in time for the Ombudman's new powers to come into effect at the same time as the stage 1 and stage 2 procedures.

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[16]Department of Health, "*Being Heard*", March 1995 pp 3-4

[17]Dept of Health circular EL(95)121 & NHS Executive, "*Interim guidance on implementation of the NHS complaints procedure*", October 1995

[18]Department of Health, "*Being Heard*", March 1995 pp 6-7

II The Bill

The *Health Service Commissioners (Amendment) Bill*, Bill 10 of 1995/96, was presented in the Commons on 30 November 1995 and is due to receive its Second Reading on 12 December. In brief, the Bill would amend the *Health Service Commissioners Act 1993* by extending the jurisdiction of the Ombudsman to include independent health services (where these are treating NHS patients), family health service providers such as GPs, and the Mental Welfare Commission for Scotland. Action taken as a result of a clinical decision would also no longer be excluded from his investigations. The Ombudsman would be given more discretion to decide whether to override the general requirement that local complaints procedures should be exhausted before he is able to investigate a particular case. Further minor amendments proposed to the 1993 Act concern the circumstances in which the Ombudsman may disclose confidential information obtained during his investigation, and the obligation to send copies of his reports to specified persons or bodies.

Clause 1 of the Bill would insert new sections 2A and 2B into the *Health Service Commissioners Act 1993*. Section 2 of the 1993 Act lists those bodies subject to investigation by the Ombudsman: the first of these new sections would include "family health service providers", that is GPs, general dental practitioners, opticians and pharmacists, in the list; the second new section would add "independent providers", that is non-NHS bodies contracted to treat NHS patients. While the intention under existing legislation has always been that NHS patients treated in private hospitals would be eligible to approach the Ombudsman, the provision was not absolutely clear; this new section aims to clarify his jurisdiction in this respect.

Clause 2 would insert new subsections 1(A) to 1(D) in section 3 of the 1993 Act. These give the Ombudsman the power to investigate allegations that a patient has suffered injustice or hardship as the result of the actions of a family health service provider or an independent provider. The Ombudsman would also be able to investigate allegations against those employed by such providers, or acting on their behalf. Where the family health service provider is a GP fundholder, then decisions concerning the fundholding budget would also come within the provisions of this section. Two further subsections, subsection (5) and subsection (6) would be inserted in section 3 of the 1993 Act, making the provision that the Ombudsman does *not* have the authority to question the merits of any decision made by any of these persons or bodies if the decision was taken without maladministration. The same limitation on the power of the Ombudsman already exists as regards decisions taken without maladministration by health authorities, NHS trusts and other health service bodies. However, these new subsections do not apply to clinical decisions, the merits of which *will* be subject to investigation: see below, clause 6.

Clause 3 would give effect to Schedule 1.

Clause 4 would amend sections 2(3), 4(3) and 7 of the 1993 Act to include the Mental Welfare Commission for Scotland (which oversees the welfare of detained patients) in the list of health service bodies subject to investigation by the Ombudsman. However, a number of the functions of the Mental Welfare Commission for Scotland would still be excluded from his jurisdiction: those concerning the discharge of patients from detention or guardianship under the *Mental Health (Scotland) Act 1984*, and those concerning the revocation of community care orders.

Clause 5 would amend section 4 of the 1993 Act in order to prevent the Ombudsman from investigating allegations of failures of service unless local complaints procedures had already been exhausted. However, he is given the discretion to investigate if in the particular circumstances it would not be reasonable to expect the local procedures to be invoked. This extends the Ombudsman's discretion: as the law stands at present, he *must* satisfy himself that the local procedures have been used before investigating himself, except in the one specific circumstance where the complaint is being brought on behalf of a patient by an NHS employee.

Clause 6 would extend the Ombudsman's jurisdiction to include the investigation of clinical complaints. Section 5 of the 1993 Act currently excludes clinical matters from his jurisdiction; this clause would omit the section. It would also add a new subsection (7) to section 3 of the 1993 Act, to make clear that although the Ombudsman cannot investigate administrative decisions where there is no maladministration (ie he cannot comment on the merits of the decision, but only the way in which it was made), he *can* investigate the merits of clinical decisions.

