Complaints in the NHS

A practical guide to handling complaints in Wales

AVMA response to consultation

Introduction

AVMA has provided annotated comments on the attached consultation document. However, there are a number of issues that AVMA would like to draw particular attention to. Our comments will focus primarily on clinical complaints as this is our main area of expertise.

General Comments

In the time since the NHS Complaints Procedure was first introduced in 1996, there have been a number of seminal events including the report of the Bristol Royal Infirmary Inquiry and the Chief Medical Officer's report, An Organisation with a Memory (June 2000). As a result of these and other developments over the recent past, the NHS is now said to be moving towards a culture where 'patient safety', 'patient centred' care, and patient and public involvement are core principles of healthcare provision within the NHS.

AVMA believes that this new ethos should be reflected in the operation of the NHS Complaints Procedure. By the nature of AVMA's work, patient safety is our key concern. It should not be overlooked that in theory, patients have had a voice in the NHS for many years in the form of the various complaints procedures but this voice has to a large extent been ignored. Clearly now that we do have a commitment to patient safety and to listening to patients, this is an ideal time to build this new ethos into the complaints procedure to ensure that one of the most important voices within the NHS, that of people who have been failed by the service or have suffered unnecessary harm, are listened to.

AVMA has long advocated that there should be an integrated approach to complaints handling, risk management, and clinical audit (see attached training material, 1995). With patient safety now high on the healthcare agenda, a completely new approach needs to be adopted in the handling of clinical complaints. This should no longer be about statistical reports to the board; this is about ensuring that the lessons that can be gleaned from individual complaints are used to reduce the risk of harm to future patients. There is concern that patients/complainants are still being largely excluded from the patient safety agenda. It is important that as partners in their care, patients have a clear voice with respect to patient safety. It is generally recognised that one of the main motivations for patients pursuing clinical complaints is to prevent the same thing happening to someone else. In other words, patients have long wanted to play a part in what we now refer to as the patient safety agenda.

We therefore need to look afresh at how the NHS Complaints Procedure operates and how we can ensure that patient safety is an underlying principle in the operation of the procedure. AVMA would advocate that there needs to be a much closer integration between the management of clinical complaints and risk management/adverse incident reporting and investigation. This would involve developing new systems for investigating clinical complaints which integrates complaints investigations with systems for investigating adverse clinical events.

An essential aspect of this is to provide trusts with much more detailed guidance on best practice for investigating clinical complaints. Far too often, the letters that patients receive in response to their complaint contain explanations which are clinically inaccurate or in some cases, deliberately misleading. For example, AVMA has recently seen a complaints response signed by a Chief Executive where the explanation as to why a young patient who had suffered an intracranial bleed was not scanned, was in fact done in the patient's best interests as the hospital was concerned to ensure that patients were not subject to excessive radiation exposure. Such an explanation was clinically untenable in the circumstances of this case and raises an important issue as to how the complaints procedure can be operated in such a way that Chief Executives are no longer putting their name to letters of this kind. It also raises questions as to the quality of the adverse incident investigation undertaken by the hospital and whether in fact the hospital had identified the failures in care that needed to be addressed to avoid a repetition of this case. AVMA would advocate that the individual signing the response should be held accountable for its contents.

Too much onus is still placed on the patient to be able to correctly identify the clinical issues that they should be questioning rather than the healthcare provider recognising that they have a responsibility both to investigate adverse events as well as providing the patient with an accurate and timely explanation. This should not be as a complainant but as a patient who has a right to information about their treatment, particularly where something has gone seriously wrong.

There are some good examples of best practice for complaints investigations available in some of the more enlightened Trusts but this is by no means universal. This best practice needs to be shared to ensure that all Trusts are both meeting the needs of patients and ensuring that they have in place systems that enable them to reduce the risk of accidents by learning from mistakes. Patients can provide a valuable insight into why things go wrong and from a perspective that cannot be gleaned from the medical records or in most cases from the staff involved. This is why complaints must be seen as a core element of the patient safety agenda.

Why Complaints are Important

The NHS Complaints Procedure has been widely criticised but it is perhaps not so much the procedure that is at fault, but the ethos with which it is operated. In theory, there is no reason why all complaints should not be resolved at local resolution stage as it allows considerable latitude in the way in which complaints are handled. One could argue that even if the perfect procedure were introduced tomorrow, it is unlikely to prove any more satisfactory, until there is a significant change in culture towards patients who have suffered as a result of failures in healthcare provision.

