

COMPLAINING AND COMMENTING IN GENERAL PRACTICE

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RCGP INFORMATION SHEET



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INTRODUCTION

Complaining and Commenting in General Practice outlines the requirements and practical arrangements associated with the complaints system in general practice, also examining further mechanisms beyond formal complaint systems, that are used to engage with patients so as to anticipate potential problems and improve services. Beginning by identifying the levels of care that constitute acceptable medical practice, the document also highlights common areas of risk and issues around patient safety, before concluding with an outline of proposed Government plans for a more “personal and comprehensive” approach to complaints in the future.

This Information Sheet will be of interest to GPs (particularly young doctors), and other members of the practice team, as well as patients and the public. Information included in the document relates only to England unless stated.

1. REQUIRED STANDARDS OF CARE AND SERVICE

It is not always clear whether valid grounds exist for submitting a complaint against an individual clinician or healthcare body. The act of complaining, or indeed expressing a concern about the performance of a clinical colleague, is in itself a process which can induce feelings of vulnerability and self-doubt. The following section therefore identifies “benchmarks” for acceptable practice or levels of service, both in terms of individual practitioners and practice organisation.

1.1 THE DOCTOR’S DUTY OF CARE

Patients have the right to expect treatment from doctors/nurses with a high standard of skill, knowledge and behaviour, delivered in a manner that maintains and encourages dignity and respect. In terms of individual doctors these standards are monitored by the General Medical Council (GMC), one of thirteen health and social care regulators in the UK**. Nurses, midwives and specialist community health nurses meanwhile, are regulated by the Nursing and Midwifery Council (NMC).

**Who Regulates Health and Social Care Professionals: www.gmc-uk.org/publications/regulator/Large_Print.pdf

As a regulating body the GMC keeps a register of all doctors who have reached the standard required to practice medicine in the UK - the *List of Registered Medical Practitioners*. It also maintains the *GP Register*, a subset of the main register which records a doctor’s eligibility to practice in the specialism of general practice. Doctors need to maintain an acceptable standard of skill, knowledge and behaviour as the GMC has the power to stop or limit a doctor’s right to practise, or issue a warning where the doctor’s fitness to practise is not impaired but there has been a significant departure from good practice.

The GMC issues guidance – *Good Medical Practice (GMP)* - on what constitutes expected standards of professional conduct and on the duty of care that is incumbent upon a doctor. This document gives a benchmark to doctors and patients of the standards of behaviour and care that are acceptable, and provides the principles that underpin fitness to practise decisions. The general principles outlined in GMP are supplemented by more detailed GMC guidance on specific areas of the doctor-patient relationship (such as prescribing, consent, and maintaining professional boundaries). The online version of GMP links to this supplementary ethical guidance, as well as to external guidance (issued by the Royal Colleges for example), and relevant legislation.

Based upon the core standards for all doctors, the Royal College of General Practitioners (RCGP) in association with the British Medical Association (BMA), publishes *Good Medical Practice for General Practitioners*. This document outlines the basic standards that a GP must uphold in order to retain his or her license to practise, as well as outlining “unacceptable” standards and highlighting those levels of care which would be identified as “excellent”. Although presently under review¹, it is likely in the near future that all doctors will need to renew their specialist certification around every five years, proving that (s) he is up to date and fit to practise as a GP, and has been practising medicine in line with *Good Medical Practice*.

Good Medical Practice: www.gmc-uk.org/guidance/good_medical_practice/index.asp

Good Medical Practice for GPs: www.rcgp.org.uk/PDF/Corp_GMP06.pdf

RCGP Ethical Guidance Database: www.rcgp.org.uk/ethicsguidance

1.2 PRACTICES AS PROVIDERS OF SERVICES

Aside from specific standards of clinical skill and professional behaviour in individual clinicians, patients are also entitled to expect a safe, comprehensive and accessible service from their GP practice. Practical arrangements associated with the organisation and running of the surgery are often the subject of complaints, due to deficiencies in administration systems, communication, staff training and equipment.

Although a myriad of regulations and good practice guidance govern various aspects of practice management, for example Health and Safety legislation, the type and level of services that must be provided by the practice are defined within the contract that it signs with the local Primary Care Organisation (PCO) - based on national regulations (General Medical Services). Although practices can choose to provide certain services, many elements of the contract are mandatory.

Core service agreements are conveyed to patients via the practice leaflet, which is available from the surgery reception. The leaflet is in essence a simplified distillation of those elements of the practice contract that affect patients directly, presented in an accessible style and format. The national contract regulations require all practices to produce a practice leaflet, and also set out the core information that each leaflet must contain. This core information includes (selected):

- The opening hours of the practice and how to obtaining access to services outside of core hours.
- How patients can make a complaint or comment on the provision of service.
- An explanation of the role and services offered by other health care professionals such as nurses and health care assistants.
- Different clinics offered by the practice, including how patients can access them.
- The criteria for home visits and the method of obtaining such a visit.
- Details of how the practice refers patients for specialist or hospital care, including information about any booking systems used by the practice and any choice of provision available to patients.

Although all practice leaflets must contain certain core information, practices can use this medium to include enhanced information for patients, in order to both manage patient expectations and anticipate potential complaints.