Clause 7 would remove the statutory bar on the Ombudsman investigating the actions of family health service providers by omitting section 6(1) and 6(2) of the 1993 Act. However, the Ombudsman would still not be able to investigate the way Health Authorities (which will replace Family Health Services Authorities from 1 April 1996) and Health Boards conduct hearings into allegations that family health service providers have breached their terms of service. This would be in accordance with the principle that the Ombudsman has jurisdiction over patient complaints but not over disciplinary matters.

Clause 8 would amend section 7 of the 1993 Act, which excludes the Ombudsman from investigating personnel matters, to include references to service under the *NHS and Community Care Act 1990* (this was an omission in the existing legislation). It would also make clear that these exclusions from the Ombudsman's jurisdiction would not affect his power to investigate complaints about the way in which a health service body operates its complaints system.

Clause 9 would omit subsections 9(5) and 9(6) from the 1993 Act. These subsections currently require local complaints procedures to be exhausted before the Ombudsman may investigate a complaint, and have been supplanted by clause 5 of this Bill.

Clause 10 would amend section 14 of the 1993 Act which is concerned with the people and bodies to whom the Ombudsman must send reports. In line with a recommendation by the Select Committee on the Parliamentary Commissioner for Administration[19], the Ombudsman would no longer be required to send a report to the health service body concerned when he decided *not* to conduct an investigation. The current requirement for the Ombudsman to submit annual reports about the performance of his functions to the Secretary of State, who then lays them before each House of Parliament, would be amended so that the Ombudsman himself would lay the report before each House. This again is in line with a recommendation by the Select Committee[20] which felt that as the Ombudsman is not answerable to the Secretary of State, it would be more appropriate for him to report directly to Parliament. The clause would also provide for reports to be sent to the health service body which, at the time the report is made, provides the service in question. At present, the 1993 Act provides for the "health service body concerned" to receive the report. The replacement wording would ensure that if a health service body had taken over the relevant functions since the complaint was made, then it would receive a copy.

Clause 11 would amend section 15 of the 1993 Act which concerns the disclosure of information obtained by the Ombudsman during the course of an investigation. Under existing provisions, no information may be disclosed except in prescribed circumstances, including for the purposes of the investigation itself and in cases of proceedings under alleged breaches of the Official Secrets Acts or allegations of perjury. In addition to these provisions, clause 11 would also allow disclosure of information where this information would not otherwise be reported as a result of the investigation and where the implication of the information is that a person is likely to constitute a threat to the health or safety of patients. If the Ombudsman chose to disclose information under this section, for example to a regulatory body, or to an employer, he would also have to inform the person involved that he had made such a disclosure and to whom he had made it. The clause would also extend the exemption from giving evidence in proceedings (which currently applies to the Commissioner and his officers) to the Commissioner's advisers.

Clause 12 makes the financial provisions for the Bill. The Department of Health estimates that the additional costs of the Ombudsman's increase in workload (with an increase from approximately 130 to 140 posts in the Ombudsman's office) would be around £5 million in the first year rising to £6.5 million in subsequent years in real terms. These increased costs would be met by transfer from the relevant Votes of the Department of Health and the Welsh

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[19]HC 33 1993/94, para 92
[20]ibid para 93

and Scottish Offices. The Department also states that there will be marginal additional costs borne by the NHS because of the increase in the number of investigations; both these costs and the costs of the transfer will be met from existing resources.

Clause 13 allows for the repeal of the appropriate sections of the 1993 Act.

Clause 14 makes the commencement provisions. The Act will come into force by order through statutory instrument; different provisions of the Act may come into force at different times, as may the provisions dealing with different parts of the United Kingdom. The general principle is that the new provisions should not be retrospective; however, where the Ombudsman is investigating a complaint about action beginning after the "prescribed date", he will be able to consider action before that date if it is all part of the same action. In other words, if the complaint relates to a course of treatment bridging the date on which the relevant part of the Act comes into force, then the Ombudsman will be able to look at the whole picture, and not just at the events taking place after the commencement date. The intention is that, if possible, the Act should come into force by April 1996, when the new two stage NHS complaints procedure will be introduced.

