Informal complaints procedure in general practice: first year's experience

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Abstract

Objective—To evaluate the first year's experience of an informal patient complaints system that encourages extensive patient participation.

Design—Audit of an informal complaints procedure.

Setting—The Marylebone Health Centre, London.

Subjects—39 complaints received over the audit period.

Main outcome measures—Types of complaints (administrative, about doctors or medical care or both, staff about patients, mixed, other) and resolution of complaints (how complaints were dealt with and their resolution).

Results—37 of the 39 complaints were resolved within two weeks. Two complaints sent direct to the family health services authority were resolved (with patients' agreement) by the informal complaints procedure.

Conclusions—The informal complaints procedure was more cost effective than the family health services authority system and was comparatively straightforward to implement within the practice without major organisational restructuring. The two way process of the procedure ensured patients received a quick response to complaints and helped morale of health centre staff.

Introduction

The increased frequency of complaints by patients about providers of primary health care has been the subject of many reports both within medicine and in the media.¹⁻⁶ The secretary of state's recent decision to set up a working party⁷ has highlighted the need for a mutually agreed system which protects both the public and professionals from the resource implications of these complaints. Defence organisation surveys showed that between 1980 and 1992 there was a 10-fold increase in complaints and that over 30% of such claims were successful.⁸ Women general practitioners aged under 50 have 50% fewer claims made against them than their male colleagues, but over the age of 50 women doctors are at slightly greater risk.⁸ Specialist publications for general practitioners have carried several surveys underpinning the stress felt by doctors associated with complaints.

Several factors have been identified as a cause of the increase in complaints. Not least is the secretary of state's statement that "complaints are to be encouraged." Other factors arise out of the new contractual obligation, the patient's charter, and the more active role of community health councils. The purchaser provider split with the emphasis on the patient as customer has probably also changed public perception, though there is no evidence that the increase in complaints reflects a decrease in standards. Family

health services authorities have at times been overwhelmed with complaints, and several have set up joint working groups with local medical committee representatives in an attempt to establish new guidelines.

Formal and informal reports on handling complaints agree that more locally based procedures should be developed and that the cumbersome and time consuming formal family health services authority hearings should be supplemented with additional procedures. It is also important to remember that within the United Kingdom the medical professional as a whole carries a very low professional negligence indemnity insurance as compared with that of other professional bodies. In the United States doctors carry negligence indemnity five times greater than that carried by the average British doctor.⁵ It is in order to prevent the trend to a more legalistic and expensive system that experiments in informal procedures are so necessary.

Background to project

The Marylebone Health Centre was established as an experimental primary health care centre to explore new ways of delivering care to an inner city population. The practice has a list size of around 5000 with a 30% turnover. There are two full time and two part time doctors. The sociodemographic distribution of the patients is very mixed, 34% not having English as their first language and over 200 classified as homeless. A practice based underprivileged area (Jarman) score was 61.4 (ward average 17.2).⁹

Part of the brief was to encourage patient participation and patient empowerment. Thus a "user" group of patients was established in 1987 and has proved popular with patients and staff alike. The aims of the group were:

- To promote dialogue about current provision of primary health care and encourage suggestions for improvement
- To plan and run jointly a health education and self care programme with the aim of improving patients' health and increasing their responsibility for maintaining their own health
- To develop a voluntary, mutual self help scheme.

This programme has been detailed elsewhere.¹⁰ The group meets every two months to discuss patients' complaints and is made up of 12 members.

Method

In 1991 a patient liaison worker was appointed to supervise all aspects of the practice's non-clinical relationship with patients. She reports directly to the practice manager under the guidance of the practice management group. Her training was in quality assurance, medical audit, and hospital accreditation. It

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Marylebone Health Centre
COMPLAINTS FORM

Complainant's details
 Name.....
 Address.....
 Contact telephone number.....

Patient's details if different from above:
 Name.....
 Address.....
 Contact telephone number.....

Summary of complaint
 (What is it that you most wish to complain about?)