Guide to Practice Leaflets: www.nhsidentity.nhs.uk/gp/downloads/gppracticeleaflettemplates.pdf
NHS (GMS Contracts) Regulations 2004: www.opsi.gov.uk/si/si2004/20040291.htm
RCGP Patient Centre: www.rcgp.org.uk/patientcentre

2. COMPLAINTS SYSTEM IN GENERAL PRACTICE (REQUIREMENTS)

By law every GP practice must have an agreed procedure for enabling patients to express comments, suggestions and complaints to the practice when they feel dissatisfied with the service provided. This must comply with nationally agreed criteria² and be widely advertised to patients. Although there are mandatory elements it is important that the process is workable in terms of the resources available to the practice, and is user-friendly for both patients and practice. The main requirements of the practice complaints procedure are laid out below.

Administration of the complaints procedure should be practice owned, meaning that the procedure will be managed entirely within the surgery. All practice staff – whether they are administrative or clinical - need to be aware of both the mechanics and the spirit of the procedures, thus inculcating a sense of common ownership. This is vital in the case of sessional GPs, and particularly freelance/locums, as these doctors often feel disenfranchised from surgery systems, and are sometimes more vulnerable to complaints. This is due to the fact that they:

- May have little or no established relationship with the patients they treat.
- Are less likely to know essential non-clinical information relating to their current clinical setting.
- Often receive poor or no induction to a practice and its clinical- and non-clinical systems.

Handling Complaints: advice for sessional GPs (National Association of Sessional GPs):
www.medicalprotection.org/assets/pdf/nasgp_mps_complaints_advice.pdf

On request the Primary Care Trust (PCT) will support practices in processing complaints, but will otherwise only become involved if the procedure does not meet the agreed criteria or if the practice or complainer asks for help in reaching a satisfactory outcome. The records of complaints are confidential to the practice and the PCT will only be sent information about numbers of complaints. If, however, a complainant remains dissatisfied and asks the PCT to investigate a complaint, it will seek information from the practice about action taken during the practice investigation.

One person should be nominated to administer the practice complaints system, though how this is achieved will be for the practice to decide. This role may be taken on by one of the partners, the practice manager or someone else given specific responsibility for handling complaints. There must also be a deputy nominated. Practices must give the procedure publicity (waiting room poster, website etc) and make written information available to anyone who asks for it via the practice leaflet. Written information should explain:

- To whom patients should speak.
- What will happen after they have made their initial contact.
- Who will contact them, either with an explanation or to set up a meeting.
- How long it will take.
- Possible outcomes of the procedure.
- How to contact the PCT.

The response to a complaint should provide patients with an explanation of what has happened; an apology where appropriate; and an assurance that steps have been taken to prevent the problem recurring, where this is possible. The Medical Defence Union has stressed that apologising is not the same as admitting legal liability, and advises that doctors adopt a candid approach as the best way of avoiding a formal complaint.

Comprehensive Practice Complaints Procedure (Education and Quality in Practice):
www.equip.ac.uk/practiceManagement/docs/protocols/pdf/Complaints_procedure_2.PDF
Guidance to Support Implementation of the NHS (Complaints) Regulations:
www.dh.gov.uk/assetRoot/04/08/76/82/04087682.pdf

3. NHS COMPLAINTS SYSTEM EXPLAINED

The current NHS complaints procedure has been in operation since 1996. It enables complaints to be made by any patient or person affected or likely to be affected by the actions or decisions of an NHS practitioner. Patients should be clear about the outcome they expect in making a complaint via the NHS Complaints System, since it is not directly a vehicle for disciplining GPs, nor is it a way of gaining financial redress for any errors made. It is rather a means of gaining emotional redress, via apology or explanation, and ensuring that the NHS learns from its mistakes.

If a patient intends to, or is taking legal action, they may not use the NHS complaints procedure. If the legal action is stopped (or there are outstanding issues that have not been resolved by the legal action), then the concern can still be pursued via the NHS complaints procedure. Although there is no direct connection between complaints procedures and disciplinary action, the investigation of complaints can reveal information about serious matters which indicate a possible need for disciplinary investigation, either by the GPs employer or the General Medical Council (GMC).

The NHS Complaints System also cannot be used for expressing concerns about the providers of private healthcare. The Healthcare Commission is responsible for the regulation and inspection of private healthcare providers in England. Patients should contact the Commission on 020 7448 9200 if they have concerns about a private healthcare provider.

How to Make a Complaint against the NHS (Department of Health Leaflet):
www.dh.gov.uk/assetRoot/04/13/91/99/04139199.pdf
How to Raise Concerns about Your Care (British Medical Association):
<http://www.bma.org.uk/ap.nsf/Content/raisingconcernsaboutyourcare>
Guide to the NHS Complaints Procedure (Medical Defence Union):
www.the-mdu.com/gp/services/publications/order_publication/index.asp

3.1 ADVISORY AND SUPPORT SERVICES

Before embarking on a formal complaint it may be useful for patients to access advice from a specialist support service. This will help patients to decide whether this is an appropriate route for expressing their grievance, and will also support them in making a complaint if this is the desired course of action.

