



**Collated Responses to Consultation ECR0075
House of Commons Health Committee – Complaints & Raising Concerns**

The following is the collation of responses from Fellows of the Royal College of Pathologists to the request for input to the Consultation ECR0075 House of Commons Health Committee – Complaints & Raising Concerns

1. Fellows have been involved for a number of years in dealing with complaints which come to the organisation regarding various pathology issues including infection control and microbiology. Frequently infection specialists (Infectious Diseases consultants or microbiologists) are not asked about complaints or to mortality & morbidity meetings, even when the problem relates to infection. Therefore specialists in areas other than infection are making judgements and assumptions when they may not be cognisant of all the facts or process involved in the diagnosis and management of infectious disease.
2. The proposed death certification reforms are commended to the Committee by the College Fellows as a mechanism by which the concerns and complaints of the bereaved can be recorded and pursued. This has always been one of the (less well advertised) aims of the reforms that they would help to identify problems in the standard of healthcare, even if those problems did not actually contribute to the cause of death. The Francis report has a chapter commending this and the pilots have demonstrated that it is effective. Indeed, comments from the relatives have been identified as one of the most useful sources of information. And relatives often feel 'abandoned' by the health service after someone dies, as the focus shifts immediately to care for those who are still alive.
3. Fellows raised concerns about resources for handling complaints.
4. Fellows raised issues with regard to whistleblowing and victimisation of these brave individuals. In particular, there is an understanding that victimisation, as far as the PDA is concerned, is only recognised if perpetrated by the 'employer' and that victimisation by colleagues is not covered by the Act. The College held a symposium on laboratory errors, entitled 'A diet of Swiss cheese' during which it was apparent that opposition and hostility to raising concerns (for example relating to quality assurance and laboratory errors), as well as persecution of the person raising those concerns, may emanate from within that person's own department. It was not clear who counts as the 'employer'. Does it, for instance, include the Lead Clinician and Laboratory Manager? Also, if persecution of a colleague for raising concerns is knowingly tolerated by the organisation, does that render the 'employer' culpable? The view held by Fellows was that an NHS Trust should be held liable for acts of employees on the basis of vicarious liability, but it would be helpful if this point could be clarified and enforced.



5. Also it was understood that there is a strict 3 month time limit in which a claim for victimisation of a whistleblower can be lodged with an Employment Tribunal. However it is clear that there are instances where evidence for a causal link between the raising of concerns and persecution of the whistleblower surfaces only after the 3 month period. Fellows of the College feel that the time limit should be relaxed in the interests of deterring victimisation of whistleblowers. I should have thought that any time limit should only start running from the time when the victim becomes aware (or should have become aware) of a causal link. The RCPATH would welcome clarification of this issue.

6. Fellows considered it a sad fact that handling of complaints has many shortcomings. In the process of raising complaint about organisational, management and operational issues, the Trust handles those complaints in a non-transparent and discriminatory way. If a staff member raises a complaint they are likely being victimised, which happens quite openly - presumably to use as a deterrent against anyone, who would raise any complaint. In the worst cases, the complaints raised by the staff are ending up as turned around, and the whistleblower becomes a subject of a quite vigorous witch-hunt. During this process, the Trust's own and other relevant procedures (like MHPS) are not followed - they are only used as a pick-and mix guide to support the intention and agenda of the management. It is also concerning that in this process evidence sometimes disappears and the management bends the rules as they see fit.

7. The professional defence organisations are relatively powerless. They are aware of the problems and despite raising them, these are routinely ignored by the management. In addition, every step of proceeding is covered in secrecy. Gagging orders are commonplace, and threaten staff members with retribution if they disclose the circumstances and flaws of the individual case management.

8. Many times staff are encouraged to raise issues, make complaints and grievances etc. following the Trust policy and then when they do so, the outcome is that either nothing happens – the whistleblower doesn't even get a reply, or the problems are dismissed as irrelevant or they are trivialised, bounced back as late, because they are more than 3 months old.

9. Fellows felt that this was very traumatic for the individuals, but the real price of these flaws and non-regulated complaint handling is that the whole healthcare system suffers as a result, and people feel uncomfortable to raise any issues - as the price often becomes very high.

10. In the opinion of the Royal College of Pathologists it is considered important to emphasise that it is not raising individual cases although many examples exist, but would wish to draw attention to the environment and the general NHS attitude, which I think would benefit from greater independent scrutiny, for the benefit of all staff and patients.