Full details of complaint
 Date Time Place
 Identify member(s) of practice

Full description of events
 (ie: the facts surrounding the circumstances giving rise to your complaint).
 Please use additional attachments if necessary

Marylebone Health Centre
COMPLAINTS FORM

Complainant's signature Date

Would you like a patient representative from the Patients' Complaints Committee involved?
 Please circle YES NO

Where the complainant is not the patient
 (Please make sure that the patient fills in this section)
 I (please fill in patient's name)
 hereby authorise the above complaint to be made and I agree that the members of the Marylebone Health Centre staff may disclose (only in so far as it is necessary to answer the complaint) confidential information about me which I provided to them.
 Patient's signature Date

Please return this form to:
Ms SYBILLA DE URAY-URA, PATIENT LIAISON WORKER,
MARYLEBONE HEALTH CENTRE,
17 MARYLEBONE ROAD, LONDON NW1 5LT.

Office use only
Date received
Type
 Administrative
 Doctor's medical care
 Complaints from MHC staff about patients
 Mixed
 Other

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FIG 1—Complaints form for informal complaints procedure

is a full time post funded by the family health services authority.

The informal complaints procedure was designed to provide complainants with an explanation of the circumstances surrounding an adverse event. It was

decided from the outset that the procedure should be a two way process and be available both to patients and to staff—that is, staff could report an adverse event concerning a patient. The informal complaints procedure does not replace or prevent access to the formal complaints procedure. Explanatory leaflets and posters were distributed at the reception and waiting room area and patients were also informed through the practice newsletter.

A patient complaints committee was recruited, made up of volunteers from the user group, and a complaints form designed to be completed for each incident (fig 1). Two patients on the committee had lodged complaints previously with the health centre and therefore had a full understanding of the informal complaints procedure. Figure 2 shows the procedures which were followed once a complaint was received. Figure 3 shows the investigation form used.

Results

All complaints were treated as separate incidents and audit undertaken of the first year's experience (January to December 1993). A total of 39 complaints were processed during the period, divided into five categories (table I).

Administrative—Five complaints concerned administrative procedures, including repeat prescriptions, telephone system, receptionist, administrative staff action or inaction, and appointment procedures.

Doctors or medical care or both—Fourteen complaints were directed at individual doctors or the medical care at the centre.

TABLE I—Numbers of complaints in each category during audit year

	No
Administration	5
Doctors or medical care or both	14
Complaints from health centre staff about patients	10
Mixed	5
Other	5
Total	39

FIG 2—Flow chart of informal complaints procedure

Complaints from health centre staff about patients—There were 10 complaints from health centre staff about patients, including complaints directed at individual patients for rudeness, repeated failed appointments, etc.

Mixed—Five complaints concerned delay or difficulty in getting prescriptions, rudeness of doctor, medical care, appointments system, telephone system, waiting time, and doctor from deputising service.

Other—Five complaints from patients did not fit into any of the above four categories. Most were directed at other NHS services—for example, concerning length of waiting lists for treatment.

Table II shows the outcome of the 39 complaints. One was not resolved.

TABLE II—Outcome and resolution (if any) of 39 complaints

	No
Letter of apology from health centre	17
Letter of explanation and clarification of health centre procedures	17
Resolved by meeting with general practitioner, patient, and patient's representative	3
Explanation from hospital to which complaint was addressed	1
Not resolved (no response from hospital outpatient department)	1
Total	39

Discussion

In the five years before the informal complaints procedure the practice had only two formal complaints lodged against it. One involved the medical defence organisation. As expected with any innovation, however, once the procedure was in place many new examples were found.

In the year of the scheme 39 complaints were recorded¹⁰ from staff (table I). Most were resolved within three days, two (concerning doctor from deputising service and medical care) requiring an

Practice implications

- Informal in house complaints procedures are more cost effective than formal family health services authority systems
- Practice based systems result in rapid resolution of complaints
- Practice based systems facilitate audit of performance and encourage policy and procedural changes
- Informal complaints procedures represent good customer relations and help morale of practice staff
- No major organisational restructuring is required

investigation period of three weeks before being resolved.