Patient Advice and Liaison Services (PALS)

PALS exist within Primary Care Trusts (PCTs) to provide information and confidential advice to patients. Although not part of the NHS complaints procedure, PALS are often able to help resolve any minor problems that patients are having within primary care without the need for a formal complaint. A recent national evaluation³ of PALS found that the service was extremely effective in filtering potential complaints and enabling patients who wish to persist in raising issues to do so in an effective, focused way. PALS will also feedback patient comments to the PCT in order to inform service improvement.

Find the Local PALS: www.pals.nhs.uk/members/officeSearch.aspx

Independent Complaints Advisory Service (ICAS)

Patients who are more comfortable talking to someone outside of the NHS infrastructure should contact the *Independent Complaints Advocacy Service*. This is a free, confidential and independent service which supports patients in making formal complaints about their NHS experience, and provides information on the various options and routes available. The ICAS serves a vital role in advising patients on how serious their complaint is, whether it is worth pursuing via the NHS Complaints System, and who to complain to.

Find the Local ICAS: www.dh.gov.uk/assetRoot/04/09/07/75/04090775.pdf
ICAS Self-Help Pack: www.icasresources.com/shipdocs/ICAS_SHIP.pdf

Action against Medical Accidents (AvMA)

The AvMA (www.avma.org.uk) is an independent, UK-wide charity that campaigns for justice for people affected by medical accidents. It also works for better patient safety and provides free advice on the medical and legal issues connected with medical accidents. AvMA case-workers can refer complainants to solicitors who are specialists in the field of clinical negligence. The AvMA helpline number is 0845 123 2352.

3.2 LOCAL RESOLUTION OF COMPLAINTS

Practice Based Complaint System

For most complaints, patients should initially contact the GP surgery to attempt local resolution. Around 90% of complaints notified to the Medical Defence Union (MDU) by GPs are resolved at this initial stage by the practice itself. Most patients simply desire an apology or an explanation from the practice, and an assurance that the practice will attempt to rectify the cause of the problem. Patients can often achieve this by quickly contacting the member of staff involved in the problem, whether it is the GP, a nurse, the receptionist, Practice Manager or other member of staff, and explaining the complaint and the desired outcome.

If a more formal process is appropriate, or if initial overtures are unsuccessful, patients should make a written complaint directly to the practice. GPs are required to operate a practice complaints procedure, and must publicise its procedure - including how and to whom to complain and what will happen as a result. Complaints should be made within six months of the event(s) concerned or within six months of becoming aware that there is something to complain about. Practitioners and complaints managers have the discretion to waive this time limit if there are good reasons why a patient could not complain earlier. A complaint can also be made by someone acting on behalf of the patient or person, with their consent where possible.

Generally the practice manager is the first point of contact for complaints. A practice will log every complaint and an acknowledgement should be sent within two days, generally to explain that the complaint is being investigated. When the investigation of the complaint is complete the complaints administrator normally discusses any "findings" with the overseeing GP partner in order to decide upon the response. Often the response will be a written explanation or the offer of a meeting to discuss the findings. In straightforward

cases, the person complaining should receive this response within 10 working days, although the practice can ask for more time to investigate complex complaints. Any response to a complaint about clinical care must come from the doctor directly involved.

The complaints procedure will generally involve a face-to-face meeting with the patient, perhaps with the help of a lay conciliator supplied by the local Primary Care Trust (PCT). Voluntary conciliation practices, although not universally applicable, can be particularly useful where there are multiple issues involved or where the doctor-patient relationship has already broken down significantly. Conciliators can also ensure a structured approach to conflict resolution, and unlike arbitration, suggestions made during conciliation are not binding on the parties involved. Conciliation services differ from place to place so patients should ask the practice complaints administrator to explain how it operates in their area.

Role of Primary Care Trusts (PCTs)

If a patient is not satisfied with the practice response and would like to continue with the complaint locally, or if s/he would prefer not to deal directly with the practice involved, then the local PCT Complaints Manager can be contacted in writing (including e-mail). Complaints are not "lodged" with PCTs as such, and they have no formal remit to directly investigate complaints made by patients against GPs. The role of the PCT complaints department in this regard is to pass complaints to the appropriate person in the practice and monitor the progress of cases. It can also provide help, support and advice during the resolution of the complaint.

As specified earlier there is no "direct" connection between complaints procedures and disciplinary action. However, as the GPs "employer" the PCT should be alerted of serious issues regarding a practitioner's professional behaviour or clinical practice as these may indicate a possible need for disciplinary investigation. This performance investigation would be to establish whether there has been a breach in the terms of service, rather than to seek redress for the complainant. These kinds of investigations are often triggered by concerns raised by colleagues, and by patient complaints that are referred back to the PCT by the General Medical Council (GMC).

If there has been a breach of the terms of service PCTs can take local disciplinary action against the GP concerned. They may also refer the practitioner to the National Clinical Assessment Service (NCAS), an organisation which becomes involved with doctors when employers, or contractors in the case of GPs, have concerns about performance which they feel require external help to tackle.

On rarer occasions, and where the circumstances fall outside the terms of service, the PCT may at the outset refer cases directly to the police, for example in cases of alleged fraud, or to the General Medical Council (GMC) where there is evidence of impaired fitness to practise.

