AvMA Response to Consultation on the draft National Health Service (Complaints) Regulations

OVERVIEW

Whilst AvMA welcomes the direction of travel of the reforms to the NHS complaints procedure, we remain disappointed that complaints handling apparently continues to be seen as a bureaucratic process separate from other processes, such as adverse event investigations and clinical governance. For example, a woman who experiences an unexpected stillbirth should not be required to make a complaint in order to have a thorough investigation, and explanations which they have statutory rights to be involved in and to challenge. We would like to see the regulations provide for integration between clinical complaints and these other processes, in the interests of patient safety as well as redress for individuals when something goes wrong.

There is also still an urgent need to make the system more robust and effective than is reflected in the draft regulations. If the public is to have confidence in the new system it will be necessary to demonstrate that the Commission for Health Audit and Inspection (CHAI) will be independent and robust in the way it investigates complaints at the second stage, and also that it has the clout to ensure recommendations made to NHS bodies are implemented. Too much discretion is given to the NHS bodies' own complaints manager over which complaints to investigate. We are also concerned that at present the regulations do not guarantee Primary Care Trusts (PCTs) receive timely information about primary care complaints. The role of the panel in the independent stage needs clarification. Below we set out a number of suggestions for improvement of the regulations which will govern the new NHS complaints procedure, clause by clause.

COMMENTS ON THE DETAIL OF THE REGULATIONS:

Clause 4 Primary Care Complaints

Clarity is needed on how complaints about out of hours services will be dealt with. The regulations should require primary care providers to co-operate with investigation of such services.

We welcome the provision under clause 5 (1) (b) (ii) for complaints about primary care to be made direct to a PCT. Many people are deterred from complaining direct to their own primary care practice. However, it will be important to publicise this option and for PCTs to be copied into all complaints (including those raised direct with the practice) for them to be in a position to include this data in their clinical governance processes and make early intervention in the interests of patient safety if necessary.

Clause 6 Complex Complaints

Within the definition of 'Complex Complaints' should be included complaints which are received by one body where it is clear that the subject matter concerns another NHS Body or primary care provider, even if the complainant has not named that provider.

Provision of services by independent providers on behalf of NHS bodies should be included in the list of what constitutes a 'complex complaint', especially where functions are being carried out in conjunction with an NHS body and/or a primary care provider.

Clause 10 Responsibility for Complaints Arrangements

More clarity is needed about the person designated to take responsibility within primary care providers. The role should not be confused with the more functional role of complaints manager, and should be of sufficient seniority – probably the senior partner or the provider themselves in single practitioner providers. The person designated should be closely associated with the clinical governance responsibilities of the provider or NHS body.

Clause 11 Complaints Manager

The regulations should define a different role for complaints managers in PCTs, who will also have responsibility for investigating complaints about primary care providers. We recommend that the PCT complaints manager should have an overarching role in supporting and monitoring complaints management in primary care providers for that PCT.

Clause 12 Who May Complain

In paragraph (2)(b), a definition is needed of which age constitutes 'a child'.

In paragraph (4), there should be a right of appeal about a complaints manager's 'opinion' that a representative did not have a sufficient interest or is 'unsuitable'. In such circumstances, the representative should be able to appeal to the CHAI.

Clause 13 Making a complaint

For the sake of clarity, in paragraph (3), a complaint made orally should be treated as received on the date that it is made, not when the complaints manager gets round to recording it.

Clause 14 Complaints which need not be considered

There is a danger here of important issues for patient safety or clinical governance not being picked up. There should be a requirement that something is done to record the issue and what needs to be done about it, even if the complainant agrees not to pursue a formal complaint.

Clause 15 Time Limit for Making a Complaint

There must be a right of appeal to CHAI over a complaints manager's decision not to investigate. The emphasis should be on investigating complaints unless it is unreasonable to do so.

Clause 16 Acknowledgement and record of Complaint

Paragraph (3). It should also be made a requirement in the case of primary care provider complaints for the primary care provider to send a copy of the acknowledgement and complaint to the complaints manager of the PCT. Without this additional clause, PCTs would only know about complaints made direct to primary care providers retrospectively if included in their reports to the PCT. This would mean that they would be unable to exercise their clinical governance function effectively, or intervene in the interests of patient safety if such complaints warranted this.

We were glad to see that the regulation 16(5) will make it a requirement to include information on Independent Complaints Advocacy Services when acknowledging a complaint.

