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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

Contents

Report	<i>Page</i>
Summary	3
1 Introduction	5
2 The NHS complaints system	6
Overview of the NHS complaints system	6
Local resolution	8
Reviews of serious untoward incidents	11
Investigation by the Ombudsman	12
3 Advice and advocacy services	16
Patient Advice and Liaison Services	16
Independent Complaints Advocacy	19
4 The role of commissioners	22
A duty of candour	22
Setting standards, monitoring improvement	23
Complaints data	25
Complaints action plans	26
5 The proposed health reforms	28
Complaints advocacy commissioning	28
Primary care complaints	29
Information and data sharing	30
6 Complaints cultures	33
Patient complaints	33
Staff cultures	34
Executive Board cultures	36
7 Litigation	39
“No-fault” compensation schemes	39
Indemnity Schemes	40
Claims Management Companies	41
The proposed civil justice and legal aid reforms	43
Timely resolution of smaller claims	44
Conclusions and recommendations	47
Formal Minutes	54
Witnesses	55
List of printed written evidence	56

List of additional written evidence	56
List of Reports from the Committee during the current Parliament	59

Summary

The existing NHS complaints system aims to resolve complaints at the local level through investigation by and resolution of complaints by the organisation being complained about (the “local resolution” stage). The Committee welcomes the improving level of satisfaction with the local stage of the complaints process, but finds that more can still be done to improve the patient’s experience. The Government is now in possession of sufficient data to enable a full review of the system, and should do so without delay. In this review, it should carefully consider the development of separate systems for investigation and resolution of customer care complaints and more serious complaints about clinical issues.

The second stage of the system entails independent investigation by the Health Service Ombudsman, who investigates complaints both formally and informally if local resolution has not been achieved. Patients and the public perceive the Ombudsman as offering a general appeals process to the local stage of the complaints system, whereas the role is in fact much narrower than that. The Committee considers that the operational and legislative framework within which the Ombudsman operates requires review to make it compatible with this wider purpose.

Within the NHS, patient advice and liaison services (PALS) listen to patient complaints and aim to resolve them speedily. They are a useful first point of contact for complainants, but need to be more capable, more visible, and integrated into other systems for resolving complaints. Independent complaints advocacy services (ICAS) support patients with the practicalities of complaining and provide important support, especially to vulnerable complainants. There are artificial boundaries that get in the way of this work. For example, ICAS cannot currently support patients to make complaints to the General Medical Council or other professional regulators, a situation that should be remedied by the Government. Meanwhile, the NHS needs to do more to promote the awareness of, and access to advocacy.

Commissioning authorities have the potential to be the engines that drive improvement in the complaints system. When things go wrong in their care, patients expect full disclosure of the facts, something that is not always the case. Supported by culture change, a contractual duty of candour between providers and commissioners, and between commissioners and their populations will support openness and honesty in the NHS. Model commissioning contracts must reflect this and must also mandate access to comparable data on complaints to commissioners. Where a complaint is found to be valid, and an organisation puts an action plan in place, these action plans must be implemented by the provider and returned to the commissioner and the Local Healthwatch, who can observe progress.

The Committee has found it difficult to establish which organisation monitors the performance of the NHS against complaints standards and can see potential for failing organisations to be overlooked. Healthwatch England should receive intelligence about NHS providers from Local Healthwatch organisations, and should monitor the performance of all providers of NHS care and treatment against a set of agreed complaints

handling standards.

Although they do support greater information sharing between bodies, the Government's proposed health reforms require further strengthening. The Committee has ongoing concerns about how primary care will be commissioned, and also how complaints about primary care will be handled in future. The forthcoming "Information Revolution" report needs to at least consider how complaints data can be used by the NHS to help it to learn and improve. We welcome the Government's proposals for ending the secrecy of Foundation Trust Board meetings.