Clause 15 sets out the extent of the Bill. The Bill would extend to Northern Ireland only in so far as the provisions in the 1993 Act extend to Northern Ireland: that is, the provisions dealing with how investigations by the Ombudsman are to be carried out, including the confidentiality of information disclosed during proceedings.

Clause 16 gives the long title.

Schedule 1 would make consequential amendments to the 1993 Act so that when the Ombudsman is investigating a complaint about family health service providers or independent providers he has the same powers and duties (for example the duty to permit the body or person concerned to comment on any complaint made about them) as he has when investigating complaints about health authorities, trusts and other "health service bodies" as defined in the 1993 Act. Similarly, a provider of family health services may not be appointed as the Ombudsman, in the same way as the current legislation prevents a member of a health service body from becoming the Ombudsman.

III Reactions to the Bill

A. In Parliament

The measures proposed in the Bill have received a generally warm response from all sides of the House. In the Third Day debate on the Queen's Speech, Stephen Dorrell, the Secretary of State for Health described the Bill and its context as follows:

> "The first [proposal] is the Bill relating to health service commissioner, which will implement a key proposal of the Wilson committee, which examined the reform of the handling of complaints within the NHS. Both sides of the House agree that the committee produced proposals that will substantially improve the handling of complaints. It suggested a three-tier approach. The first is to encourage complainants and the local health care deliverer to resolve their difficulties informally. If that fails, the second is the establishment of a three-person lay panel at local level, with the majority of its members being independent of the trust or health care provider, to consider the complaint. If both these fail, the third tier is for the complaint to be examined by the health service commissioner.
>
> If we are to deliver that system, which the Government accept and endorse, we need to extend the commissioner's powers to allow him to examine both the activities of the family health services and the clinical questions and complaints put to him. The Bill will provide for that. It is an important step forward in ensuring that the health service respects its obligation to listen to patients and to their complaints and to learn from them. It will ensure that the health service treats its patients as human beings as well as as patients."[21]

In response, Labour's health spokesperson, Harriet Harman said that "we welcome the Bill to strengthen complaints procedures and look forward to studying its detail"[22] and Paddy Ashdown for the Liberal Democrats stated that "we would support a sensible Bill to strengthen the powers of the health service ombudsman".[23]

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[21]HC Deb 17 November 1995 c.242
[22]HC Deb 17 November 1995 c.261
[23]HC Deb 15 November 1995 cc 39-40

B. Organisations representing patients

Patients' organisations have also welcomed the increase in the Ombudsman's powers, while having a more mixed reaction to the new complaints system as a whole. In a letter[24] to the Secretary of State for Health, the Association of Community Health Councils for England and Wales (ACHCEW) stated that "this Association has long supported the need for such legislation and welcomes the action taken by the Government on this matter". In response to the announcement of the new complaints procedures in March, however, ACHCEW stated that:

> "ACHCEW welcomes changes intended to speed the system, provide better training for staff dealing with complaints and ensure that most problems are dealt with as and where they arise. But we are concerned about those patients whose complaints are too serious or complex to be handled in an informal manner - there is no right of access to an investigation which is independent of the NHS. Under the proposals, the all-important "Stage 2" investigation may not be available to these people, as cases are to be screened by non-executive Directors of NHS Trusts or Members of health authorities."[25]

ACHCEW also suggested in their letter to the Secretary of State that the new legislation would offer an opportunity for community health councils to be brought within the jurisdiction of the Ombudsman. ACHCEW have been pressing for this for some time, but the Bill as currently drafted would not change the Ombudsman's powers in this respect.

In their evidence to the Select Committee's report on the powers of the Ombudsman[26], the Patients Association (a voluntary body representing patient views) had raised a number of concerns subsequently addressed in the Bill: these include the need for an independent arbiter such as the Ombudsman to look at clinical complaints and the clarification of the position of NHS patients being treated in the private sector. In their press notice[27] responding to the announcement of the new complaints procedures, the Patients Association stated that they "welcome[d] the Government's proposals for improved complaints procedures which will mean a quicker and more accessible service"; they also highlighted a number of factors which they felt still needed to be clarified, such as the details of the stage 1 procedures and how independent the appeal panels at stage 2 would be in practice.