Clause 17 Handling of Complex Complaints

Paragraph 1(a). The consent of the complainant should be obtained before another body or provider is notified of such a complainant.

Clause 18 Matters Subject to Concurrent Investigation

We very much welcome the acceptance that investigations can run concurrently to the NHS complaint investigation, including where there is a stated intention to take legal proceedings. However, regulation 18(a) as it stands goes against the spirit of the reforms and would create practical difficulty in implementing the procedure. This regulation should be re-worded to apply to situations where the complainant has "commenced" legal action. Stating in writing that there is an *intention* should have no bearing on a complaints investigation. We believe that (18)(2) and 18(3) also need re-wording. It is not acceptable for the organisation complained about to have sole decision making authority over whether a complaints investigation should go ahead. The emphasis should be on carrying out the NHS complaint investigation according, unless either the complainant, following consultation, requests that the complaint investigation should be put on hold whilst the other investigation is conducted. There is the potential for the NHS body or primary care provider to abuse its position of being able to determine whether or not an investigation can be conducted concurrently with, say, a clinical negligence action. Perhaps CHAI could be the arbiter if the two sides are not in agreement?

Clause 20 Investigation

Paragraph 5 (b). Conciliation and Mediation can be useful tools in resolution of complaints. However, these methods can only work if there is agreement on their use by both sides. The complaints manager should only be allowed to make arrangements for conciliation or mediation if there is agreement by all parties involved in the complaint.

Clause 21 Response

Paragraph (1)(c) should be deleted. It is inappropriate in a final response letter to be explaining "what action will be taken to resolve the complaint". The response should represent the respondent's considered opinion following robust investigation and use of any other appropriate means of investigation and resolution of the complaint. (1)(e) – the action that may be taken in the light of the complaint is what is really appropriate in the response, and may or may not 'resolve' the complaint.

Paragraph (3). We welcome the clear regulation to respond to complaints within 25 working days. However, there needs to be a means to move things on if this deadline is exceeded by a large extent without the complainant's permission. We suggest that for a non 'complex' complaint, the complainant should be able to refer to CHAI for investigation if the response is not received by 3 months after the complaint.

In Paragraph (4) we do not consider that it is satisfactory to give respondents as free a licence as to respond "as soon as reasonably practical", notwithstanding the ability for a complainant to refer to CHAI after six months (Clause 22, paragraph (1)(b)). Six months should be the point at which a complainant can automatically instigate an investigation by CHAI. The target for responding to a complex complaint should be as soon as practically possible, and no longer than 3 months from the complaint.

Clause 22 Complaints to CHAI

Consideration needs to be given as to how the process of patients bringing serious incidents directly to CHAI and their investigation through that process marries with the NHS complaints procedure.

Paragraph (1)(b). We very much welcome the introduction of a timescale after which any complaint can be referred for investigation by CHAI. This will address some of the most gross failures in complaints handling. However, whilst 6 months may be the appropriate point to spark such an investigation of a 'complex' complaint, as discussed above, we would advocate that a complainant should have this right after 3 months following a non 'complex' complaint.

Paragraph (2)(b). The relevant PCT covering the primary care provider complained about should also be a point at which a request for CHAI to investigate can be lodged.

Paragraph (2)(c) would be the appropriate place to regulate for the ability to refer to CHAI over a decision by a complaints manager not to accept a 'representative' as sufficiently interested to make a complaint, or not to investigate a complaint because of likely compromise or prejudice to a concurrent investigation.

Clause 23 Decision on handling of Complaint

Paragraph (2)(b). We do not believe that it should be possible for CHAI to refer the complaint back to the NHS body or primary care provider complained about for further attempts at resolution without the consent of the complainant. This could recreate the unacceptable dilemma faced by many complainants now where despite an NHS body or primary care practitioner failing to investigate properly or keep to timescales, they are forced once again to try to elicit a satisfactory investigation and response to their complaint when they request an Independent Review. This results in some complainants simply being worn down and giving up. This should certainly not be a permissible outcome of a referral to CHAI brought about by virtue of Clause 22(1)(b) where a complaint has not been responded to after 6 months.

Clause 25 Panels

We are concerned about an apparent lack of clarity about the purpose or remit of the proposed panels. As set out the panels have the power to hear evidence but nothing else. There are requirements on CHAI to report on the results of its investigation but not on the findings of the panel. It is not clear whether the panel can come to findings which are different to the CHAI investigation or which would take precedence.

