CHAPTER SEVEN

Complaints and Discipline after 1996

Introduction

7.1 As I indicated in the last Chapter, the Government's proposals for new procedures for handling patient complaints in the NHS were published in March 1995. The procedures were introduced in April 1996. In this Chapter, I shall describe the 1996 procedures, as they applied to complaints about general practitioners (GPs), and will summarise the evidence received by the Inquiry as to how they worked in practice. I shall also discuss the shortcomings of the 1996 procedures and consider the Government's recent proposals for reform.

7.2 In the last Chapter, I described the operation of three complaints which resulted in disciplinary proceedings being taken against Shipman under the pre-1996 procedures. This Chapter will not contain any similar descriptions. So far as was known to the West Pennine Health Authority (WPHA), only one complaint against Shipman was made in the years 1996 to 1998. The development and operation of the 1996 complaints procedures and the changes to disciplinary procedures that came about after 1996 are of interest to the Inquiry because they form the link between the pre-1996 procedures and a new set of procedures, parts of which have been introduced in July 2004 and parts of which are still under discussion. It is my intention to make recommendations about those aspects of the new procedures that are still to be settled.

The 1996 Complaints Procedures

The Wilson Report

7.3 The Government proposals were based upon the principles expounded in the Wilson Report 'Being Heard', which was published in May 1994, and adopted many of its procedural recommendations. The Report stated that the principles underlying a complaints procedure should be responsiveness, quality enhancement, cost-effectiveness, accessibility, impartiality, simplicity, speed, confidentiality and accountability. The Report stressed that there was a need to draw a clear distinction between complaints and disciplinary procedures. Complaints should not necessarily result in disciplinary action although, if a disciplinary issue emerged, the issue should be passed to family health services authority (FHSA) management for it to determine whether disciplinary action was appropriate. It was said that the degree of investigation into a complaint ought to be governed by the wishes of the complainant but that those responsible for the management of the doctor concerned might need to undertake further investigation for management or disciplinary purposes.

7.4 The Report recommended that every complaint should be handled first by the organisation against which it was made and second, if necessary, by an external body. Every organisation should have a complaints manager, who would be responsible for handling the complaint. In general practice, this person would most often be the practice manager or a partner in the practice. An initial response to the complaint should be made

very quickly, within 48 hours of receipt, and would be aimed at satisfying the complainant by providing either an explanation or an apology, as appropriate. If necessary, that should be followed by an investigation and/or an offer of conciliation, following which a written response would be provided. If the complainant was dissatisfied with that response, the complaint should be considered by a senior officer of the responsible trust. That person should have a range of options available, such as conciliation, personal discussion with the complainant, further more detailed investigation, taking independent advice on clinical matters or, in effect as a last resort, establishing an independent inquiry.

The Government Proposals

7.5 In announcing its proposals, the Government stated that it wished to ensure **'maximum commonality'** of procedures throughout the NHS. The philosophy underlying the complaints process was that it was to be a **'learning process'**. To that end, complaints were to be completely separated from disciplinary proceedings. If it appeared that disciplinary action was appropriate in relation to the circumstances underlying a complaint made by or on behalf of a patient, the disciplinary proceedings would begin only after the complaints procedures were completed.

7.6 The 1996 complaints procedures were to have two stages within the NHS. The first stage would be conducted by the NHS body that had provided the service from which the complaint arose. Complaints against GPs were to be handled, at the first stage, by the practice. Conciliation was to be available as an adjunct to the first stage of the complaints process. If a complainant was dissatisfied with the outcome of a complaint about a GP, s/he could move to the second stage and seek an independent review. He or she would apply to a 'convenor', who would usually be a non-executive director of the health authority (HA), who would decide whether to grant a review. If a review was granted, it would be heard by a panel of three non-medical persons. The report of the panel would be sent to the chief executive of the HA, who would send copies to various involved parties, including the chairman of the HA. A complainant who had exhausted these two stages but remained dissatisfied could resort to the Health Service Ombudsman (also known as the Health Service Commissioner). Advance guidance on the implementation of the new procedures was distributed to all NHS bodies in October 1995.

The Legislation and Guidance

7.7 The legislation governing the 1996 complaints procedures came into force on 1st April 1996, the same date as the creation of the unitary HAs which combined the functions of the district HAs (which previously had responsibility for secondary care) and the FHSAs (which previously had responsibility for the provision of primary care). The requirements for GPs to operate practice-based procedures were brought into effect by amendment of the GPs' terms of service in the National Health Service (General Medical Services) Amendment Regulations 1996. The arrangements that HAs were required to make for the provision of conciliation services and for the appointment of convenors and independent review panels (IRPs) were set out in directions issued by the Secretary of State for Health (SoS). The new disciplinary arrangements were to be found in the National Health Service

(Service Committees and Tribunal) Amendment Regulations 1996. At the outset, guidance was issued to HAs, convenors and GPs as to the way in which they were to carry out their new functions.

The First Stage

7.8 For complaints against GPs, each practice was to develop its own practice-based complaints procedures. The way in which the complaint was to be handled was left largely to the discretion of the practice. The only mandatory provisions were that the practice had to nominate a person to administer the procedures; it had to provide information for patients about how the procedures operated; and it had to acknowledge a complaint within two working days and provide an **'explanation'** within ten working days of receipt of the complaint. In all other respects, the detailed operation of the procedures was for the practice to decide. The written guidance provided advice on best practice and GPs were encouraged to seek the assistance of the HA if in doubt. The policy was to encourage practices to devise procedures that would work well for them and their patients. It was stressed that every member of the practice team involved in the circumstances giving rise to the complaint had also to be involved in responding to the complaint and had to be prepared to co-operate in handling a complaint. It seems to have been assumed that all GPs would take their duties seriously and in the spirit of **'learning'** that underlay the new procedures.

7.9 The guidance suggested that the person nominated to be in charge should be the practice manager or one of the partners, although some other person might be appointed. If the complaints manager was not a doctor, one of the doctors should be an **'overseeing partner'**. Advice was given as to the information to be made available to patients. Standard letters and forms for record keeping were proposed for adoption or adaptation. Practices were advised of the need to keep good records of complaints. It was intended that these would enable the practice to ensure that it was using the resolution of complaints as a learning process. The practice might be required to provide information to the HA in the event that a complaint was not resolved at practice level, but practices were assured that they would not be required to produce their records to the HA.

7.10 The practice's initial response to a complaint should be to arrange an interview, either face to face or by telephone, between the complaints manager and the complainant. Much good advice was given about the right approach. The complaints manager should then **'investigate'** the complaint. The guidance said that this **'may include establishing the facts by talking to practitioners or staff involved'**. That was all the advice given on this crucial aspect of the process. It was suggested that, if necessary, advice might be sought from the practitioner's defence organisation, the local medical committee (LMC) or the HA's complaints manager. The practice complaints manager should then discuss his/her **'findings'** with the overseeing partner to decide upon the response, which might be a letter of explanation or an offer of a meeting. If it was thought that conciliation might be appropriate, the HA should be approached. Advice was given as to the tone and content of a letter of explanation. This should include information about the next stage of the complaints procedure. Finally, suggestions were made about how practices should learn from the complaints received.

7.11 Under the heading **'Helpful Hints'**, practices were advised to encourage patients who intended to complain to do so within a reasonable time after the relevant events, but it was suggested that practices should adopt a flexible approach to late complaints. If a complainant appeared unwilling to lodge his/her complaint with the practice, s/he should be given information about the appropriate contact at the HA and the Community Health Council (CHC). I have described the role of the CHC in Chapter 6.

7.12 It was thought that small or single-handed practices might have difficulty in setting up an adequate complaints handling process. Several possible solutions to this problem were suggested. The practice might join with other practices to operate the complaints system together or a practice might ask the LMC to nominate a member who would assist with the process. A further possible solution would be to offer complainants the services of a HA lay conciliator. I mention in passing that Shipman did not take up any of those suggestions. He appointed himself as complaints manager and the practice nurse, Sister Gillian Morgan, as his deputy. The practice's written complaints procedure said that clinical complaints would be handled by Shipman **'or by another GP'**. However, there was no other GP in the practice and Sister Morgan was not aware of any arrangement with another practice for the handling of complaints.