*Find Your Local PCT (NHS Website): www.nhs.uk/england/authoritiestrusts/pct/default.aspx
National Clinical Assessment Service: www.ncaa.nhs.uk/*

3.3 INDEPENDENT REVIEW

If a patient is unhappy with the way their complaint has been dealt with by the practice or PCT the patient, carer or relative can refer it to the Healthcare Commission for independent review. The complaint must be submitted to the Healthcare Commission within two months of the date of the final response letter from the original healthcare provider. Complaints should be referred to the Commission if a patient: feels that the investigation by the local NHS organisation or practitioner was inadequate, incomplete or unsatisfactory; has reason to believe that the underlying issues which led to the complaint have not been fully uncovered or understood; or feels that the healthcare provider's response did not address all the issues raised by the complaint. The following process will be followed by the Commission:

Initial Review: A case manager will undertake an initial review of the case, with the help of expert advice if necessary, to determine the appropriate course of action. The possible outcomes are:

- Take no further action.
- Refer the complaint back to the NHS organisation, in order for them to try to resolve the issues.
- Carry out a full investigation.
- Refer the case to an independent panel.

- Refer the case to mediation or conciliation.

A letter, outlining the outcome of the initial review, will be sent to the complainant and the organisation or practitioner about whom they are complaining.

Investigation: If further investigation of the complaint is necessary, the Healthcare Commission will agree the terms of reference with the complainant and the organisation or individual about whom the complaint has been made. Both will receive a full report of the Healthcare Commission's findings at the end of the investigation, including remedial recommendations.

Panel Review: Those who are unhappy with the outcome of the investigation have the right to request an independent panel, consisting of three members of the public, who are not connected to the NHS but who have been specially trained to deal with NHS complaints.

Pamphlet for Patients on Review Process: www.healthcarecommission.org.uk/db/documents/04017700.pdf

3.4 HEALTH SERVICE OMBUDSMAN

Most complaints are resolved either through the practice-based procedure or Independent Review. However, if a complainant remains dissatisfied after these two stages, (s)he is entitled to refer the complaint to the Health Service Commissioner (Ombudsman). The Ombudsman is accountable to Parliament and is completely independent of the NHS and of Government. Examples of the sorts of complaints the Ombudsman can look into include:

- Receiving the wrong or poor treatment.
- Errors in diagnosis or treatment.
- Communication problems within or between services.
- Significant mistakes over appointments to see a doctor or go to hospital.
- Delay that could have been avoided.
- Faulty procedures or failure to follow correct procedures.
- Unfairness, bias or prejudice.
- Giving advice which is misleading or inadequate.
- Rudeness and not apologising for mistakes.

When a complaint is received it is first screened to see whether it falls within the Ombudsman's jurisdiction. If it does the Ombudsman retains the discretion of whether or not to investigate, based on sufficient prima facie grounds existing. There is no appeal against this decision. If the Ombudsman decides to investigate he will send the body or person complained against a Statement of Complaint setting out the "terms of reference" for the investigation. The bodies or persons to be investigated are asked to send the Ombudsman all the documents needed for the purpose of investigation, and it may also be necessary to interview the complainant and any other person who can provide information or evidence. Having considered all the evidence the Ombudsman decides whether the complaint should be upheld or not.

The Ombudsman will then send a draft of his report to the body investigated in order to (i) check that the facts are correctly stated, and that the evidence has been correctly understood and summarised; and (ii) to secure agreement to any apology and to implementation of any recommended remedial action. If the actions of a GP is criticised, the Ombudsman will request that an apology be conveyed to the complainant. If remedial action is deemed appropriate in order to prevent a recurrence, this will also be recommended in the findings.

Making a Complaint to the Ombudsman: www.ombudsman.org.uk/make_a_complaint/health/index.html

3.5 ROLE OF THE GENERAL MEDICAL COUNCIL

The General Medical Council (GMC) regulates doctors in the United Kingdom, and has the power to stop or limit a doctor's right to practise medicine, or issue a warning where the doctor's fitness to practise is not impaired but there has been a significant departure from good practice. Warnings are not given when concerns relate exclusively to a doctor's physical or mental health.

There is no direct link between the NHS complaints system outlined above and the disciplinary processes operated by the GMC. However, both PCTs and the Independent Reviewer will refer complaints to the GMC if there is evidence that a doctor's general professional performance is seriously deficient; or it is apparent that a doctor's fitness to practise is seriously impaired by ill health; or allegations of serious professional misconduct are made.

Although patients are entitled to take a complaint directly to the GMC it is generally advised that, in the first instance, patients raise their concerns through local complaints procedures. However, there are cases in which direct complaints to the GMC may be justified. These would include:

- Serious or repeated mistakes in carrying out medical procedures or in diagnosis, for example incorrect dosages on prescriptions, prescribing inappropriate drugs.
- Failure to examine patients properly or to respond reasonably to patients' needs.
- Fraud or dishonesty.
- Serious breaches of a patient's confidentiality.
- Failure to gain a patient's consent to treatment.
- Making sexual advances towards patients.
- Misusing alcohol or drugs.

If the GMC feels that a complaint received directly from a patient is not serious enough to question a doctor's ability to practise safely but is of concern, it will refer that complaint to the local PCT. The GMC will not normally investigate complaints about matters that took place more than five years before unless it considers that it is in the public interest for the case to proceed.