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[24]dated 15 November 1995
[25]ACHCEW press notice, 22 March 1995
[26]HC 33-II 1993/94 pp 247-251
[27]dated 22 March 1995

C. Professional organisations

The Royal College of Nursing issued a press notice after the Queen's Speech, welcoming the principle of the Bill, while commenting on the need for scrutiny of aspects of its implementation:

> "The RCN welcomes this proposal as one of several measures aimed at creating a single, unified complaints procedure. The timetable is very tight. It is proposed that the new system should be up and running by 1 April 1996. Training will be needed and a whole cultural change in the NHS is required for the new system to operate as intended. The Ombudsman will need to obtain clinical advice from a range of health professionals, including nurses, in order to screen complaints prior to investigation and during the course of the investigation. The RCN will be carefully scrutinising the proposals for how he obtains clinical advice."[28]

The British Medical Association reacted to the proposals with a little more caution. In a press notice[29] issued after the publication of "*Acting on complaints"*, they responded positively to the aim of bringing the two complaints procedures for hospitals and for GPs together, but had a number of concerns about the way in which it was being done. It was felt that the hospital procedure would become less informal and more legalistic as a result of the changes, and that giving NHS trusts responsibility for organising complaints procedures threatened the existence of a national system. On the particular issue of the powers of the Ombudsman, some doubts were expressed about the question of clinical complaints:

> "The decision to extend the jurisdiction of the Health Service Commissioner to cover clinical complaints points to a particular need for the Commissioner to have access to appropriate professional advice. The GMSC [General Medical Services Committee of the BMA] welcomes the Commissioner's widened involvement in administrative complaints, but views his involvement in matters of clinical judgement with some concern."

A later press notice[30], issued after the Queen's Speech, stated that "the BMA wants to ensure that the new complaints system will be fair to both the users and professionals working within the health service" and that "the BMA will consider the contents of the Health Service Commissioner (Amendment) Bill when published". Unfortunately, at the time of writing this more detailed response was not yet available.

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[28]RCN parliamentary briefing, 16 November 1995
[29]dated 22 March 1995
[30]dated 20 November 1995

Appendix

The Role of the Health Service Ombudsman[31]

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It is almost impossible to pick up a newspaper these days without reading an article critical of some aspect of the National Health Service. It might appear from press reports of the cases investigated by my office that I am one of that band of critics. Although I express criticism when it is due after dispassionate investigation, my perception is that in general staff are committed to delivering a standard of service of which any profession would be proud. Why has my role as Ombudsman come nearer centre stage during the last few years? It is obviously because what the NHS does or does not do affects members of the public very directly and at a time when they are at their most vulnerable. Continuing debate about the NHS and care in the community can generate understandable fears about resources, about patient choice and about standards of quality generally. Lurid stories make those who need the NHS worried that the same thing might happen to them. Yet paradoxically this concern shows what a high value is currently placed on the present service.

Complaints can bring to light failures of service or bad performance, of which any profession should be ashamed. The NHS should always be prepared to learn from these failures. When I read the reports of other Ombudsmen, I feel reassured that errors or deficiencies are not the monopoly of the caring professions. Any professional organisation should have as one of its purposes the putting right of failures in service or bad performance. It should not be determined to resent complaints or to reject the help of lay persons, perhaps of independent arbiters or of ombudsmen, to help to restore public confidence, to achieve redress and to point up the need for training in order to deliver improvement for the future.

At present I can look into complaints about the NHS where I am satisfied that-(i) the complainant (or the person on whose behalf the complaint is being made) has suffered hardship or injustice as a result of maladministration or failures of service (including nonprovision of service) and (ii) the complaint falls within my jurisdiction. My main tasks are to consider complaints to see if they are investigable, to achieve redress if a complaint is justified (not all are), and to try to improve procedures or systems (or even persons) in order to reduce the chance of repetition. Sometimes redress can be as simple as an explanation of what went wrong or an apology for a misunderstanding.