The Second Stage

7.13 If a complainant remained dissatisfied at the end of the first stage, s/he could apply, within 28 days, for an independent review. In considering whether to grant a review, the convenor would establish the precise nature of the complainant's remaining grievances. The convenor had first to consider whether the initial complaint had been made within the time allowed. Complaints were to be made within six months of the events complained of, or within six months of the discovery of the facts to be complained of and, in any case, within 12 months of the occurrence of the events. However, convenors could exercise discretion to allow a complaint to proceed if the delay was not unreasonable and if it was still possible to investigate the complaint satisfactorily. Before reaching a decision, the convenor had to consult with the person who would be the chairman of the review panel (IRP) if the application was granted. The chairman was a lay person selected from a list nominated by the SoS. If the complaint involved issues of clinical judgement, the convenor was supposed to seek the advice of a suitably qualified clinical adviser. It should be noted that, although the convenor had to consult with the proposed chairman, and possibly with a suitably qualified clinical adviser, s/he did not actually investigate the complaint.

7.14 Guidance was issued as to the approach convenors should take. An application should be refused if it appeared that the local resolution process had achieved all that could be hoped for and that a panel could add no further value, if further conciliation seemed appropriate or if the complainant had begun or had expressed an intention to begin a claim for damages. In practice, only a small proportion of applications for independent review were granted. According to national figures provided by the Department of Health (DoH), in the years between 1996 and 2001, there were between 1040 and 1430 applications made annually, of which between 219 and 341 were granted. The overall percentage allowed was between 22% and 23%. In Tameside, where between 14 and 24 requests were made annually over the same period, the percentages were not dissimilar,

although in one year, only one request was granted out of 23 requests made. Any complainant who was dissatisfied by the refusal to grant a review could ask the Health Service Ombudsman to consider the matter.

7.15 If the application for independent review was granted, the convenor would establish the terms of reference for the panel. A panel would be convened by an officer of the HA. The independent lay Chairman would already have been identified. Another independent lay person would be selected from the list of SoS nominees. The convenor would be the third member. If the complaint related to matters of clinical judgement, two independent clinical assessors selected from a list nominated by the SoS would be appointed to advise the panel.

7.16 Miss Andrea Horsfall was Deputy Consumer Liaison Manager for the WPHA and is now Complaints Manager for the Oldham Primary Care Trust (PCT). She told the Inquiry that she was responsible for making the practical arrangements for IRP hearings and would prepare a bundle of relevant documents on the instructions of the Chairman. Asked whether any further investigation ever took place in advance of the hearing, Miss Horsfall said that, on occasion, the Chairman would direct that a particular witness should be asked to attend to give evidence (although no witness could be compelled to attend). The witness would not be interviewed in advance but would be sent an explanation of what the case was about so that s/he would know what s/he would be asked about. It appears that, although relevant documents were assembled and witnesses invited, there was no investigation of the issues raised by the complaint.

7.17 The hearing before the IRP took place in private. The procedure to be followed was not laid down. The intention was that it should be informal, flexible and non-confrontational. The procedure should be adapted to suit the occasion and the issues to be considered. Sometimes the complainant would be accompanied by a friend or (until the abolition of CHCs in December 2003) a representative of the CHC. The doctor would usually be accompanied by a representative of his/her defence organisation. Either participant could be accompanied by a lawyer, but the lawyer was not permitted to act as an advocate. It appears that many panels chose to interview witnesses in the absence of the opposing party, although this was a matter for the discretion of the panel. Miss Horsfall said that, in her experience, it was usual for the complainant to be asked first to give his/her account of events and to explain why s/he remained dissatisfied with the outcome of the complaint. The panel would ask questions. Then any witnesses the complainant had brought would give their accounts and be questioned. After that, the complainant and his/her witnesses would leave the room and the doctor complained against would come in to give his/her account, followed by any witnesses s/he had brought. Any witnesses asked to attend by the Chairman would then give evidence. A full note of the evidence given would be taken by an administrator from the HA – Miss Horsfall often attended for this purpose – and the proceedings were recorded 'as a back-up'. At the end of the evidence, there would be a brief discussion between the panel members and possibly the assessors, if any. The assessors would then retire to write their report(s) on the clinical issues. The panel would disband.

7.18 The assessors' report(s) (if any) and the notes of evidence would be supplied to the Chairman, who would write a draft report to be circulated to the other members for

agreement or amendment. The report had to contain the relevant findings of fact and the panel's opinion (with reasons) on the complaint, having regard to the findings of fact. The panel was not obliged to accept the report of the assessors on clinical issues but, if it did not, it had to give reasons for its disagreement. The report could contain suggestions for improvements in the services provided by the practitioner concerned. It could not include any recommendation that disciplinary proceedings should be taken. However, Miss Horsfall said that, sometimes, panels expressed themselves quite strongly and their views would be clear. The report was sent to the Chief Executive of the HA, who had to distribute it to a list of interested parties.

7.19 If the complainant was dissatisfied with the IRP's report, s/he could apply to the Health Service Ombudsman, whose powers were extended in 1996 to include the investigation of complaints against GPs and complaints involving the exercise of clinical judgement.

7.20 From April 2002, PCTs took over responsibility for primary care from HAs and assumed the relevant functions under the complaints procedures. The procedures that came into effect in 1996 remained in operation until the coming into force of the National Health Service (Complaints) Regulations 2004 (the 2004 Complaints Regulations) on 30th July 2004.

Reactions to the 1996 Complaints Procedures

The Medical Law Review

7.21 Some criticisms of the 1996 complaints procedures were voiced at an early stage after their introduction. In 1997, Ms Diane Longley wrote an article in the Medical Law Review[1]. She recognised that the new procedures had not been in force for long and that teething troubles were to be expected. However, her main criticism was that the new system was flawed because it was not sufficiently independent of the NHS. First, she noted that convenors were non-executive directors of the HAs and not therefore independent of them. Moreover, their role was not an easy one; they had a wide element of discretion, to be exercised in consultation with the person selected to be the chairman of the IRP. If the application was granted, the IRP was formally a committee of the HA and the presence of the convenor on the panel might give rise to an appearance of in-built bias.

7.22 Ms Longley also drew attention to the need for a complaints system that covered all aspects of the health service, as, she observed, many complaints arose out of the interaction of several different agencies. Although the new procedures for primary and secondary care were similar, they were not connected. It would be difficult for a patient to complain about treatment that spanned more than one NHS body.

7.23 Ms Longley extolled the virtues of the systems operated in the Australian state of New South Wales and in New Zealand, suggesting that they offered a holistic approach to healthcare complaints and true independence from healthcare providers. The New Zealand system is based upon a statutory code of patients' rights. This provides broadly stated standards for the provision of services against which complaints can be assessed

[1] Longley D (1997) 'Complaints after Wilson; another case of too little too late?', Medical Law Review, 5, Summer 1997, pp. 172–192.

and judged by the Health and Disability Commissioner. I was able to read some of the decisions of the current Commissioner, Mr Ronald Paterson, who attended the Inquiry seminars. Because he gives fully reasoned decisions, it has been possible to develop certain standards to be applied in specific types of case or situation. His decisions can, where appropriate, be referred to the relevant professional disciplinary body.

Evidence to the Inquiry of Reactions to the New Procedures

7.24 The Inquiry heard evidence that the 1996 procedures did not bring complete satisfaction. Miss Horsfall was responsible, among other things, for advising general practices about complaints, for arranging conciliation services and for administering the independent reviews. She said that she thought that the 1996 complaints procedures were much better than the previous ones. They were far less stressful for everyone, largely because they were no longer linked to discipline. However, she became aware that complainants were reluctant to complain about their GP directly to the practice. She thought that some were deterred from complaining at all on account of this. Some feared that they might be removed from the doctor's list if they lodged a complaint. If a complainant contacted the HA, the staff had to advise the complainant to make the complaint to the practice. Usually, staff would try to smooth the path for the complainant, possibly by suggesting that the complaint be put in writing or by proposing conciliation. Miss Horsfall had found that conciliation was extremely useful in a wide range of complaints, including some involving issues relating to clinical treatment, as many complainants were only seeking an apology.