Referring a Doctor to the GMC: a guide for patients: www.gmc-uk.org/concerns/complain/guide.asp

4. PREVALENCE AND NATURE OF COMPLAINTS

4.1 PREVALENCE OF COMPLAINTS AND CONCERNS

For a variety of reasons it is difficult to collate robust data on the number of complaints/expressions of concern that are received about family health services or individual GPs. Firstly, complaints can be taken up at a number of levels: with the practice; with the independent reviewer (Healthcare Commission); with the Health Service Ombudsman; and with the regulator (General Medical Council). Doctors whose performance is giving cause for concern can also be referred to the National Clinical Assessment Service (NCAS), a body which makes recommendations which will support practitioners in resolving such problems. Secondly, official statistics only generally account for those complaints that have been submitted in a written form. Many complaints in general practice are satisfied via a verbal apology or explanation, and are not recorded centrally. Thirdly, if a patient is pursuing separate legal redress then they may not also use the NHS complaints procedure, and the complaint will not be recorded in complaint returns.

Quantitative complaints data can also create ambiguity, as it is only the outcomes of such complaints (positive or negative) which tell us anything meaningful about the prevalence of unacceptable practice and the reasons for it. These misgivings aside, the selected statistics below give a rough outline of the volume of complaints that are received by the various organisations involved in this process.

- In 2004/05 there were 35,431 written complaints about medical family health services in England. Considering that there were 8,451 practices in England in 2005, this figure equates to roughly 4.2 written complaints per practice annually.
- In 2003/04, of the 34,307 written complaints submitted to medical family health services, 953 (2.8%) were subsequently referred for independent review.
- In 2005 the GMC received approximately 400 new complaints against UK NHS doctors each month, of which nearly half came from patients. Each year, approximately 300 UK doctors appear for the first time before fitness to practise panels operated by the GMC.
- In 2005/06 the Health Service Ombudsman concluded 139 complaints against GPs, upholding 42% of these.
- Doctor referrals to the National Clinical Assessment Service (NCAS) from England are currently around 620 a year - 250 a year from the GP sector and 370 from secondary care.

4.2 TYPE AND NATURE OF COMPLAINTS IN GENERAL PRACTICE

There are two basic types of complaint in general practice. The first concerns essentially private grievances of patients against a doctor or practice involving rudeness, appointments or not receiving a prescription or sick note etc. The second type has wider implications for patient safety, for example a failure to diagnose a serious condition, a prescribing error with potentially serious consequences, or an error in carrying out some form of minor surgery.

Unfortunately there is no subject breakdown available for all the written complaints received in general practice in England. The available sources of information regarding the common causes of complaints/concerns in general practice are the Medical Defence Organisations (MDOs), the Independent Reviewer (Healthcare Commission) and the Health Ombudsman. However, this data tends to be skewed towards the more serious end of the complaints spectrum, either having been referred beyond the local resolution stage, or been deemed serious enough to warrant notification of an MDO by the clinician involved.

In 2003/04 the written complaints concerning family health services, which were subsequently referred for independent review, were analysed by subject of complaint and published by the Department of Health. The results of this analysis are presented in the table below:

Total	1,248	
Communication/Attitude	209	16.8%
Premises	5	0.4%
Practice/Surgery Management	124	9.9%
PCT Administration	20	1.6%
Clinical	802	64.3%
Other	88	7.1%

In 2003 the Medical Defence Union (MDU) analysed a 10% sample of the complaints of which it was notified by GPs in 2001/2002. It found that over a quarter of complaints (28%) followed the death of a patient, while almost a third (32%) followed the patient's hospital admission. The following were found to be leading causes of complaints notified to the MDU:

Reason for Complaint	% of Complaints
Failure or Delayed Referrals	15%
Medication Errors	12%
Failure of Delayed Visit	8%
Inadequate or Failure to Examine Patient	5%
Breach of Confidentiality	3.4%
Inappropriate or Rough Examination	3.2%
Inaccurate/Alteration of Clinical Record	2%

Medication errors account for a quarter of settled claims against GP members of the MDU. A 2004 analysis of 100 patient safety incidents reported to the MDU medico-legal advice line showed that just over a third (35%) of those reported in primary care involved medication errors, and of these 65% were vaccine errors.

Medical Error (NPSA, MDU, MPS):
www.saferhealthcare.org.uk/IHI/Products/Publications/MedicalError.html

4.3 REASONS FOR REFERRAL FOR PERFORMANCE PROBLEMS

The National Clinical Assessment Service (NCAS) becomes involved with doctors when employers, or contractors in the case of GPs, have concerns about performance which they feel require external help to tackle, but where those concerns have generally not led them to refer the doctors in question to the GMC.

In 2006 the NCAS published data⁴ describing referral patterns over a four-year period (2001-2005). The data revealed that doctor referrals from England are currently around 620 a year - 250 a year from the GP sector and 370 from secondary care. The one-year risk of referral to the NCAS is approximately 0.5% for all

doctors, rising to 1% if doctors in training are excluded. The rate of referral to NCAS increases with age and rises steeply after 60 amongst GPs, but not for secondary care practitioners. Referral rates are lower for women than men in both sectors.