The total time spent and amount of correspondence generated by all 39 complaints were less than those in relation to the two complaints received in the preceding five years. Hence personal stress was considerably reduced. Two complaints that were sent direct to the family health services authority were directed (with the patients' agreement) to the informal complaints procedure, so reducing involvement of the authority. The two complaints were satisfactorily resolved.

The procedures for administering such a scheme are comparatively straightforward and do not require major organisational restructuring. Appointing a patient liaison worker to pilot and manage the scheme in our centre was no doubt a factor in its success, but practice managers should be able to undertake the task within existing job descriptions. Recruiting patient representatives as members of the complaints panel ensures equity and helps patients feel that they are represented and that the procedures are not there merely to protect staff.

For health centre staff the reciprocity of the scheme ensured that their own grievances and complaints about patients could be acknowledged and were validated as appropriate by an "independent" panel. The reciprocity of the scheme also improved morale of staff.

Many of the complaints resulted in review of existing practice procedures and development of practice protocols and standard setting. For example, staffing arrangements were altered after a complaint about delay in answering the telephone at busy times. Issues of confidentiality need to be properly addressed, especially when the complainant is not the patient. Consent forms need to be issued and confidentiality statements signed by patients, patient representatives, and all staff involved in investigation of the complaint.

The cost implications of a practice based informal complaints procedure are minimal when compared with the cumbersome and lengthy procedures currently in place. Family health services authorities may therefore wish to finance the initial start up costs of similar schemes through developmental budgets and patient's charter initiatives.

Patient complaints have helped the practice reflect on its performance and encouraged the development of policy and procedural changes. Complaints procedure may be an inappropriate term for good customer relations.

We thank Dr Sally Hargreaves, of the Kensington and Chelsea and Westminster Family Health Services Authority, for supporting this project.

Marylebone Health Centre

COMPLAINT INVESTIGATION FORM

To:

Re:

Date:

From:

Please find attached a complaint received from:

.....

Please could I have any information about the attached complaint.

Please could you give me a statement below so that we can amalgamate this information and address the issues raised in this letter of complaint and return to me within 14 days.

Statement:

.....

.....

.....

.....

.....

.....

Signature:

FIG 3—Investigation form used for informal complaints

- 1 Royal College of General Practitioners. Council report. Complaints. *Connection* 1993 Aug;3.
- 2 Panting G. How to establish an in house general practice complaints procedure. *Medical Protection Society Casebook* 1993;2:6-9.
- 3 Department of Health. *Health service indicator 1991-2*. London: DoH, 1993.
- 4 Owen CA. Formal complaints against general practitioners. *Br J Gen Pract* 1991;41:113-5.
- 5 Stütte P. *What the complaints survey means for GPs*. London: Medical Defence Union, 1993.
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- 7 British Medical Association. *Evidence to the NHS Complaints Review Committee*. London: BMA, 1993.
- 8 Medical Defence Union. *Coping with patient complaints in general practice*. London: MDU, 1993:2.
- 9 Chase D, Davies P. Calculation of a practice under-privileged area score. *Br J Gen Pract* 1991;41:63-6.
- 10 Pietroni PC, Chase D. Partners or partisans? Patient participation at Marylebone Health Centre (discussion paper). *Br J Gen Pract* 1993;43:341-4.

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Cancer Prevention in Primary Care

Reducing alcohol intake

Joan Austoker

This is the third in a series of articles looking at how cancer can be prevented in general practice

Alcohol is second in importance only to smoking as a proved cause of cancer. The risk associated with excessive alcohol consumption can be reduced by adopting national and local population based policies. The population approach is aimed at reducing the level of consumption across the whole population, which contains many modest drinkers. Underlying this approach is the fact that a larger proportion of the total morbidity and mortality attributed to alcohol in a population occurs in modest drinkers, even though individually they are at lower risk. This approach should be complemented by risk reduction initiatives in primary care, focused on high risk individuals. Several studies have shown the efficacy of brief interventions by general practitioners in patients with excessive alcohol consumption. Brief interventions, taking 5 to 10 minutes, use simple assessments to identify those at risk and provide information and advice. Evidence exists that general practitioners underuse opportunities to identify and advise patients about excessive drinking.