7.25 Miss Horsfall also expressed concern that the new system was still 'patient driven', as the old one had been. It was up to the complainant to take matters forward to the second stage. There was no one who would take the complaint over and advance it, if the complainant did not want to pursue it. She thought that some complainants gave up, even though they were not satisfied. This was so even where the allegation was of a nature which could raise serious concerns about the competence of the doctor.

7.26 One of Miss Horsfall's major concerns related to the information that was available to the HA. The HA regarded complaints as an important source of knowledge about the GPs in its area. Under the old system, all complaints came direct to the FHSA. Under the new system most complaints were made direct to the GP practice. The practice only had to inform the HA how many complaints had been received in the past year. It did not have to give any information about the subject matter of a complaint or the way in which it had been resolved. The HA found out about few complaints. If a complainant contacted the HA, s/he might or might not tell Miss Horsfall what the complaint was about. Only in a few cases did Miss Horsfall find out at that stage whom the complaint was against and what it was about. If Miss Horsfall was asked to arrange conciliation, she would find out whom the complaint was against and would receive the practice's records relating to the complaint for transmission to the conciliator but, officially, she was not allowed to use that information. If the complainant proceeded to the second stage, the HA would find out what the complaint was about. Miss Horsfall's concern was that the HA did not have a complete picture of complaints in the area. Since 2002, when PCTs took over responsibility for the provision of primary care and the administration of the second stage of complaints procedures in their area, the same problems have remained. Miss Horsfall said that,

nowadays, the collection of information about complaints is an important aspect of clinical governance. She thought that practices should be required to provide information about complaints to PCTs much more frequently than annually and should have to include copies of the complaint and the final letter of explanation.

7.27 Miss Horsfall also had reservations about the criteria for determining whether or not there should be an independent review. She thought they were too narrow and that this resulted in dissatisfaction on the part of complainants. She was particularly unhappy about the effect of the rule that complainants were not allowed to proceed to the second stage if they intended to sue for damages. Her instructions were to ask complainants about this. If a complainant said s/he intended to sue, the application would be refused.

7.28 The Inquiry also heard evidence that there was dissatisfaction in some places (although not in Tameside) with the way in which convenors carried out their duties. The question was also raised at the Inquiry about whether convenors might be influenced against the convening of an IRP by the knowledge that it would put the HA of which they were directors to some expense. I was told that a review would cost the HA about £1500 to £2000. The guidance that was issued recognised that cost might operate as a disincentive to recommending independent review, expressly stating that cost should not be taken into account.

7.29 Miss Horsfall told the Inquiry that although she had reservations about the rules and guidance under which the convenors had to operate, she considered that Mr Geoffrey Lamb, the convenor for the WPHA, applied the guidelines fairly and with the utmost care. There was no suspicion in her mind that he might ever have rejected an application because of the expense that would be incurred by the HA if it were granted.

7.30 Miss Horsfall thought that complainants were generally satisfied with the conduct of IRP hearings. Complainants often said that they had found the experience less stressful than they had expected. Dr John Givans, who had considerable experience of representing GPs at panel hearings on behalf of the Medical Defence Union, said that many of his clients were dissatisfied because they did not have the opportunity to hear the complainant's evidence. This was particularly unsatisfactory in cases where there was a conflict of evidence about what had happened and the panel had to decide between one version and another. He understood that many complainants also expressed a similar view.

7.31 Miss Horsfall said that some complainants were pleased with the outcome of their reviews and some were disappointed. Some were dissatisfied because there had been no sanction against the doctor, even though the complaint had been upheld.

7.32 Miss Horsfall said that it was not always possible to complete the IRP process within the target timescale of three months. Examination of data published by the DoH in September 2003 shows that, in the year 2002–2003, IRP action was concluded outside target times in about 55% of cases.

7.33 When the IRP's report was received, the HA (and later the PCT) would decide what action, if any, should be taken to remedy any problems identified by the panel. However, the IRP

had no power to insist that the HA/PCT take any action to implement the recommendations or to deal with the GP's shortcomings in any way.

7.34 It is interesting to note that, for the two and a half year period during which Shipman practised while the 1996 complaints procedures were in place, the WPHA became aware of only one complaint made against him and, in line with practice at the time, no details of that were supplied by him. The evidence suggests that, in fact, at least three complaints were made to the practice over that period. Forms described as 'Complaint Control Sheets' relating to two complaints were stapled into Shipman's complaints book, which was recovered from the surgery after his arrest. The first was an oral complaint about the wording used by Shipman in a hospital referral letter. The Complaint Control Sheet described Shipman as the **'Investigating Officer'** and recorded that, after a meeting, the complainant had been happy with the outcome. The second was a detailed oral complaint about a member of the practice staff refusing to provide information about surgery times. The complainant had subsequently declined to be seen and it was recorded that the complaint would be dealt with as and when a formal complaint was received. A third complaint was not recorded on a Complaint Control Sheet at all. All that is available is a copy of a letter sent by Shipman from which it is possible to glean that the patient had complained about his refusal to undertake her maternity care if she wanted a home delivery. The outcome of the complaint is not known.

7.35 It is a matter of some concern that, if there is no external supervision of complaints, a practitioner might be able to mollify a complainant on a false basis, for example, by claiming that what had happened was an unfortunate outcome but was something that did happen from time to time. Another possibility is that a doctor might make an apparently sincere apology for, say, a prescribing error, which satisfied the patient but did nothing to correct the doctor's poor practice. Or, as apparently happened with Shipman, the information supplied by the practice to the HA or PCT about the number of complaints received could be inaccurate.

The 1996 Disciplinary Procedures

7.36 As I have explained, whereas, under the pre-1996 procedures, complaints that amounted to a breach of the GP's terms of service were directly linked to disciplinary procedures before a medical service committee, from April 1996 this was no longer the case. The National Health Service (Service Committees and Tribunal) Amendment Regulations 1996 came into force at the same time as the 1996 complaints procedures. HAs (and later PCTs) could arrange disciplinary proceedings in any matter (apparently amounting to a breach of the GP's terms of service) that, in their opinion, was serious enough to warrant disciplinary action. From 1996, decisions on whether to initiate proceedings were taken by a committee of the HA or PCT, usually known as the reference committee. If it became necessary to hold a disciplinary hearing, a medical disciplinary committee would be provided by an adjacent HA or PCT so as to provide a degree of independence from the HA or PCT which was, in effect, the complainant or prosecutor. A rather cumbersome adversarial procedure would be followed. However, in practice, such proceedings became very rare. Miss Horsfall told the Inquiry that, over a period of seven years, only one doctor had been referred to a disciplinary panel in Tameside, and he and one other

doctor had been reported directly to the General Medical Council (GMC). Nationally, there was a dramatic reduction in the number of disciplinary proceedings held. Whereas, in the latter years of the old regime, annually there had been between 325 and 552 GPs found in breach of their terms of service, between 1997 and 2003 the corresponding figures were between three and twelve. This reduction was in no way foreseen. Mr David Laverick, who was Chief Executive of the Family Health Services Appeal Authority (FHSAA) at the time of the transition, told the Inquiry that it had been anticipated that the numbers would remain the same as before, and that the FHSAA had planned for about 400 findings annually. The 2002/2003 Annual Report of the Council on Tribunals described many substantive and procedural shortcomings that had been revealed by their observations of the working of medical disciplinary committees. Several of these originated from the fact that so few hearings were in fact being held. Specifically, inconsistencies in the rules were exploited by medical defence organisations, and deliberation and decision-making were often laboured and unstructured.

7.37 There seem to be at least two reasons for the marked reduction in numbers of hearings. First, it was not possible for a HA or PCT to take disciplinary proceedings in respect of any matter arising from a patient complaint unless and until the complaints procedures had been completed. If a complaint went to independent review or to the Health Service Ombudsman, the process could take a long time. When it was completed, the HA or PCT could not use the evidence already given to the IRP but had to ask the complainant and his/her witnesses, if any, to give evidence again. Not all were willing to co-operate so long after the event. This procedure was necessary out of fairness to the doctor who, previously, might not even have heard the complainant's evidence, let alone had the opportunity to challenge it directly.