In terms of reasons for referral the analysis produced some interesting results, and suggested that concerns about practitioners' behaviour are at least as common as concerns about clinical capability. The main findings are summarised below:

- Behavioural issues alone precipitated referral in 29% of cases, and when concerns were taken collectively, more cases related to behaviour (67%) than clinical capability (61%).
- Concerns about behaviour alone were more likely in men (31%) than women (22%); and more likely among younger practitioners (34% in <35s, 21% in 65+s).
- Concerns about clinical capability increased with age (46% in <35s, 72% in 65+s).
- Health concerns seem to be independent of age, but were more common amongst women (28%) than men (18%)

4.4 SPOTLIGHT ON REMOVING PATIENTS FROM LISTS

Complaints and Removing Patients

The law allows a GP practice to remove a patient from its list under certain circumstances. This usually occurs when the relationship between a practice and a patient suffers an irreconcilable breakdown, and is seen as a last resort when other options have been exhausted. However, there is public concern that patients may be removed from the list simply for making one or more complaints. The fear of unjust removal is not entirely unfounded – although such incidents are rare. The Health Service Ombudsman's 2005-06 Annual Report⁵ identified the removal of patients from GP lists as featuring significantly in the complaints against GPs that the Ombudsman concluded that year (32 complaints, or 23% of the total 139 complaints against GPs). Additionally the MDU has recently identified examples from general practice where "difficult" patients had been removed from the list - for example patients who had made complaints about the practice or failed to attend appointments.

In its guidance on this issue the British Medical Association's General Practitioners Committee (GPC) states that it cannot condone the removal of patients solely because they have made a complaint⁶. Similarly RCGP guidance⁷ advises that neither persistent questioning of clinical techniques, safety measures or other practice matters NOR the making of informal or formal complaints, would normally justify removal from a practice list. However, GPC guidance also states that complaints that take the form of a scurrilous personal attack on members of the practice, or contain allegations which are clearly unfounded, usually indicate a serious breakdown in the patient-doctor relationship. It is a breakdown of the relationship rather than a complaint per se which must form the basis of any decision to remove a patient from the list.

Good Practice in Removing Patients from Lists

GP practice leaflets must outline both the patient removal policy and the circumstances that might lead to its implementation. Removal from a list will follow a transparent process that should include a warning to the patient. The *National Health Service (General Medical Services) Regulations 2004* state that patients must be given a formal warning in the 12 months prior to removal. Practices are required to give specific reasons as to why the removal has occurred, though in certain circumstances a statement to the effect that the relationship between the patient and the practice has irrevocably broken down will suffice (see RCGP guidance below). The General Medical Council (GMC) advises doctors to inform the patient orally or in writing why they have ended a professional relationship and ensure arrangements are made for the continuing care of the patient and the handover of records.

The circumstances leading to the removal of a patient from a GP list are often complex. Guidance has been prepared by the Patient Partnership Group of the RCGP listing the type of circumstances in which a patient removal would be appropriate and those in which this would be an unacceptable action (below).

Removal of Patients from GP Lists (BMA Guidance):

www.bma.org.uk/ap.nsf/Content/removepatients/

Removal of Patients from GPs Lists (RCGP Guidance):

www.rcgp.org.uk/PDF/Corp_removal_of_patients_from_gp_lists1.pdf

4.5 COMMON RISKS IN GENERAL PRACTICE

Health related processes carry inherent risks that can lead to healthcare professionals being involved in patients' complaints and claims. These problems are not always directly related to clinical practice, but could be due to deficiencies in administration systems, communication, staff training and equipment. General practices have a statutory duty to improve the quality of patient care and reduce medical error, by identifying the risks that can compromise safe practice.

A recent report from the Medical Protection Society⁸ outlined the most common risks found in GP practices by analysing the findings of recent practice risk assessments undertaken in the UK. The report identified potential breaches of patient confidentiality as the top risk, with 95% of practices recognising outstanding issues in this area. The next four highest risk areas were: problems with prescribing; health and safety; communication; and record keeping. The list below shows the common issues identified in these areas:

1. **Confidentiality (95%):** Breaches of confidentiality in waiting rooms and reception areas; issues relating to Caldicott Guardians and Caldicott principles; staff contracts not including a clause covering confidentiality post-employment; shredders not always being used or available; patient medical records not securely stored; active computers left unattended.
2. **Prescribing (92%):** No repeat prescribing protocol; reception staff allowed to add acute and repeat medications to the computer; no medication review dates set; no recall systems for patients on long-term medication.
3. **Health and Safety (90%):** No health and safety assessments; no Control of Substances Hazardous to Health assessments; dealing with clinical waste; storage of medication; dealing with sharps; unlocked doors; security at the practice, including safety of staff.
4. **Communication (85%):** No regular meetings; no primary care meetings; using inappropriate communication methods to convey information.
5. **Record Keeping (84%):** Home visit consultations not always recorded on the computer; letters scanned onto computer occasionally saved into wrong record; telephone advice not always recorded; duplicate paper and computer records used creating a risk of not having a complete medical record on either system; illegible writing in the records.

The report also found that the majority of practices were not following advice given in *Guidance on the Role and Effective Use of Chaperones in Primary and Community Care Settings* (2005); and had not developed a formal system for reporting and dealing with patient safety incidents and "near misses".