A small minority of complainants seek redress for their complaints through the legal system via litigation. The Committee has examined no-fault compensation schemes and finds that the existing, fault-based system offers the best opportunity possible for patients to establish the facts of their case and obtain redress. Within this system, some changes need to take place. The activities of "claims farmers" drive up the costs of pursuing a legal case and these organisations must be subject to tighter regulation. The Government has accepted proposals ending legal aid for clinical negligence cases, and this could erode the settlements for the most seriously injured claimants, and could undermine access to justice for many. The Government should bring forward the details of its plans for speedy resolution of smaller claims.

Change will only happen in the NHS if there is a change in the culture, as well as in the procedures and practices. Staff must feel that there is clear guidance on when they will be held to account for errors, and when these will be seen as systemic failings of an organisation. They should receive regular feedback on the volume and nature of the complaints about them and their teams, and anonymous patient feedback should be used to support improvement.

1 Introduction

1. The NHS in England has embarked on a period of substantial change. The requirement to deliver a 4% efficiency gain, four years running (the “Nicholson Challenge”) is creating unprecedented demands on all staff of the service; at the same time there is considerable uncertainty about the future management structure of the service. Yet despite this uncertainty, the Committee is reminded of the dedication and professionalism of the NHS workforce, even when radical change is underway.

2. Patients have the expectation of, and are frequently given, world class care and treatment by the NHS. Sometimes experience falls well below the high standards expected, and when this happens patients should have access to a responsive and effective complaints system. However, the NHS complaints system sometimes compounds and exacerbates the negative experiences of patients. In such situations, patients have little choice but to give up or turn to the legal system. It is worth noting that the motivation of complainants is often not to seek compensation for failures of care but rather to have their concerns listened to and acted upon in order to reduce the likelihood of similar failings happening again.

3. The Committee has taken evidence from people who have complained about the failures in the care, treatment and professional standards given by Mid Staffordshire NHS Foundation Trust and in other NHS provider organisations in England. However, our report has been prepared before we have learned the outcome of the Mid Staffordshire inquiry and we are not seeking to reach judgements on what happened there. We thank those who gave evidence before the Committee for their bravery, and for the valuable contribution that they have made. We also thank the many other people who have sent us written submissions detailing the failings in care that they have experienced. Other reports into failures in the NHS have also informed our work, including the Shipman, Neale and Ayling inquiries.²

4. There are unwarranted variations in how the complaints system works across England, some elements of the system are ineffective, and the cultures that exist often do not support effective resolution and redress. The Committee’s objective is to look at how the complaints system can be further strengthened to give good and timely outcomes for patients, contain the costs of litigation and ensure that the NHS learns from complaints; it is a key objective that the experience derived from proper consideration of complaints should lead to changes and improvements in the care available to other patients. The Committee recognises that complaints are only one form of patient experience feedback and that many other, less adversarial, means to give feedback about the NHS are available to patients.

2 The independent public inquiry into the issues arising from the case of Harold Fredrick Shipman, the independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling and the investigation into how the NHS handled allegations about the performance and conduct of Richard Neale.

2 The NHS complaints system

Overview of the NHS complaints system

5. It is not the Committee's intention to give a comprehensive history of the NHS complaints system, as this can be found elsewhere.³ The Committee notes however that the first comprehensive complaints system for the NHS was introduced in 1996, replacing a highly fragmented system where NHS organisations had their own approaches to complaints handling. Since then, the complaints system has largely maintained and built upon the core principles that complaints should, where possible, be resolved by the organisation concerned to enable speedy investigation, organisational learning and resolution to the satisfaction of the complainant.⁴

6. Where complaints are not resolved locally, independent review of a complaint has also been available for some time, albeit in a number of different guises. In 2003 the independent review stage was handed to the predecessor body of the Healthcare Commission.⁵ Throughout these changes, the role of the Health Services Commissioner (or the Health Service Ombudsman as it has become known) has continued to provide the final stage of the complaints system. Where complainants failed to achieve resolution either locally or through independent review, the Ombudsman has, within certain parameters, offered another opportunity to investigate and resolve complaints.