7.38 The second, and perhaps more important, reason for the decline in disciplinary proceedings was that there had been a change of culture. There is now a general view that it is preferable that a doctor whose conduct or performance has been in some way unacceptable should be helped to improve rather than be subjected to punishment. In Chapter 5, I described the ways in which HAs (and more recently PCTs) developed committees or groups whose function was to ensure that any concern about a practitioner, however it was brought to the notice of the HA, was adequately addressed. To a very large extent, the activities of such committees or groups had replaced disciplinary proceedings at local level even before the introduction of the list management procedures that PCTs can now invoke to deal with more serious or intractable problems with GPs. In Chapter 5, I also described the list management powers that PCTs have had since April 2002. These enable (and in some limited circumstances require) a PCT to suspend or remove a doctor from the PCT's list or to impose conditions on the doctor's continuing inclusion.

7.39 It was an inevitable consequence of the sharp reduction in disciplinary proceedings that very few appeals were made to the FHSAA and, later, the FHSAA (Special Health Authority) and, in consequence of that reduction, very few doctors have been reported by that body to the GMC. After 1996, the usual mechanism for the reporting of a doctor to the GMC was either by means of a direct complaint by a patient or representative or by the HA or PCT itself if it took the view that remedial measures it had itself applied had not been, and were not likely to be, successful. Among those responsible for the administration of

disciplinary measures, their demise does not appear to have given rise to significant dissatisfaction. However, it does appear that some patients or their representatives who pursued a complaint against a doctor remained dissatisfied even though their complaints may have been upheld, because their perception was that the doctor had not been held accountable. To some extent, this problem arose because complainants were not entitled to be informed (and, in practice, were not informed) about any remedial measures that the doctor might have been required to undergo as the result of an IRP's report. However, it may be that there is a fundamental problem with the 1996 complaints procedures in that they do not provide any clear focus or objective. Before 1996, the objective was at least clear, unsatisfactory though it may have been: it was to punish the doctor who breached his/her terms of service. Since 1996, the objectives have been to **'satisfy the complainant'** and to learn from mistakes. So far as the complainant is concerned, there is no redress other than perhaps an apology. I shall return to the issue of redress later in this Chapter.

The Power to Suspend a General Practitioner from NHS Practice

7.40 One unsatisfactory aspect of the 1996 disciplinary procedures was brought into sharp focus in 1998, when the WPHA was advised by the Greater Manchester Police (GMP) that Shipman was under investigation for the murder of a patient, Mrs Kathleen Grundy, that a number of other sudden deaths gave rise to suspicion and that Shipman was thought to be a risk to his patients. Shipman had not at that stage been arrested or charged with any offence. He was practising, as usual, from 21 Market Street, Hyde. On 14th August 1998, Detective Superintendent Bernard Postles (later Detective Chief Superintendent), the officer in charge of the investigation into Shipman, requested that the WPHA take steps to suspend Shipman from practice. He also contacted the GMC but was informed that that body had no power to suspend a doctor during the investigation of a criminal offence.

7.41 The WPHA itself did not have the power to suspend Shipman either. The procedure under the National Health Service (Service Committees and Tribunals) Regulations 1992, as amended, was for the WPHA to apply to the NHS Tribunal, which did have the power to impose interim suspension, pending the hearing of an application by the WPHA for removal of Shipman's name from their list. Liaison between the WPHA's solicitor and the Clerk to the NHS Tribunal revealed that the NHS Tribunal would require a written application supported by evidence from the police, including witness statements. The police were unwilling to reveal such information at that time, as disclosure to Shipman might prejudice their investigations. Further communications between the WPHA and the Clerk to the NHS Tribunal resulted in a formal application being made on 21st August, supported by a summary of the position and letters in which the GMP explained the reasons for its **'mounting concerns'** about the safety of Shipman's patients. The procedure required a hearing before the Tribunal. Shipman had to be given 14 days' notice of a hearing; in fact the hearing was fixed for 29th September.

7.42 The police decided to act and arrested Shipman on 7th September. He was charged with murder and forgery and was remanded in custody. His patients were now safe, although the GMP feared that an application for bail might succeed. In any event, the WPHA wished to take over the management of Shipman's practice, as the consortium to which Shipman

belonged was having difficulty in finding locum doctors to provide services to patients. Both the GMP and the WPHA wished to pursue the application to the NHS Tribunal. Further evidence was lodged, on affidavit.

7.43 A hearing took place before the Tribunal in London on 29th September. An application to adjourn the proceedings, made on Shipman's behalf, was refused. The Tribunal's decision was reserved and was delivered, in writing, on 15th October. The Tribunal had decided to suspend Shipman from the list of practitioners providing general medical services to the WPHA. However, the decision did not take legal effect until the expiry of a further 14 days, during which time Shipman was entitled to lodge an appeal. In fact, he did not do so and the order took effect from 29th October 1998. Both the WPHA and the GMP were deeply dissatisfied that it had taken ten weeks to obtain an effective order.

7.44 The difficulties experienced by the WPHA and the GMP in this case led directly to a decision by the GMC to seek extended powers of interim suspension, which it now has. Also, the Health and Social Care Act 2001 abolished the NHS Tribunal and granted to HAs (later PCTs) the power to suspend and remove a GP from their lists. A PCT can take action only in respect of its own list. If appropriate, a PCT can refer a case to the FHSAA (a new body created in December 2001), which can impose national disqualification.

Research into the Operation of the 1996 Complaints Procedures

The Public Law Project

7.45 In July 1997, the Public Law Project commenced research into the operation of the 1996 complaints procedures from the perspective of health service users. Its report, entitled 'Cause for Complaint? An evaluation of the effectiveness of the NHS complaints procedure', was published in September 1999.

7.46 Local resolution was reported to be generally satisfactory in practices that were committed to the process but less good with defensive practitioners who merely **'played the game'**. A number of concerns were expressed. First, it was apparent from an examination of the decisions of convenors that many practices did not operate fair procedures; many failed to investigate the complaint adequately or to give an adequate explanation at the end of the process. In 47% of the cases examined, the convenor had sent the case back for a further attempt at local resolution. There were also more fundamental concerns. The local procedures failed to take account of the imbalance of power inherent in the relationship between healthcare professional and patient. It was very difficult for patients to challenge the organisation that had treated them. The procedures whereby an organisation investigated its own conduct or performance were unlikely to be impartial. Local NHS complaints procedures were not accountable to any external body. These problems were particularly acute in the primary care sector, where the need to bring the complaint directly to the practice acted as a deterrent to complaining. The handling of a complaint by a small organisation could become uncomfortably personalised. Patients feared retribution such as being removed from the practice list. Some were sceptical about whether they would receive honest or impartial explanations. It was felt that there was a need for complainants to be able to take their grievances to an independent authority which would assume responsibility for overseeing any investigation.

7.47 Concern was expressed about the inability of the new procedures (particularly at a local level) to deal adequately with complaints that raised serious questions about performance, conduct or competence, such as might place patients at risk. One of the major problems was the inadequacy of the investigation of the complaint. Not only did the complaints manager not always have the necessary skills, there was often a defensive attitude which amounted to **'collective back-covering'**. It was in this area in particular that there was a need for independence and competence in the handling of complaints.

7.48 Convenors were seen to be less than independent and were perceived as **'insiders'** of the NHS. Nearly 50% of all the convenors interviewed said that they felt compromised by their role as a non-executive director of the HA. Some had insufficient experience or training to fulfil their functions satisfactorily.

7.49 The conduct of IRP hearings was also unsatisfactory. It was reported that most panels opted to hear the participants separately. Many complainants felt dissatisfied that they had not been able to hear the doctor's explanation. There was also a feeling that some panels and assessors were biased towards the NHS. Sometimes, IRP chairmen lacked the necessary skills to function well.