Alcohol consumption is associated with raised morbidity and mortality. Excessive drinking increases the risk of raised blood pressure and stroke, liver cirrhosis, deaths from accidents, and the development of some cancers. The relation between alcohol and heart disease is complex. Recent research has shown that men who drink up to 30 units of alcohol a week are less likely to die from coronary heart disease than non-drinkers. Any specific protective effect for coronary heart disease, however, is likely to be rapidly offset even at fairly low levels of consumption by the increasing morbidity and mortality from all causes. Alcohol consumption leads to around 28 000 deaths each year in England and Wales alone. Eight million working days are estimated to be lost each year through absenteeism related to drinking.

Alcohol and cancer

Alcohol is second only in importance to smoking as a proved cause of cancer. Three per cent of all deaths from cancer (around 4300 deaths a year) are related to excess alcohol consumption. In some countries it may be responsible, in conjunction with smoking, for as many as 10% of all deaths from cancer. The observational evidence that the risks of several types of cancer increase sharply with the amount drunk to more than 10 times that in lifelong non-drinkers, combined with high risks in occupations associated with high consumption, low risks in social groups that abjure alcohol, and reduced risks in ex-drinkers, suggests incontrovertibly that alcohol is carcinogenic in humans.

Several cancers show evidence of a dose-response relation. Table I shows the types of cancer caused in part by alcohol.

There is strong evidence that alcohol acts synergistically with tobacco. Studies on oral, pharyngeal, and oesophageal cancers have shown that alcohol combines with smoking multiplicatively so that people who smoke and drink heavily have high risks compared with those who neither smoke nor drink (table II). The carcinogenic effects of alcohol may also be synergistic with some aspects of malnutrition. For these cancers, the highest risk is associated with heavy drinkers who also had a low fruit and vegetable intake. Thus the risk of these cancers associated with moderate drinking in well nourished non-smokers is small.

Alcohol consumption

The overall risk of problems related to alcohol increases continuously with rising consumption. Table III gives an indication of the overall levels of risk in relation to the number of units of alcohol consumed a week. People drinking more than the recommended limits (>21 units a week for men, >14 units a week for women) are referred to as hazardous drinkers when they are experiencing no problems as a result of alcohol consumption and as harmful drinkers when they have problems.

TABLE II—Relative risks of oral or pharyngeal cancer in men by alcohol and tobacco consumption^{1,2}

Smoking status	No of drinks*/week				
	<1	1-4	5-14	15-29	≥30
Non-smoker	1.0	1.3	1.6	1.4	5.8
Ex-smoker	0.7	2.2	1.4	3.2	6.4
Smoker (No of cigarettes/day for ≥20 years):					
1-19	1.7	1.5	2.7	5.4	7.9
20-39	1.9	2.4	4.4	7.2	23.8
≥40	7.4	0.7	4.4	20.2	37.7

*Standard drink in United States, which is 1.5 times the standard drink in United Kingdom. Therefore maximum risk, ≥30 drinks/day, is 45 British drinks (units) or 22½ pints (13 litres) of beer.

TABLE III—Alcohol consumption by men and women and risk of social and health problems*

Alcohol intake (units/week)	Risk of problems
Men 0-21 Women 0-14	{ Low
Men 22-50 Women 15-35	{ Increasing, particularly in smokers
Men >50 Women >35	{ High (definitely dangerous); very high in smokers

*Adapted from *Health of the Nation*.³

TABLE I—Cancers produced by alcohol consumption

	Cancer
Definitely	Mouth Pharynx Larynx Oesophagus
Possibly	Liver Breast Rectum*

*Beer consumption only.

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