7. In addition to the complaints system, further reforms were proposed following a number of inquiries into failings in the NHS. Most notable of these were the Neale Inquiry⁶ (set up following the poor standards of care delivered by former gynaecologist Richard Neale) and the Ayling Inquiry⁷ (following the conviction in 2000 of former GP Clifford Ayling on 12 counts of indecent assault). These inquiries directly led to the establishment by the Department of Health of Patient Advice and Liaison Services (PALS) and Independent Complaints Advocacy Services (ICAS), both of which will be considered in more detail later in this report.

8. The complaints process is underpinned by statutory instruments and by the NHS Constitution. The Constitution guarantees that patients have the right to a proper investigation of their complaint, to know the outcome of this, to take their complaint to the Health Service Ombudsman should they not be satisfied, to make a claim for a judicial review if they have been unlawfully dealt with and to be compensated for any harm done.⁸

9. In her 2005 review of the NHS complaints system, the Ombudsman found that a number of actions were required in order to improve complaints handling in the NHS.

3 The Health Service Ombudsman, *Making Things Better*, (London 2005)

4 *Ibid.*

5 *Ibid.*

6 Department of Health, *Committee of Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale*, Cm 6315, August 2004

7 Department of Health, *Committee of Inquiry into how the NHS handled allegations about the conduct of Clifford Ayling*, Cm 6298, July 2004

8 The Department of Health, *The NHS Constitution*, March 2010

These included the establishment of a clear set of national standards to be adhered to by all providers of NHS care and treatment, the requirement for regulators to ensure that providers are meeting these core standards, the integration of the health and social care complaints systems and the development of alternatives to in-practice resolution of complaints about GPs.⁹

10. The current NHS complaints system was created in 2009 and is, to a degree, based on the Ombudsman's recommendations. Patient Advice and Liaison Services were retained in order to offer immediate advice to complainants and to support early resolution of complaints, and Independent Complaints Advocacy Services were also retained to offer information, advocacy and support. A simplified two-stage process was created, and the intermediate stage of the process (independent review by the Healthcare Commission) was abolished in order to speed up resolution of complaints. Additionally, the NHS and social care complaints systems were integrated for the first time.

11. The Committee has heard evidence that the new approach to complaints in the NHS is an improvement on the previous system, which had been seen as taking too long to achieve resolution for patients. The Ombudsman told the Committee:

I believe very strongly that the new system is well designed and has the potential to produce quicker, simpler, better outcomes and better feedback than anything in place before now.¹⁰

12. In their written evidence to the Committee, the providers of complaints advocacy services have stated that:

Satisfaction with the outcome of local resolution has increased over the last four years, with over 70% of clients happy with the outcome in 2009/2010 compared to 45–56% in 2006/2007.¹¹

13. The Committee welcomes the improving level of satisfaction with the local resolution process for complaints, but finds that the Government can still do more to improve patient experience of the complaints system.

14. Despite improving satisfaction with local resolution, the Committee has heard evidence that full implementation of the new complaints system has not yet been achieved. Mrs. Hazeldine told us:

[...] it is soul-destroying to follow the current complaints system that we have, I feel. It may be a very good system, but it is only as good as the hospital that is implementing it. If they are not following their own systems, it is incredibly difficult for a lay person to then challenge them.¹²

15. Mrs. Hazeldine's experience is unfortunately not unique. Complaints advocacy services are independent of the NHS and support people throughout England who wish to make

9 The Health Service Ombudsman, *Making Things Better*, 2005

10 Q 73

11 Ev 107

12 Q 49

complaints about NHS organisations. Their view of the implementation of the new complaints system is clear:

The experience of our advocates is that early adopter Trusts, all of whom received considerable additional support to introduce the new system, have made significant improvements. Many other Trusts still lag behind and continue to frustrate people who want only to be heard and for Trusts to learn from their experiences. The lesson is that the new system has much to commend it – but too many organisations cannot or will not implement it properly without support and oversight.¹³

16. The Committee is clear that the current two-stage model of the complaints system has the potential to give speedy resolution of, and earlier learning from, complaints. However, there is still a considerable amount of work to do in order to fully implement the system throughout England.