7.50 The report highlighted the problem, mentioned by Miss Horsfall in evidence to the Inquiry, that HAs and PCTs were unable to monitor the handling of primary care complaints because they had little information about them. This had led to a loss of accountability of practitioners. The authors also reported that the commitment of NHS organisations to using the complaints process as an instrument of change was variable. Not all made much effort to implement IRP recommendations. Concern was expressed about the effect of the dissociation of discipline and complaints procedures. It was noted that there had been a marked decline in the number of disciplinary proceedings taken in primary care. It appeared that there was a preference for dealing with shortcomings by retraining and skill improvement. It was suggested that the drawback to this was the lack of any sanction. There was an appearance that healthcare professionals were not accountable.

7.51 The report concluded with a number of recommendations. I shall highlight five. First, it was said that primary care patients should be able to complain directly to an officer who was independent of the practice and who would have responsibility for overseeing the investigation of the complaint. Second, it was suggested that the DoH should develop a framework for fast tracking complaints that raised serious questions about performance, conduct or competence which put patients at risk. Such complaints should be considered by a 'screener' who would decide whether they should be referred immediately to more formal investigatory or remedial processes. Third, the second stage of the process should be conducted under the auspices of a regional, rather than a local, NHS body, to increase independence and efficiency. Fourth, guidance should be disseminated for the conduct of IRPs to improve fairness and transparency. Finally, accountability should be improved by the provision of information about primary care complaints to HAs, by permitting IRPs to recommend disciplinary action and by keeping complainants informed of the outcome of disciplinary action.

7.52 In my view, this research was well conducted, reached careful conclusions and recommended sensible measures. Although it did not result in any immediate action, it

may well have stimulated the commissioning of further research and may have influenced Government thinking.

Report on the Research Undertaken by the York Health Economics Consortium

7.53 In 1999, the Government commissioned the York Health Economics Consortium to undertake research into the operation of the NHS complaints procedures. The Consortium published its report (the York Report) in March 2001. As with the work of the Public Law Project, this research appears to have been well conducted. It was, however, more widely based and surveyed the experience of all types of people who operated the procedures as well as those who used them. The findings bear a remarkable similarity to those of 'Cause for Complaint? An evaluation of the effectiveness of the NHS complaints procedure', although, as I shall explain, the recommendations were far less radical.

7.54 Among complainants, there was a high level of dissatisfaction in respect of local resolution and the second stage. At local level, only about one third of complainants were satisfied with the process. Dissatisfaction related to the handling of the complaints, the time taken, unfairness and bias, stressfulness and outcome. Patient interest groups emphasised the difficulty that many patients experienced in complaining directly to a service provider. There were reports of patients being removed from a practice list following a complaint. Specific criticisms related to unhelpful, aggressive or arrogant attitudes of staff, poor communication and lack of information and support. At the second stage, only a quarter were satisfied. Dissatisfaction again related to delay, unfairness and bias, stressfulness and outcome. Only 13% were satisfied with outcome. The main complaint about the second stage was of lack of independence.

7.55 Among NHS staff who had been the subject of a complaint, there was a high level of satisfaction. Most thought the complaint against them had been handled well and that the process had been fair and unbiased. Some complained that they had not been kept sufficiently informed of progress. In my view, the stark difference between the satisfaction levels of those complaining and those complained against is very significant. It strongly suggests that the procedures were weighted against complainants.

7.56 In the eyes of most of those involved in the operation of the procedures the view was that they were superior to those in force before 1996. However, the need for improvement was recognised, in particular in respect of the independence of those involved in the second stage. Some of those involved thought that the second stage procedures were too time-consuming and expensive. Some thought that the performance targets were difficult to meet. IRP members wanted better training and feedback.

7.57 The York Report discussed the policy implications of the findings and made many specific recommendations. In relation to primary care services, the recommendations were developmental rather than radical. The main thrust of the proposals was to ensure that complaints handling at local level was given a higher priority. It was suggested that complainants must be offered the opportunity to complain otherwise than directly to the practice. This was to be achieved by encouraging practices to work together to share information and to offer support in providing acceptable procedures. There should be less discretion afforded to practice complaints managers about how complaints should be

handled. Wider use should be made of conciliation. There should be a named individual in each PCT, to whom complainants would have access, with responsibility to **'handle complaints about member practices'**. Also it was proposed that PCTs should receive more information about complaints, including the causes of complaints and the action taken or proposed to prevent a recurrence. PCT boards should receive a quarterly report on complaints and should take responsibility for ensuring that agreed actions were implemented. The quarterly report should be disseminated to local patients' organisations. Consideration should be given to the development of a National Service Framework for the management of complaints.

7.58 Proposals for improvement of the second stage related mainly to increased independence of convenors and panels. The second stage should be conducted at a regional or sub-regional level. Consideration should be given to increased powers for panels, for example to summon witnesses and take evidence. Improved training should be provided for all those operating the second stage. The Health Service Ombudsman should be asked to consider how to operate a fast track procedure whereby, in appropriate cases, the second stage would be conducted by the Ombudsman. The board of the relevant NHS body should take active responsibility for ensuring that, following the receipt of an IRP report, an action plan was produced and the action implemented.

Report of the Commission for Health Improvement into the Case of Peter Green

7.59 In August 2001, the Commission for Health Improvement (CHI) published a report of its investigation into the conduct of a GP, Peter Green, who had been convicted in July 2000 of sexual assaults on a number of patients. The report criticised **'an NHS culture that did not listen to complaints or treat them inquisitively'** and **'an NHS complaints system failing to detect issues of professional misconduct or criminal activity'** over a number of years. Concerns about Green's conduct had been raised with a variety of different bodies on no fewer than 23 occasions between 1985 and 1997. These included the FHSA, doctors at Green's practice, the GMC and the police. The complaints had not been logged or cross-referenced and the pattern had not been noticed.

7.60 The CHI report focussed on the systems failures and did not make specific recommendations for the reform of the complaints procedures. However, it described a telling example of the way in which local procedures can fail completely if the attitude of the practice is not open and fair. One of Green's victims made a complaint to the practice in 1996. After **'investigation'**, the official response was that there was **'no evidence that Dr Green was guilty of any professional misconduct or that he had motives other than to benefit you** (*the complainant*) **in his treatment of you'**. Of course, there was evidence of professional misconduct – from the complainant – but the practice had not taken it sufficiently seriously and had apparently accepted Green's explanation of what had occurred.

Commitment to Reform: Consultation

Statements of Intent

7.61 In July 2000, the Government published 'The NHS Plan, A plan for investment, A plan for reform' (the NHS Plan), which contained its proposals for the modernisation of all aspects

of the health service. The NHS Plan included an undertaking to reform the complaints procedures and also to improve the information and assistance to be available to patients. It announced the future formation of the Patient Advocacy (later to be changed to 'Advice') and Liaison Service (PALS), which, it was said, would **'steer patients and families towards the complaints process where necessary'** and would take over the functions then performed by the CHCs in supporting complainants. CHCs provided free advice and support for complainants at all stages of the complaints procedures. CHCs would draft and deal with correspondence, would advise about the issues raised and would accompany the complainant at any hearing. The evidence received by the Inquiry suggests that many did their work well and that their services were much appreciated, not only by complainants but also by those with responsibility for administering the procedures, such as Miss Horsfall.

7.62 In September 2001, the Government published a Consultation Paper entitled 'Reforming the NHS Complaints Procedure: a listening document'. The consultation took place shortly after the publication of the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995. The Consultation Paper explained that it was the Government's intention to improve the accountability of the NHS and to give patients and the public a greater role in shaping health care. The Consultation Paper summarised the findings of the York Report and sought views on its recommendations. Some specific questions were posed for discussion. The Government promised to listen to patients' views. Consultation closed in October 2001.