Common Risks in General Practice (MPS):

www.mps-riskconsulting.com/content/mediaassets/pass/Final%20report.doc

5. PATIENT SAFETY

Although there is always a temptation to view complaints in a negative light, the NHS is working hard to create a more open culture in which they are seen more as a precious source of customer feedback. The current patient safety agenda is being built around encouraging learning from adverse events. Consistent reporting of such events, by both clinicians and patients, is dependent upon a sea-change in attitude, whereby clinicians can communicate honestly and sympathetically with patients when a mistake is made, and patients feel empowered to share their experiences in a non-confrontational situation. It is also dependent on doctors putting the interests of patients ahead of personal and professional loyalties to colleagues whose conduct, performance or health is posing a risk of harm to patients.

5.1 PROFESSIONAL DUTY OF DOCTORS

It is part of a doctor's professional duty to protect patients from risk of harm posed by their own or another colleague's conduct, performance or health, or by inadequate premises, equipment, policies or systems. A doctor must either put these matters right personally or draw the matter to the attention of the employing or contracting body. There may be reluctance on the part of doctors to report concerns because it may cause problems for colleagues, adversely affect working relationships, have a negative career impact, or result in a complaint. However, the General Medical Council (GMC) reminds doctors that:

- A doctor's duty is to put patients' interests first, and actions to protect them must override personal and professional loyalties
- The Public Interest Disclosure Act 1998 provides legal protection against victimisation or dismissal for individuals who disclose information in order to raise genuine concerns and expose malpractice in the workplace.
- Doctors will be able to justify raising a concern – even if it turns out to be groundless – if they have done so honestly, promptly, on the basis of reasonable belief and through appropriate channels.

Raising Concerns about Patient Safety (GMC): www.gmc-uk.org/guidance/current/library/raising_concerns.asp
 Whistleblowing Guidance for GPs (NHS Employers): www.nhsemployers.org/practice/whistleblowing.cfm

5.2 NATIONAL PATIENT SAFETY AGENCY (NPSA)

The National Patient Safety Agency (NPSA) is a Special Health Authority created to co-ordinate the reporting of mistakes and problems effecting patient safety and help the NHS learn from these incidents. A key aim is to encourage staff to report incidents without fear of personal reprimand and know that by sharing their experiences others will be able to learn lessons and improve patient safety. This national drive is embodied within its *Being Open* policy.

The *National Reporting and Learning System* (NRLS) is the primary mechanism for the NPSA to collect information on patient safety incidents from across England and Wales. The NRLS data set is designed to collect a notification report of a single patient safety incident soon after it occurs. Doctors can report mistakes to the NPSA in two ways, online and anonymously through the NPSA's website (www.npsa.nhs.uk/health/reporting/reportanincident), or through their own NHS trust's reporting systems and onward to the NPSA via local risk management systems linked to the NPSA database. The table below maps the reported incident types in general practice up to the end of March 2006⁹.

Incident Type	Number	% of total
Access, admission, transfer, discharge (including missing patient)	278	10.6
Clinical Assessment (including diagnosis, scans, tests, assessments)	250	9.5
Consent, communication, confidentiality	404	15.3
Disruptive, aggressive behaviour	17	0.6
Documentation (including records, identification)	409	15.5
Implementation of care and ongoing monitoring/review	68	2.6
Infection control incident	15	0.6
Infrastructure (including staffing, facilities, environment)	111	4.2
Medical device/equipment	44	1.7
Medication	597	22.7
Patient abuse (by third party)	16	0.6
Patient accident	179	6.8
Self-harming behaviour	35	1.3
Treatment, procedure	135	5.1
Other	77	2.9
Unknown	1	0.0
Total	2,636	100.0

Although the NPSA cannot investigate individual complaints, patients can also report any unexpected suffering or harm they have experienced resulting from contact with NHS services via its **Please Ask** website: (www.npsa.nhs.uk/pleaseask).

Being Open (NPSA): www.npsa.nhs.uk/health/resources/beingopen
Seven Steps to Patient Safety for Primary Care (NPSA): www.npsa.nhs.uk/display?contentId=4370

5.3 MEDICINES AND HEALTHCARE PRODUCTS REGULATORY AGENCY (MHRA)

The Medicines and Healthcare products Regulatory Agency (MHRA) is a government agency responsible for ensuring that medicines (including herbal remedies) and medical devices are effective and acceptably safe. It runs the *Yellow Card Scheme* which acts as an early warning system for the identification of previously unrecognised adverse drug reactions (ADRs). The continued success of the scheme is dependent on the vigilance of UK healthcare professionals and their willingness to report suspect ADRs, even if they are uncertain about cause and effect. Patients can also use the scheme to report unwanted side effects from medicines or herbal remedies.

Health Professional Reporting of Adverse Drug Reactions:
www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=745
Patient Reporting of Adverse Drug Reactions:
www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=755

6. COMMENTING AND GETTING INVOLVED

6.1 PATIENT EXPERIENCE QUESTIONNAIRES

Patient experience questionnaires enable patients to comment on numerous aspects of their care including: physical environment; convenience of services; practice/patient relationship; helpfulness of support staff; and appropriateness and timeliness of the episode of care.