17. The Committee takes the view that the two year period since implementation of the new system should give the Government sufficient data to undertake a review and to make improvements. The Committee endeavours to support this process with this report.

Local resolution

18. The first step in the NHS complaints system is termed the “local resolution” stage. This entails the individual complainant raising their complaint directly with the individual practitioner, with the NHS organisation concerned, the commissioner of the service or with the organisation’s complaints manager. Most complaints in the NHS are resolved in this manner and financial compensation is not ordinarily available in locally-resolved cases. Complaints are normally made in writing, and if made orally, are to be logged in writing by the person taking the complaint.¹⁴ Complainants should expect an efficient and effective investigation and a timely response.¹⁵ Responses usually come in the form of a report which details how the complaint was considered, conclusions and remedial actions (or “action plan”). The complaints regulations were clarified in 2010 to ensure that complaints made orally and not resolved within one working day are logged formally as complaints.¹⁶

19. Those complaints that are not resolved at this stage can be referred by the complainant to the Health Service Ombudsman. The Ombudsman can investigate all aspects of NHS care including failures in service by the NHS or maladministration by or on behalf of an NHS body. Complaints about the performance or fitness to practice of individual practitioners can also be referred to their relevant professional body e.g. the General Medical Council or the Nursing and Midwifery Council.

20. Prior to the introduction of the new complaints system, the number of complaints received about the NHS was growing at a somewhat steady rate of 1.1% per year. The total

13 Ev 107

14 Local Authority Social Services and National Health Service Complaints (England) 2009 (SI 009/302)

15 *Ibid.*

16 The Department of Health, *Clarification of the Complaints Regulations*, January 2010

volume of complaints was standing at 89,139 in 2008–09 and there had been a significant (11%) increase seen in complaints about general practice and dental health services.¹⁷ 2009–10 was the first full year of operation of the new NHS complaints system; in that year complaints rose by 13.4%, to 101,077, the biggest annual rise since 1997–98,¹⁸ with an increase in general practice and dental health services complaints of 4.4%.

21. In written evidence the Ombudsman told the Committee:

The increase in written complaints [...] does not come as a surprise. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which came into effect on 1 April 2009, imposed stricter requirements for recording NHS complaints.¹⁹

22. The Committee is mindful that the rising numbers of complaints is not just an NHS phenomenon. We have heard evidence that complaints to the Financial Ombudsman have risen by 119% in the last year, that the Housing Ombudsman has seen a 43% increase in complaints and that the Press Complaints Commission reported a 7-fold increase in annual complaints.²⁰

23. In written evidence to the Committee, the recent rise in complaints about the NHS has been variously attributed to the 28% rise in demand for healthcare over the last ten years,²¹ greater consumer awareness of the complaints process²² and also a deterioration in the standard of care delivered by the NHS.²³ The Committee has also heard that:

It is difficult to say whether there has been a deterioration in care as a whole.²⁴

24. Additionally, organisations that are proactive on their complaints policy and see complaints as useful intelligence on patient satisfaction will often encourage more complaints and consequently have higher complaints figures. **The NHS complaints statistics show an increase of 13.4% in complaints between 2008–09 and 2009–10. This is comparison of data between two distinct complaints systems is unreliable. Furthermore, the growing number of people treated by the NHS, the stricter reporting arrangements, more information about how to complain and a general improvement in consumer rights awareness may have added to the volume of complaints that the NHS receives.**

25. In the course of this inquiry, the Committee has heard numerous stories in oral and written evidence of significant failures in NHS care and treatment. The Committee does not seek to pass judgement on the standard of care in the NHS in this report. Rather, we are struck by the volume, variety and complexity of complaints that are received in the

¹⁷ The Information Centre for Health and Social Care, *Data on written complaints in the NHS 2008–2009*, November 2009