There is always a risk with any complaints procedure that the reason for having the procedure is lost somewhere in the bureaucracy that surrounds the operation of the process. It is going to be important to work towards changing the culture surrounding complaints and adverse events and ensuring that the needs of patients, staff and the organisation are addressed.

AVMA has always advocated a pro-active approach to adverse events. AVMA has seen too many examples where a serious adverse event has taken place but the patient or relatives have been forced to make a formal complaint and all too frequently, litigate, in order to obtain any form of explanation. With the current emphasis on patient safety and a patient

centred NHS, this an opportune time to bring about change. As soon as an adverse event is identified, this should trigger an investigation which in tandem addresses the needs of the patient.

Where a patient does make a complaint about clinical care, they have a right to expect a clinically accurate response. It is AVMA's experience that leaving the investigation of clinical complaints to a complaints manager without any medical background, is going to lead to patients often not receiving the explanation they have a right to. Seeking an explanation from the treating physician or nursing staff is often going to be inadequate and unsafe because those involved may lack the necessary insight to recognise failures in the care. Other methods for investigating complaints need to be explored in order to ensure that failures are identified and addressed. This should include obtaining independent medical assessments, particularly in the case of serious adverse events. This is not just for the benefit of the individual patient. It is about working towards reducing the number of adverse events.

In summary, it is AVMA's view, that whilst it is important to look at the nuts and bolts of the complaints procedure, it is perhaps more important to look at why the present complaints procedure has failed to both satisfy complainants and enable the health service to learn from mistakes and why it is that major failures in healthcare provision are often only coming to light when the number of injured patients has reached a critical mass. In the context of adverse events, the complaints procedure should act as a fail-safe mechanism rather than the primary trigger for investigating adverse events. We need to move away from the complaints procedure acting primarily as an appeasement process and work towards ensuring it is recognised as an essential part of the armoury within the patient safety agenda.

Questions for Consideration

1. Who can complain?

The regulations do need to be amended. A patient is anyone who receives a service from a practitioner and/or anyone seeking NHS treatment from a practitioner who at that time is registered as providing NHS services.

2. Conciliation

A range of different options including conciliation should be made available to Trusts providing this is not made compulsory with respect to patients and inappropriate pressure brought to bear. It should be remembered that the reason why complainants often refuse to accept the outcome of a complaint is because the investigation has failed to actually provide an accurate explanation and response to their complaint.

3. Independent Review

- *Should the Panel be reduced to two lay members? There might be difficulties if there is disagreement between Chair and member and may require a change in Regulations. (paragraphs 185-186).* No, 3.
- *Should the lay chair be the independent lay member who was appointed to advise the screener or should the screener fulfil the role of lay chair? (paragraphs 185-186)*
- *Should the number of Clinical Assessors also be reduced to one per specialty, otherwise it may seem to the complainant that professionals dominate. (paragraphs 190-195)* This is not an issue providing the complainant is satisfied with the 'independence' of the clinical assessors. If you were to reduce the number of clinical assessors to one per speciality, then the patient should be given the option of a second clinical assessor, in the event that it is felt the first has lacked independence or has failed to appropriately address the issues.

- *In the current Regulations Clinical Assessors are required to produce a preliminary report, but as this rarely happens it has been suggested that they should only produce advice to help the Panel in advance (paragraphs 193-197)* What form would this 'advice' take? The complainant has a right to know what information is being given to the panel and if it is given on a less formal basis, the complainant has little opportunity to address what is being said. It might be better to ensure that the Clinical Assessors do in fact produce a preliminary report to which the complainant is given access.
- *What administrative support will Lay chairs need, including note taking during the Panel interviews? It has been suggested that they should be required to take notes as well as write the report. (paragraph 214)* No, lay chairs require support.
- *If a legally qualified person attends the Panel interview as a friend should they be excluded from speaking, as at present? (paragraphs 207-208)* No.See comments on annotated report.
- *Should the power of Panels to make recommendations to Boards be strengthened? And if so how? (paragraphs 220)* They should have the ability to recommend that the trust / local health board or primary care practice consider providing compensation to the complainant.
- *What should the role of LHBs be in following up IR Panel reports for FHS practitioners? (paragraph 223).* There should be regular monitoring of the issues arising from complaints as part of the clinical governance programme and also performance in relation to investigating and responding to complaints. Failure to comply should invoke disciplinary procedures / referral.