7.63 Also in September 2001, a second Consultation Paper was published, entitled 'Involving Patients and the Public in Healthcare. A Discussion Document'. The principal measures proposed were the formation of the Commission for Patient and Public Involvement in Health (CPPIH), which would have an overarching and co-ordinating responsibility for patient involvement in the health service. Two new bodies would be formed, PALS and a locally based Independent Complaints Advocacy Service (ICAS). A Patients Forum would be set up in every NHS trust. The remit of the Patients Forums would be to monitor and review the quality of local services from the perspective of patients. CHCs would be abolished. The two new services, PALS and ICAS, would, in the words of the Consultation Paper, **'be a key means of ensuring that patients' concerns would be dealt with rapidly and to everyone's satisfaction'**. The intention was that PALS would be able to provide on-the-spot advice and help to patients in the resolution of a wide variety of problems. ICAS would provide assistance to patients in advancing a complaint. The proposal to abolish the CHCs was met with widespread expressions of dismay, particularly from organisations representing patients' interests.

7.64 In 'Delivering the NHS Plan', published in April 2002, the Government announced its intention to form the Commission for Healthcare Audit and Inspection (now known as the Healthcare Commission), which would, among many other functions, have responsibility for the independent scrutiny of healthcare complaints.

After the Community Health Councils

7.65 The abolition of the CHCs proceeded more or less as planned and a branch of PALS was set up in each area. PALS advisers are NHS employees; they may be employed by a

hospital trust or a PCT and, in some areas, PALS may serve both the primary and the secondary sectors. PALS is intended to give advice about a wide range of problems that a patient might encounter within the NHS; it is not limited to advice about complaints. A PALS adviser might tell a patient how to go about lodging a complaint and might advise him/her how to obtain the support of ICAS. PALS does not provide independent support for a complainant. It would be inappropriate for it to do so, as those who run the service are NHS employees.

7.66 In May 2003, the Association of CHCs published a preliminary survey of the accessibility and efficacy of PALS. I recognise at the outset that this survey was undertaken by one of the bodies that was being supplanted by PALS. It might reasonably be said that the Association had a point of view to promote. However, I have no reason to suppose that its data is inaccurate. The survey showed that the provision of the new service was very patchy. Of 100 sample calls made to the switchboards of 100 different NHS trusts, requesting access to PALS, only 51 calls resulted in a personal response. The rest were either not connected to PALS or were met by an answerphone response. This survey was conducted in the early days after PALS was set up. It is to be hoped that there has been some improvement during the last 18 months.

7.67 ICAS has taken a little longer to set up. As its name implies, ICAS is intended to be independent of the NHS. Contracts for ICAS provision were being signed when Sir Nigel Crisp, Chief Executive of the NHS in England, gave evidence to the Inquiry in July 2003. ICAS services are currently commissioned centrally by the CPPIH and are provided by Citizens' Advice or similar organisations. In July 2004, the Government announced its intention to abolish the CPPIH and, at present, it is not clear to me who will be responsible for the commissioning of ICAS services. When the Inquiry was hearing oral evidence, ICAS was in its infancy and the precise ambit of its functions was not yet clear. In July 2004, however, according to the CPPIH website, ICAS could offer to **'help clients identify the options for taking forward their complaint/s about NHS services'** and **'make sure lessons from users' experiences of the NHS are fed back into the service and to those responsible for scrutinising the NHS'**. It cannot, however, help with complaints about private healthcare treatment or services that arise outside the NHS, nor can it assist complainants who are pursuing or intend to pursue litigation concerning a complaint about NHS services.

7.68 The Inquiry has not received evidence as to how ICAS is functioning. It seems likely from information currently on its website that it will in fact provide support for complainants throughout the complaints process. There is a need for complainants to have access to free, independent and well-informed advice. It is not sufficient that a complainant is told how to proceed. He or she needs someone with whom to discuss the issues and the merits of the complaint. He or she needs advice about whether, and exactly how, to proceed. He or she needs someone to support him/her at a hearing, if any. If ICAS is indeed able to provide such advice and support, its work is to be very much encouraged.

The Government Proposals for Complaints Procedures

7.69 In February 2003, the Government's proposals for reform of the complaints procedures were published in 'NHS Complaints Reform: Making Things Right'. This document

acknowledged all the defects of the existing system that had been highlighted in the research and which had, apparently, been confirmed during the consultation exercise. These included difficulty in pursuing complaints, delays, negative attitudes by those operating the procedures, lack of fairness, lack of support, lack of independence at the review stage, lack of redress and a failure to use feedback from complaints to improve services.

7.70 The essential proposals were to improve the operation of the local procedures, to reform the second stage radically and to improve the mechanisms for learning from complaints. It was recognised that, if local procedures were to be improved, there would have to be a change of attitude in some of those operating the procedures. In particular, it was said that complaints should be valued as an aid to learning and improving the quality of service; they should be dealt with positively and willingly, not defensively. The proposal was to bring about this change of attitude by improved training and development programmes. Also, patients who wished to complain were to be given improved information and greater support.

7.71 I feel bound to observe that it would be a fine thing if attitudes towards complaints could readily be changed by training and education. I think that they can be improved but that change will be a long and gradual process. First, I have the impression that, for many doctors, a hostile attitude to complaints is deeply embedded. In the medical press, it is not uncommon to find opinions that most complainants are obsessive and their complaints unfounded. Second, it is human nature to be defensive when criticised. Being on the receiving end of a complaint can be distressing, irritating and very time-consuming. That is not to say that the effort to bring about change in attitudes is not worth making. I think it is. In respect of the second stage, 'NHS Complaints Reform: Making Things Right' proposed that the independent review should be carried out, not under the auspices of the local PCT, but by what is now the Healthcare Commission. This organisation would be seen to be independent and efficient. It would be able to identify what was required to put matters right and would also ensure that lessons were learned where mistakes had been made. Third, complaints and their resolution should become an integral part of the systems of quality control in the NHS. Overall responsibility for complaints handling would rest with senior management. Information derived from complaints would be used for clinical governance purposes.

Proposals to Include the Provision of Redress for Justified Complaints

7.72 I referred earlier to the lack of any redress for complainants whose complaint is found to have been justified. At present, and indeed under the draft National Health Service (Complaints) Regulations (the draft Complaints Regulations) setting out the proposed new complaints procedures, if a complaint is upheld, the complainant should receive an apology and an explanation of what has occurred. There is no possibility of even limited financial redress. Historically in this country, there has been a complete separation between the making of a complaint and the seeking of financial redress. Financial redress can be obtained only by legal action in the courts and, consequently, only in cases in which the claimant can prove damage due to a breach of the legal duty of care owed to the patient by the doctor or the organisation. As I mentioned earlier, any patient who

decides to take legal action is, at present, barred from pursuing a complaint to the second stage and can expect no assistance from ICAS.

Consolatory Payments

7.73 A complaints procedure that cannot provide any financial redress is unlikely to give satisfaction in many cases. Indeed, it is my understanding that some financial redress is usual nowadays for complaints against other professionals; certainly the procedures operated by both solicitors and barristers provide limited financial compensation. When a patient complains about a doctor, there will be times when all that s/he wants is an apology or to find out what has happened or reassurance that steps have been taken to prevent the recurrence of the problem that gave rise to the complaint. Sometimes, a complainant will feel that that reassurance can be provided only if the doctor complained of is subjected to some disciplinary process, possibly even amounting to erasure from the medical register. Sometimes, a complainant will want – and should be entitled to – an apology, an explanation, or a reassurance that lessons have been learned, and some, albeit modest, redress.

7.74 In his Annual Report for 2000–2001, the Health Service Ombudsman reported that NHS bodies had found themselves in difficulty when they wished to make a small consolatory payment, for example, to a person who had suffered some injustice, because they could not do so under NHS rules. A payment could be made only if the person involved was able to demonstrate financial loss, or if the NHS body was found guilty of maladministration. The Ombudsman suggested that the rules should permit the payment of a modest sum in acknowledgement of delay or **'botheration'** and make plain that such a payment does not amount to an admission of liability. Such a rule would, in his view, be more in keeping with a modern NHS. The Ombudsman said that he had raised this point with the SoS in connection with a particular complaint but the SoS was apparently unwilling to consider any change on the basis that consolatory payments would divert funds from patient care. The Ombudsman pointed out that, in principle, the rule against consolatory payments applies not only to the NHS, but also to central and local Government, both of which, the Ombudsman claimed, were willing to make consolatory payments. In my view, the opinion of the Health Service Ombudsman was interesting and valuable. He was in a uniquely good position to estimate the value of consolatory payments in achieving satisfaction for complainants.