The Government has this year given me responsibility for receiving complaints about refusal of access to information. The Government's Code of Practice on openness which came into effect on 1 June [1995] aims to make sure that the public are able to get information about the NHS, the cost of services, and the standards of service to expect. They should be given an explanation about any proposed changes to services and given the chance to have a say in the decisions made about those changes. They should know the reasons for decisions and actions affecting their treatment. If such information is unreasonably withheld, members of the public will have the right to put their complaints to the Ombudsman, having first put their complaints to the body concerned. I can consider complaints that information has been refused, or that the information that has been released is incomplete or misleading, or about delay or overcharging when Health Departments or other bodies respond to requests for information.

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[31]The Scottish Office Home and Health Department, "*Health Bulletin*", Vol 53(6), November 1995 pp 349-352

I cannot at present investigate complaints about clinical decisions or complaints about primary care services provided by family doctors, dentists, opticians or pharmacists. The Goverment's recent announcement on complaints would greatly enlarge my responsibilities. From 1996, if Parliament approves such a change, the Health Service Ombudsman would be empowered to investigate complaints against such practitioners in primary care, and complaints about the clinical judgement of doctors, nurses and other professional staff in hospitals and the community. The first change should remove the unhelpful confusion between complaints and disciplinary procedures. The Ombudsman will continue to have no responsibility for discipline and personnel matters.

I am currently recruiting staff and making changes in my office to cope with this - the most significant change since the Health Service Commissioner was set up 22 years ago. I shall obviously be heavily reliant on the guidance of experts. Already I have begun to discuss the implications of the altered jurisdiction with professional interests, with those who represent patients, and with the Health Departments.

One result of the proposed changes may be to put into a more explicable form - certainly in the eyes of the complainant and, I trust, in the profession's eyes too - the consideration of complaints about clinical judgement. At present the regional variations in granting independent professional reviews are inexplicably wide. Some alignment in practice seems to be needed for the sake of equitable treatment. It may prove feasible to have a comprehensive review of complaints involving clinical episodes because at present the medical or surgical clinical assessors cannot investigate the part played by *other* professionals such as nurses, midwives and paramedics. Particular consideration will need to be given to deciding whether the complainant may have a remedy in courts or before a tribunal, and whether it is not reasonable to expect the complainant to pursue such a remedy. Account will need to be taken of the expansion of the jurisdiction of the General Medical Council. The Ombudsman will need to consider what has gone on at Stage 1 or Stage 2 of the procedure before the complaint has reached his office. He will certainly require expert assessors to whom he can turn for expert views of their peers' actions, he will want them to be covered by the absolute privilege accorded to his reports, and he will need on his staff (or on tap) a qualified professional or two to help him get the appropriate advice for each case of clinical judgement.

My aim will be to try to ensure that my office is ready to tackle these new responsibilities without detriment to the scrutiny and investigation of the increasing number of complaints sent to me within the limits of my existing jurisdiction. Indeed I am determined to reduce the time between complaint and report. So are my staff. My aim will be to have in place arrangements which the public and the professions within the NHS will see as independent, fair and effective.

Patients and their families have, understandably, found the present complaints system confusing and daunting. Ideally complaints are best sorted out quickly and satisfactorily at the local level. The Government has included in the new arrangements a second stage to the NHS complaints procedure which will be operated at local level, and which will involve non-executive members of boards. I should be the last resort when local investigations have not worked to the satisfaction of the complainant or if the professional complained about considers that Stage 2 has not been fair to his or her side of the story.

To have a complaint lodged against you can be upsetting, stressful and time-consuming to the professional. That is why I am very careful in screening complaints to ensure that there is a genuine grievance to be investigated. For reasons of jurisdiction mainly I reject many of the complaints that I receive. Of the complaints I investigate I find about 50 per cent to be justified. My investigations are thorough and can therefore be long but it is essential for my findings to be soundly based in order to be as fair as possible to all concerned.