¹⁸ The Information Centre for Health and Social Care, *Data on written complaints in the NHS 2009–10*, August 2010

¹⁹ Ev 146

²⁰ Ev 142

²¹ *Ibid.*

²² Ev 80

²³ Ev 153

²⁴ Q 5

NHS on a daily basis. **In particular we are concerned about the number of individual cases where complainants did not feel the NHS was sufficiently responsive to their concerns. It is in this variable individual experience, rather than in movements in the headline totals, that the Committee feels that there is a real issue which the NHS needs to address.**

26. Complaints undergo a process of grading, generally though not universally at the beginning of the process. “Traffic-lighting” or grading complaints is used to support the effective assessment of the risks associated with the complaint i.e. the likelihood of it recurring and its consequences for the patient, and the consequences for the organisation such as likelihood of litigation, likely costs incurred and potential for adverse media interest.²⁵ Grading can also support prioritisation of complaints and can indicate the type of investigation that is required in order to resolve it, though the evidence from individual patients to the Committee suggests that this is not always the case.

27. Broadly speaking, complaints fall into two distinct categories; customer service-type complaints, relating to the non-clinical aspects of care including how clinicians interact with patients, and those complaints relating to clinical care which are by nature more serious in terms of their potential outcome for the patient. Clearly, these complaints need to be handled in a very different manner.

28. Customer service complaints often can and should be resolved immediately by the person receiving the complaint apologising and rectifying the issue, be they a clinician, a PALS officer or any other employee of the NHS. Due to the nature of these types of complaints, admitting that there was a problem, dealing with it and apologising will save time and resources that can be diverted to prompt and effective investigation and resolution of more serious and complex cases.

29. The Minister of State for Health, Simon Burns, acknowledged that complaints need to be resolved more quickly:

Also, again from being a constituency MP rather than a Minister, there can sometimes be frustration at the length of time it might take to investigate and come to a conclusion on a complaint that has been made at a local level.²⁶

30. It was suggested to the Committee that in order to resolve complaints more speedily there may well be a case for two separate “channels” within the complaints system. The Minister stated that:

[...] one could say yes, in principle, but I fully take on board the rather practical point you are making: whether it would be more effective, efficient and sensible to have a two-channel system or where serious clinical and medical decision complaints are treated in one tier and the example you give of food and things that are important to people—but, in the run of things, may not be considered as critical as where there

25 For example, NHS Healthcare Workforce website, NHS Bolton and NHS Stockport Complaints Policies

26 Q 361

has been a significant failure in care—in the same tier so that it clogs up the whole system rather than prioritising them in different channels.²⁷

31. It will always be difficult for a single complaints system to manage complaints about the great diversity of issues that occur on a daily basis. In its review of the complaints system in England, the Government should consider carefully the development of separate systems for investigation and resolution of customer care complaints and more serious complaints about clinical issues. A stratified set of standards relating to each part of the system should also be considered.

Reviews of serious untoward incidents

32. Incident reporting is the mechanism through which staff raise issues or concerns with senior managers, and is a routine aspect of all clinical care in the NHS. Staff are required to report any incident across a broad range of categories, from threats of, or actual violence from patients through to unsafe working conditions.²⁸ Staff will generally complete a paper-based form and bring this to the attention of their manager immediately.

33. Organisations use different terminology to describe very serious incidents, such as critical incidents or serious crucial incidents, but the common terminology is serious untoward incidents. A serious untoward incident (SUI) is an unexpected event that has the potential to:

[...]cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service. This may be because it involves a large number of patients, there is a question of poor clinical or management judgement, a service has failed, a patient has died under unusual circumstances, or there is the perception that any of these has occurred. SUIs are not exclusively clinical issues, an electrical failure for example may have consequences that make it an SUI.²⁹