'Making Amends'

7.75 In June 2003, the Chief Medical Officer published 'Making Amends', a Consultation Paper setting out proposals for reforming the approach to clinical negligence in the NHS. I do not intend to describe the content of the Paper in any detail. In essence, it sets out a long-term strategy to improve health care by learning from mistakes and to provide a holistic response to patients who complain about an adverse event in health care. The paper recognises the need for patients who have suffered an adverse consequence as the result of something 'going wrong' to receive an apology, a frank explanation of what has happened, remedial treatment and care and, where appropriate, financial

compensation. My understanding is that the financial compensation envisaged would be much larger than a consolatory payment but much less than the damages that would be awarded by the courts.

7.76 The thinking behind the proposals is that a system that provides these four elements will, in the long term, ensure that the NHS focusses on the prevention of harm and the reduction of risks so that the quality of care is improved and the level of medical error is reduced. Also, the proposals should lead to a better co-ordinated response to harm resulting from inadequate health care. A reduction in the level of medical error would mean that fewer patients would have cause to sue the NHS and a better response to harm would mean that fewer patients would wish to sue, because their complaints would have been properly dealt with without recourse to action in the civil courts. Not unnaturally, there is a hope that the high cost of clinical negligence claims will eventually be reduced.

7.77 The Consultation Paper focusses mainly on the suggestion for a NHS redress scheme, which is described in some detail, although it also suggests some changes in the law of tort in relation to clinical negligence claims. The scheme for redress would be available in cases where harm has been suffered as the result of serious shortcomings in the standard of care, where the harm could have been avoided and where the adverse outcome was not the result of the natural progression of an illness. At present, the proposal relates only to the secondary care sector, although, if successful, it is hoped to extend it to primary care.

7.78 The Consultation Paper stresses the need for the thorough investigation of all adverse events and the duty on healthcare professionals and managers to provide an honest explanation to patients about what has gone wrong. One particular recommendation relates to a **'duty of candour'** of healthcare professionals. It is suggested that there should be a legal duty upon such professionals to inform patients where they become aware of a possible negligent act or omission. The paper also suggests that, concomitant with the duty of candour, there should be an exemption from disciplinary action by employers or professional regulatory bodies for those reporting adverse events, **'except where the healthcare professional has committed a criminal offence or it would not be safe for the professional to continue to treat patients'**.

7.79 In its response to 'Making Amends' the GMC pointed out that doctors are already under a professional duty to give patients a frank explanation when things have gone wrong. This is wider than the suggested duty to tell patients when the doctor thinks there might have been negligence. Also, the GMC suggested that a legal duty would be difficult to police and would, therefore, be undesirable. The GMC would prefer a professional duty. As for the suggested exemption from disciplinary action, the GMC reminded the Government of the policy enunciated in 'A Commitment to Quality, A Quest for Excellence: A statement on behalf of the Government, the medical profession and the NHS', published in June 2001. In that document, the Government and the profession had agreed that, without lessening the commitment to quality and the accountability to the public, honest failure by a healthcare professional should not be dealt with primarily by blame and retribution but by learning from mistakes. However, as the GMC pointed out in its response, the exemption from disciplinary action now being proposed went beyond the commitment in

the joint statement of policy and would be incompatible with the GMC's own statutory duty to take appropriate action (possibly including disciplinary action) when a complaint is received. Mr Ian Hargreaves, retired Regional Director, Royal College of Nursing, also told the Inquiry that he considered the idea of exemption from disciplinary action undesirable in the case of any healthcare professional.

7.80 The consultation period allowed in 'Making Amends' expired in October 2003 but, at the time of writing in late 2004, the Government has not announced how it intends to proceed.

Proposals for Reform of the 1996 Complaints Procedures

7.81 In July 2003, when the Inquiry embarked upon the Stage Four hearings, which covered all issues relating to the monitoring of GPs, the Government had not yet produced any firm proposals for change to the complaints procedures. The Stage Four hearings included an investigation of the operation of the complaints handling system. In October 2003, the Inquiry published a Consultation Paper, entitled 'Safeguarding Patients: Topics for Consideration at the Stage Four Seminars', which was designed to elicit responses to, and provoke discussion of, ideas that had occurred to the Inquiry team during the investigative stage and the first few weeks of the hearings. The issues and responses were to form the basis for discussion at the seminars to be held in January 2004. Five of the topics raised in the Consultation Paper related to patient complaints.

7.82 In December 2003, the DoH published detailed proposals for change in the form of the draft Complaints Regulations. By this time, the Inquiry had already heard evidence about patient complaints but, fortunately, the draft Complaints Regulations were published before the seminars took place. It appears that the Government had continued to 'listen' to reactions to its outline proposals, because the detailed proposals in the draft Complaints Regulations contained some important developments. The major reform presaged in 'NHS Complaints Reform: Making Things Right' (i.e. the transfer of the second stage review to the Healthcare Commission) was provided for in Part IV of the draft Complaints Regulations. However, in respect of the first stage, it appears to have been recognised that negative attitudes towards complaints prevalent in some NHS organisations could not be changed within a reasonable timespan by education and training alone.

7.83 The Health and Social Care (Community Health and Standards) Act 2003 was passed and provided for the creation of the Healthcare Commission, which came into existence in April 2004. As the proposal to transfer the second stage of the complaints procedure to the Healthcare Commission had been widely welcomed and it was becoming increasingly difficult to operate the IRP system, the Government was anxious to bring the provisions governing the second stage into effect. However, the proposals for the first stage of the procedures had not met with such wide and complete approval. In particular, some reservations about them were expressed at the Inquiry's seminars and it was known that this Inquiry would make relevant recommendations. The Government also wished to await the Reports of two other Inquiries (the Neale and Ayling Inquiries) that would have a direct bearing on complaints issues. Accordingly, in April 2004, the DoH informed this Inquiry that regulations governing the transfer of the second stage to the Healthcare Commission would be made in July 2004. It was also stated that the implementation of any changes to

the first stage of the procedures would be deferred pending the Reports of all three Inquiries. The regulations made would consolidate and rationalise the various existing Regulations governing the first stage. I am grateful for the opportunity to have my recommendations taken into account before the forthcoming legislation is finalised. I shall discuss the issues raised in greater detail in Chapter 27. The reports of the Neale and Ayling Inquiries were published in September 2004.

7.84 As I have explained, the 2004 Complaints Regulations came into force on 30th July 2004. There are two main parts to the Regulations. The first part covers the handling and consideration of complaints (i.e. the first stage) by NHS bodies but it does not cover providers of primary care (where the previous Regulations therefore still apply). A 'NHS body' means a strategic health authority, a NHS trust, a PCT or a special health authority. In the context of this Report, a 'primary care provider' means a GP practice. The second part covers the handling and consideration of complaints by the Healthcare Commission (i.e. the second stage) and applies to complaints about providers of primary care as well as complaints about other bodies. I shall discuss the second part in detail in Chapter 27.

7.85 The draft Complaints Regulations would require primary care providers, as before, to appoint a complaints manager to take responsibility for the investigation of any complaint received by that body. However, in the context of primary care, the proposal now is that patients should have the option of complaining either to the PCT or to the primary care provider. Complaints made to the practice would be investigated by the practice, as now. Complaints made to the PCT would be investigated by the PCT. I think the introduction of this choice would be welcomed by many patients for the reasons already discussed. Most patients would find it easier to complain to the PCT, particularly in respect of matters involving personal criticism of a doctor.