As part of the patient experience domain of the Quality and Outcomes Framework (QOF), the vast majority of GP practices collect the views of patients by asking them to complete annual patient experience questionnaires. This creates an opportunity for practices to assess patients' views, and be alerted to strengths and weaknesses in their set-up. If a practice is to receive all the available points and payments for this component of the QOF it must analyse the results of its survey and use patient views to influence positive changes in procedure. This will include producing a two-year action plan that:

- Describes how the practice will report the findings to patients (for example, posters in the practice or a meeting with a patient practice group or approved patient representative).
- Describes plans for achieving the identified priorities, including indicating the lead person in the practice.
- Considers the case for collecting additional information on patient experience, for example through surveys of patients with specific illnesses, or consultation with a patient group.

Details of the two questionnaires that have been accredited for use in support of the QOF can be found via the links below.

General Practice Assessment Survey (GPAS): www.gpag.info/
Improving Patient Questionnaire (IPQ): www.cfep.net/

A new GP patient survey - *Your Doctor, Your Experience, Your Say* - will be sent to five million patients in January 2007, and will specifically monitor public satisfaction with access to GP services. This survey will be additional to the patient experience questionnaires mentioned above, and will form a component of two single-year directed enhanced services, the Improved Access Scheme and the Choice and Booking Scheme. The Department of Health (DH) has commissioned Ipsos MORI to conduct the survey, which will trigger payments to practices based on patient experiences of access to their GPs.

6.2 PATIENT PARTICIPATION GROUPS

Practices have a duty to involve patients when changes in the practice are made, and Patient Participation Groups (PPGs) are often the means by which patients are engaged. PPGs are also an excellent means by which a practice can identify and anticipate any problems that may lead to complaints. As well as taking part in discussions about practice procedures, PPGs also start patient initiatives independently - such as transport schemes for elderly or disabled patients or self help groups.

The initiative to start a PPG often comes from patients themselves. It may be a permanent group meeting at regular intervals or a focus group brought together to examine a single issue. It generally works in partnership with the practice, but is run by patients with decisions about aims/activities made independently. Most PPGs register as charities. The *National Association for Patient Participation* (www.napp.org.uk/) campaigns to establish PPGs in every practice, and maintains a volunteer network of officers who train practices in setting up Groups in their locality.

Setting Up a Patient Participation Group in a GP Surgery (NAPP):

www.napp.org.uk/publications.htm

Tools and Techniques for Involving Patients, Users and Carers (NHS):

www.cgsupport.nhs.uk/downloads/Patient_Experience/Tools_Techniques_for_Involving.pdf

CONCLUSION

The NHS Complaints System has come under intense scrutiny in recent years, with the Government resolving to introduce a more “user-friendly” and robust approach in the next few years. The drivers for such change have been two-fold: firstly the wider Government agenda to make healthcare more accessible, community-based and patient-orientated; and secondly the wide-ranging review of the regulation and monitoring of doctors, precipitated by the investigation of Dr Harold Shipman.

In January 2006 the Department of Health published its White Paper *Our Health, Our Care, Our Say*¹⁰ which set out the Government’s vision for the integration of health and social care services outside hospitals. It proposed a new comprehensive single complaints system across health and social care by 2009, focused on resolving complaints locally with a more personal and comprehensive approach. To ensure people are supported, it also announced that the Patient Advice and Liaison Service (PALS) will develop further capacity, and that a new Independent Complaints Advocacy Service (ICAS) will be unveiled.

As part of the new system, it is proposed that when a specified number or proportion of users petition a GP practice for improvements, it will have to respond within a specified time explaining how it will improve the service or why it cannot do so. The Government will also specify other “local triggers” relating to public satisfaction and service quality, to which a PCT will be expected to respond if there is evidence that public needs are not being met.

In July 2006 the Chief Medical Officer for England, Sir Liam Donaldson, published his long-awaited review into the quality assurance and safety of doctors’ practice in the UK, including the system for medical regulation. *Good Doctors, Safer Patients*¹¹ was highly critical of the current NHS complaints system, and also of the tendency within the NHS to view complaints in a negative light rather than as a source of customer feedback. Specifically the review identified the following weaknesses within the system:

- Poorly publicised, complex, and confusing with a wide range of bodies to which a complaint might reasonably be addressed.
- Not designed to deal with complaints that fall under the remit of more than one body.
- Inaccessible to some patients from ethnic minority groups and others who are unable to frame their complaint and present it effectively because of language or literacy issues
- Dependent on high-quality investigation, for which some organisations lack capacity.

The review identified complaints relating to the care provided by GPs as a particularly challenging area, because PCTs and the Healthcare Commission have limited powers to investigate them in the absence of cooperation from the individual doctor. It recommended that patients and their representatives be given the ability to lodge complaints relating to primary care with the NHS PCT and not just at the level of the practice. Such arrangements should be publicised widely in surgeries and within patient information resources.

APPENDIX: COMPLAINING IN THE REST OF THE UK

Northern Ireland:	<i>How to Complain about NHS Medical Treatment in Northern Ireland:</i> www.bbc.co.uk/dna/actionnetwork/A2494343
Scotland:	<i>How to Complain about NHS Medical Treatment in Scotland:</i> www.bbc.co.uk/dna/actionnetwork/A2494172 <i>Can I Help You? Learning from Comments, Concerns and Complaints:</i> www.show.scot.nhs.uk/publications/me/complaints/docs/1guidance010405.pdf
Wales:	<i>How to Complain about NHS Medical Treatment in Wales:</i> www.bbc.co.uk/dna/actionnetwork/A2494127

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