34. Such incidents are reported and investigated, commonly using the Root Cause Analysis framework, so that lessons can be learned and recurrence can be minimised or prevented, and patient complaints can also be registered as an SUI. In written evidence to the Committee, Sands (the stillbirth and neonatal death charity) brought the case of Baby L, who died in 2009, to our attention. Baby L's parents stated that:

We felt that if we went through the complaints procedure we just weren't going to get anywhere. The hospital has been so obstructive and unhelpful. We have no faith in them at all.³⁰

35. Sands went on to state that:

27 Q 391

28 For example, see NHS Surrey, *Incident Reporting Policy*, March 2011

29 For example, see NHS London, *Serious Untoward Incident Reporting Guidance*, October 2007

30 CAL 38

On L's anniversary a year later parents requested a third meeting with the hospital . At this meeting they were informed that a Serious Untoward Incident report had been conducted eight days after L had died which answered some of the questions they had been asking the Trust for months, but also conflicted with their version of events. They were not asked for their input or informed that an SUI was being conducted at the time.³¹

36. The Committee recommends that in all cases where serious untoward incidents are being investigated, whether or not a complaint has been made, those directly affected should always be included as full participants in the process.

Investigation by the Ombudsman

37. The second and final stage of the NHS complaints system (complaining to the Health Service Ombudsman) is normally instigated only when the local resolution stage has been completed. The Ombudsman undertakes independent investigations into complaints about NHS funded care and treatment brought to that office by complainants or their relatives. According to the Health Service Commissioners Act 1993 complaints may be made to the Ombudsman on the grounds of maladministration and/or poor service.³² This being the case, a further two tests are applied before the Ombudsman accepts a complaint for formal investigation or intervention. Firstly, a person must have suffered injustice or hardship as a result of the poor service or maladministration, and secondly there must be the prospect of "a worthwhile outcome".³³

38. The Ombudsman has noted a significant increase in complaints proceeding to stage two of the complaints system. In 2009–10 complaints to the Ombudsman more than doubled on the previous year—a total 15,579 complaints were closed in that particular year.³⁴ Just over a half of these complaints (9,011) were closed as they had not completed the local resolution stage.³⁵ The Ombudsman told us that:

Closing these complaints often involves engaging with the NHS body in question and can result in that body carrying out additional work or simply expediting the complaint.³⁶

39. A further 1,373 complaints were withdrawn by the complainant at this stage. The remaining complaints were looked at in detail in order to decide if a full investigation was warranted. This involved the Ombudsman calling for more information from the body being complained about, reviewing papers or taking professional advice, and some complaints were resolved without the need for formal investigation.³⁷ In 4,210 cases complaints were examined and it was found that there was no evidence of

31 *ibid*

32 Health Service Commissioners Act 1993, Section 3

33 *Ibid.*

34 The Health Service Ombudsman, *Listening and Learning: The Ombudsman's review of complaint handling in the NHS in England 2009–10*, October 2010

35 Ev 161

36 *Ibid.*

37 *Ibid.*

maladministration or unremedied injustice, or that the outcome sought by the complainant e.g. disciplinary action against a clinician, was not achievable.

40. The Ombudsman told the Committee that many people are satisfied with the service provided by that office:

[...] 90% of people whose complaints we investigated were satisfied with our service overall. 70% of people whose complaints we didn't investigate were happy with our service. The figures and the numbers are there for the Committee if you want to look at them.³⁸

41. Despite these positive statistics, the Committee has heard significant concerns from patients and patient representatives about the numbers of cases accepted for investigation:

Our biggest concern about the Ombudsman is that [...] they take very, very small numbers of complainants, either as official investigations or what they describe as intervention where they don't investigate a complaint but they will contact the trust. Combined, it is something like 2% to 3% of those people that take their complaint to the Ombudsman. So we are talking about thousands of people who have, for whatever reason, felt that the response they received locally was not adequate, who do not receive any kind of independent scrutiny of that response.³⁹

In 98% of cases the Ombudsman doesn't investigate—98%. Less than 1.5% are ever investigated and this service costs us £34 million per annum. It's wrong.⁴⁰