7.86 A number of other changes were proposed in the draft Complaints Regulations and some, though not all, have been introduced for NHS bodies by the 2004 Complaints Regulations. The time limits for making a complaint were to be extended from six months to one year but they have been kept at six months for NHS bodies. I am not sure whether this preservation of the *status quo* was intended to be temporary, pending publication of the Reports of the three Inquiries. As I shall explain in Chapter 27, it is my view that the period should be 12 months. Some of the restrictive rules, which provided that complaints could not in certain circumstances proceed, were to be modified under the draft Complaints Regulations, but these modifications have not been made by the 2004 Complaints Regulations. First, under the 1996 procedures, a complainant who intended to take legal proceedings could not be granted an independent review. Under the draft Complaints Regulations, the complaints manager of the NHS body to whom the complaint was made was to consider, in consultation with the complainant, how the complaint should be handled. He or she could investigate the complaint provided that s/he considered that the NHS investigation would not compromise or prejudice the concurrent proceedings. Under the 2004 Complaints Regulations, however, any complaint against a NHS body about which the complainant has stated that s/he intends to take legal proceedings is excluded from the operation of the Regulations. Similarly, the fact that a NHS body was taking disciplinary proceedings against a doctor would not, under the draft Regulations, have precluded the furtherance of the patient's complaint; however, the existence of proposed

or actual disciplinary proceedings in relation to the substance of the complaint will, under the 2004 Complaints Regulations, now cause that complaint to be excluded from the operation of the Regulations. In my view that is not satisfactory and I shall make recommendations on this topic in Chapter 27.

7.87 One welcome change proposed in the draft Complaints Regulations has been introduced covering the application of the first stage to complaints about NHS bodies. The categories of person allowed to complain have been extended under the 2004 Complaints Regulations. Formerly, the only persons permitted to complain were patients, former patients and such other persons as could properly represent the interests of patients and former patients who could not pursue a complaint for themselves. Now, any person (or the representative of such a person) who is affected by or likely to be affected by the action, omission or decision of a NHS body or primary care provider would be able to lodge a complaint. This is a welcome change.

7.88 Another proposed change that I welcome is the provision to be made for 'complex' complaints. Nowadays, many complaints involve more than one NHS body. Until now, it has not been possible to make a single complaint about the conduct or performance of more than one NHS body or indeed the liaison – or lack of it – between two NHS bodies. This problem was highlighted in Ms Longley's article in the Medical Law Review in 1996 referred to earlier in this Chapter.

7.89 The 2004 Complaints Regulations impose upon the complaints manager of the NHS body who receives the complaint the duty to investigate it **'to the extent necessary and in the manner which appears to him most appropriate to resolve it speedily and efficiently'**. The draft Complaints Regulations would impose the same obligation on the primary care provider. If some complaints about a primary care provider are to be directed to the PCT (as I hope they will be), the proposal gives rise to potential difficulties owing to the lack of training, expertise and resources of PCTs to handle complaints well. I shall discuss these difficulties in more detail in Chapter 27. To some extent these potential difficulties seemed to have been recognised by Government, as the draft Complaints Regulations provided that, where it appeared appropriate, the complaints manager of the NHS body or primary care provider handling the complaint could refer it directly to the Healthcare Commission or to the Health Service Ombudsman. Such a referral could be made only with the consent of the complainant and of the Healthcare Commission or the Health Service Ombudsman. This provision seemed also to be designed to meet the concern expressed in the Public Law Project report that there has, in the past, been inadequate provision for the rapid resolution of complaints that gave rise to serious concerns about conduct or performance and that might bring about the risk of harm to patients. In effect, this provision would have allowed for a complaint to be fast tracked to and investigated by the Healthcare Commission or the Health Service Ombudsman. This seemed to be a welcome proposal, although I was concerned to hear from Mrs Elizabeth Dimond, Complaints and Helpline Project Lead at the Healthcare Commission, that this provision was, in fact, intended primarily to allow a referral in cases in which the complainant had 'lost faith' in the NHS procedures. I note that it is not in the 2004 Complaints Regulations. I will discuss this further in Chapter 27.

Disciplinary Procedures after April 2004

7.90 In paragraphs 7.36–7.38, I explained why in 1996 disciplinary proceedings against GPs at local level fell into disuse immediately after the introduction of the new complaints procedures. They were still used occasionally, however, and their operation still depended upon establishing a breach of the GP's terms of service. As I have explained in Chapter 5 with the introduction of the new General Medical Services Contract in April 2004, terms of service have ceased to exist. In their place, the National Health Service (General Medical Services Contracts) Regulations 2004 (the 2004 Regulations) have introduced a wide range of contractual conditions and obligations. Services will be provided under a contract between the PCT and the practice, not between the PCT and the individual doctor. There are conditions relating to the constitution of the practice. Obligations on the practice include, for example, a requirement that the practice carries out its duties with reasonable skill and care, and practices must co-operate with the investigation of complaints.

7.91 Paragraphs 110 to 120 of Schedule 6 to the 2004 Regulations provide powers for the PCT to deal with breaches of conditions or obligations. These are quite separate powers from the list management powers I have already described in Chapter 5. Under the 2004 Regulations, the PCT may, in some circumstances, terminate the contract with the practice. For example, it may do so if it finds that the practice provided false information in respect of certain important matters when entering into the contract. Also, the PCT may terminate the contract if the practice's financial situation puts the PCT at risk of material financial loss. The PCT has the power to issue a remedial notice if the practice breaches an obligation which is capable of being remedied and is not of such importance as to warrant termination. For example, a failure to provide a practice leaflet might be dealt with by a remedial notice. In the case of a breach which has occurred and cannot now be remedied (such as a failure to visit a patient in circumstances in which a visit was required), the PCT may serve a notice on the practice requiring it not to repeat the breach. The PCT may terminate the contract for repeated breaches or repeated failures to heed notices if it is satisfied that the cumulative effect of the breaches is such that it would be prejudicial to the efficiency of the services for the contract to continue. The PCT also has the power, where appropriate, to impose sanctions on a practice. For example, it might terminate or suspend the provision by a practice of certain specific services, such as, for example, child health surveillance. It may also withhold or deduct monies payable under the contract.

7.92 There is no formal procedure laid down which must be followed before a contract can be terminated or a sanction imposed. However, if it is reasonably practicable to do so, the PCT must consult with the LMC when it is considering termination of a contract or the imposition of a sanction. Also, the PCT must give notice in writing of its intention to terminate the contract or impose a sanction and the practice then has 28 days in which to invoke the NHS disputes resolution procedure before the termination or sanction takes effect. If the disputes resolution procedure is invoked, the termination or sanction would not normally take effect until the conclusion of that procedure. However, the PCT can terminate the contract or impose the sanction before that stage is reached if it is satisfied

that it is necessary to do so to protect the safety of patients or to protect itself from material financial loss.

7.93 These powers, combined with their list management powers, mean that PCTs do now have quite extensive powers, at least on paper, to insist on the provision of appropriate services and to dispense with the services of practices that cannot provide them. It is too early to say how these new powers will work in practice. I do fear that there will be some tension between a PCT's wish to dispense with services that are not up to standard and the need to provide GP services to the population at a time when there is a shortage of GPs. The problem is likely to be particularly acute in areas which are not attractive to or popular with GPs. However, in my view, it is better that the powers are in place, even if they are not used as effectively as the PCT might wish, than that they do not exist at all.

Conclusions

7.94 So far as complaints procedures are concerned, it has been recognised that the arrangements that have existed since 1996 were in need of change. From the perspective of this Inquiry, it appears to me that there are several vital improvements to be made. One is that PCTs should have full information about all complaints received about a GP, not only those that proceed to the second stage of the procedure. Such information is a vital component of clinical governance. Another is that complainants should have the option of making a complaint about their GP or the practice to the PCT and should not be obliged to 'face' the doctor or the practice staff directly. Third, there is a real need to ensure that PCTs have the responsibility and the resources to investigate the more serious complaints adequately, including those involving an allegation of substandard clinical care. It seems to me that, in the past, complaints have not been 'bottomed' because there has been no one responsible for and capable of conducting an independent investigation. Complainants have lacked resources and know-how and it is not always in the doctors' interests to ensure the production of all the available evidence. I welcome the decision to transfer the conduct of the second stage of a complaint to the Healthcare Commission, which is setting up a team of investigators. I hope that the Healthcare Commission will develop real expertise in investigation. However, the existence of an investigative team at the Healthcare Commission will not remove the need for PCTs to have their own facilities available. Finally, I am convinced of the need for the provision of appropriate support for complainants at all stages of the process. I shall make my recommendations for change to the complaints procedures in Chapter 27.