My experience is that in a very high proportion of cases complaints are caused by a failure in communications. That is why I commend clear explanations. I urge clear and careful records. Then there should be no doubt that the correct medication was given, that there was a care plan which was adhered to, that the nurse did pass on the request to the doctor, that the ambulancemen were told the ambulance was urgent, that the patient's name was put on the right list. Shortcomings in records can have serious repercussions for patients and can cause real

distress to them and their families. All too often I find that the quality of care - for example in relation to attending to pressure areas, to giving appropriate supervision to a disturbed patient, to arranging discharge from hospital - has been damaged by failures to pass on or record important information. To ensure continuity of care and understanding, records need to be maintained and information has to be passed on unambiguously to colleagues. Few decisions are taken in isolation and effective care relies on good multidisciplinary team work. There should be no room for doubt about what has been decided, why, and what action needs to be taken, who is to take it and when. There are many examples of bad practice in my files: poor oral and written communications not only among staff but with patients and relatives; lack of procedures; ignorance of procedures; failure to comply with procedures; and of inadequate training in handling bereavement. One fault I find in cases of all kinds is the assumption on the part of one professional that he or she need not take action because another professional is expected to take it.

Complaints may arise because of inadequate explanation of treatment. Is this due to lack of time - pressure of work - or because of an assumption that the perception of the non-medical hearer does not matter? A 1976 publication 'Doctors Talking to Patients' records one doctor saying, 'I see no reason at all to explain a patient's condition to him. If he asks an intelligent question I might offer some simple explanation, but on the whole I prefer not to.' This attitude would rarely be found nowadays but in an investigation I completed a couple of years ago I criticised a consultant who did not tell a patient, or his son, that he suspected cancer, did not brief the nurses about it but said that they could have deduced it from the clinical records and that they - not he - could have passed on the diagnosis.

If complaints are not dealt with very well at the local level they may be referred to me. I do not accept a case for investigation unless it has first been put to the health service body against which the complaint is lodged and adequate time has been given to that body to make its own investigation and reply to the complainant. Regrettably my investigators often find that a complaint has not been investigated thoroughly by the health authority concerned and that the first some members of staff know about it is when I have agreed to investigate.

Only exceptionally will I investigate a complaint about matters which are more than 12 months old. This time limit makes sense in protecting professionals from being in permanent jeopardy and also because of the difficulty of getting at the truth when a considerable period has elapsed. A complaint is first screened to see if it comes within my jurisdiction. A complaint may cover several issues and some may be excluded and others included. The complainant and the health service body are informed of the issues I will investigate. Investigations typically involve not only examination of earlier papers relating to the complaint but also of other papers held by the health service body and interviews with the complainant, those against whom the complaint is made and any other relevant staff. My investigating officer should be able to obtain at the start of an inquiry all the relevant medical and nursing records and to see that the same summary of complaint is available to each and every witness. When I have compiled the report of my investigation results, the facts are checked for accuracy with the body complained about. If I find a divergence between the evidence given by the health authority and the complainant I make further investigations so that I arrive at the truth or, at least what, on the balance of probabilities, appears to be the truth. Where I find failures, I look for a remedy in the shape of an improved system, or the implementation of an existing system or clearer procedures for staff to follow. That should produce benefits for future patients. The top management in any organisation should use complaints as a means of testing the standard of service provided, employing them as an opportunity for learning what the users of the service think of it and for making it better and more responsive. Copies of the final reports go to the complainant, to the health service body (and staff) involved, and to the body which is above the one complained about. Summaries of individual reports are circulated by the Health Departments. In published volumes I include at least one example of a complaint not upheld. I may make a special report on cases of particular significance (e.g. in 1994 on the case in Leeds relating to NHS responsibilities for providing continuing health care). My reports are recommended reading for the object lessons they offer. The most serious complaints which I find justified are examined by the House of Commons Select Committee on the Parliamentary Commissioner for Administration. The management and professionals concerned may be called before the Committee to account for their actions. That, as those who have been subject to it will attest, can be a very stimulating experience.

The fact that the number of complaints goes up each year is not necessarily an indication that the quality of service is steadily deteriorating. There is now a much more open and receptive attitude to complaints and a stated determination to look upon them as part of local and national strategies for improving service quality. The evidence of many complaints is that satisfaction is affected by what the service feels like as much by the actual clinical care given.