It is essential that if the independent panel is to adjudicate over the findings of a CHAI staff investigation that it has statutory powers and is independent of CHAI staff. CHAI as well as the NHS body would need to have a duty to comply with the findings of the panel, otherwise what is the point? One alternative is that rather than referral to a panel being another stage in the complaints process, that there be a right to have a panel hearing as part of the CHAI investigation. The panel could both be part of the investigation process and have the role of contributing to or possibly approving the report of the CHAI investigation. Either arrangement carries with it practical difficulties, such as how the panel is to be serviced. Clarification is urgently needed.

Paragraph (7). A participant should have the right to be accompanied both by a friend (or relative) and an advocate, as with the current independent review process. We also think it would be better to specify whether or not they may be represented by a legal representative as such or not, rather than leaving it up to the chairman to decide.

We would like to see the regulations stipulate that the complainant should have access to any information which the CHAI or its panel have access to as part of their investigation or consideration of the complaint. There have been instances in the current system where independent review panels have taken into account 'evidence' supplied by the respondent without the complainant themselves having the opportunity to see it or challenge it.

Clause 26 Report of CHAI Investigation

Please see comments under "Clause 25 Panels" above about the lack of a reporting requirement of the panel, and lack of clarity about the status of the report of the CHAI investigation and the panel's findings.

Paragraph (2). We take this to mean that recommendations might include the payment of compensation or ex-gratia payment by way of Redress, which we would fully support.

We think it imperative for the regulations to place an obligation on the NHS body or primary care provider to whom recommendations are made to respond to the recommendations within a reasonable timescale both to CHAI and the complainant. This reply should clearly indicate if, when and how the recommendations will be implemented. We further recommend that the procedure should include a 'closure' meeting, if the complainant wants it, where the NHS body or primary care provider meet with the complainant and CHAI to explain their response to the recommendations and have the opportunity to apologise face to face.

We believe that CHAI should be required to undertake to review progress on implementing its recommendations six months after its report, and at periods it deems appropriate thereafter and provide feedback to the complainant. The Clinical Governance review conducted by CHAI should include a review of actions taken in respect of any recommendation that has been made to an NHS body following a complaints investigation.

Reports of investigations identifying patient safety issues should also be sent to the National Patient Safety Agency to ensure the data is captured and built into patient safety initiatives.

Clause 28 Publicity

Paragraph (2). The publicity of primary care provider complaints arrangements must include the option to complain directly to the PCT.

Publicity of all the complaints arrangements should also provide information on Independent Complaints Advocacy Services. (At the moment the regulations only provide for the complainant being told about them in acknowledgement of the complaint. Their help at an early stage would help ensure the complainant makes an informed choice about the action to take and their complaint is made in as clear and effective way as possible).

The publicity should also inform complainants of the ability to refer serious incidents directly to CHAI for them to investigate where there are issues of patient safety or system failure.

Paragraph (3). Providers of Independent Complaints Advocacy Services (ICAS) should be added to the list of bodies who should be advised of NHS bodies complaints arrangements.

Paragraph 3(c). Both the patients' forum covering the relevant NHS Body and the relevant PCT patients' forums should be informed.

Paragraph (4). Primary care providers should also be required to ensure providers of ICAS and the relevant PCT Patients' Forum are informed of their complaints arrangements.

Clause 30 Monitoring

Paragraphs (1)(b) and (2). Not only should primary care providers be required to report fully to a PCT on complaints, but the PCT should be required to make this report available to its Board. Otherwise, these reports would not be subject to the same degree of overview and scrutiny as those about NHS bodies' complaints. It is essential that PCTs make full use of primary care provider complaints data to inform their clinical governance functions.

NOTE: If our suggestion of making PCTs responsible for complaints management of its contracted primary care providers is adopted, it would make the complaints procedure much easier to access and less threatening for complainants, ensure that PCTs had all the relevant data, and lessen the burden on individual primary care providers.

Clause 31 Annual Reports

The relevant patients' forum and local authority overview and scrutiny committee should be added to the bodies who must be sent a copy of NHS bodies' and primary care providers' annual complaints report. In the case of strategic health authorities this should be to all the PCT patients' forums overview and scrutiny and committees in its area of operation. These bodies have a crucial role in monitoring local health services and information from complaints is vital if they are to do this effectively. It is important to ensure that this information is passed to these new bodies now that Community Health Councils have been abolished in England. Community Health Councils found complaints information extremely useful in informing their monitoring activity.

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