Action against Medical Accidents also expressed some concerns about the numbers of complaints being independently investigated:

Bearing in mind that the Healthcare Commission had dealt with 7,827 independent reviews in 2007–2008 these figures would suggest that many people are being 'bounced' back to attempt further local resolution with the NHS body they are complaining about. Whilst we accept that in some circumstances this might be appropriate, we are worried that in others it is not.⁴¹

42. In her evidence the Ombudsman reported that her department does a significant amount of informal work on improving complaints handling in the NHS, including informal measures to support resolution and in supporting people to make their complaints to the right organisation at the right time. Although only 3% of the complaints received by the Ombudsman were accepted for formal investigation or intervention,⁴² the evidence shows that a considerable minority of well-made complaints were unofficially examined by the Ombudsman.

43. A majority of the complaints brought to the Ombudsman each year are incorrectly made or have not been through local resolution. The small number of cases accepted for

38 Q 90

39 Q 8

40 Q 55

41 Ev 16

42 Ev 149

formal investigation and intervention each year disguises the fact that a considerable amount of informal investigation takes place.

44. As previously mentioned, the final test applied to whether a complaint is accepted for investigation by the Ombudsman is that a “worthwhile outcome” could be achieved.

45. The Ombudsman told us that:

[...] the final one [test] is about whether we could get what we would describe as a worthwhile outcome. Hopefully, we would use more sensitive language than that when writing to the complainant.⁴³

46. It is the point about a “worthwhile outcome” that has arisen time and again during the inquiry. Several complainants and organisations have told us that this terminology is often used in letters to them, telling them that their case has been closed by the Ombudsman:

In fact, they tactfully ignored any recommendation that would benefit me, [...] this was reinforced through the ineffective intervention by the Parliamentary, Health Care Ombudsman, wasting years of my time to achieve nothing but a ‘not worthwhile outcome’⁴⁴

In February 2010 the Ombudsman declined to investigate because missing medical records meant the family were unlikely to get a ‘worthwhile’ response.⁴⁵

[...] Case has been refused by PHSO for an investigation as “no Worthwhile Outcome” can be identified....despite ‘6 months reconsideration’⁴⁶

47. Although the Committee has heard that the Ombudsman will generally only accept complaints that have progressed through the “local resolution” stage of the process, some flexibility does exist within this. The Ombudsman told us that:

[...] we have to say, “Unless something extraordinary is going on here, we think the NHS body should have the opportunity to look at this first.”⁴⁷

48. We recommend that the Ombudsman urgently reviews the manner in which data on complaint handling by her office is communicated to the public as she appears to be significantly more actively engaged in reviewing NHS complaints than is obvious from the published data.

49. The terminology “no worthwhile outcome” which arises from the Health Service Commissioners Act is being used in communication with complainants. Several have told us that their complaints were rejected because “no worthwhile outcome” could be achieved. The Committee recommends that the Ombudsman urgently reviews the use

43 Q 96

44 CAL 46

45 CAL 38

46 Ev 87

47 Q 79

of this terminology in correspondence as it appears significantly to undermine public confidence in the complaints handling process.

50. Many people see the role of the Ombudsman as a general appeals process for the complaints system, but the remit under the Health Service Commissioners Act is much narrower than that. The Committee is of the view that a complainant whose complaint is rejected by the service provider should be able to seek independent review. The legal and operational framework of the Ombudsman's office should be reviewed to make it effective for this wider purpose.

3 Advice and advocacy services

Patient Advice and Liaison Services

51. Patient advocacy and advice has been available in the NHS for some time, though this has largely been confined to the fields of mental health and learning disability.⁴⁸ In response to a number of inquiries and increasing numbers of complaints⁴⁹ Patient Advice and Liaison Services (PALS) were established across the NHS between 2000 and 2002 and aim to ensure that the NHS:

[...] listens to patients, their relatives, carers and friends, and answer their questions and resolves their concerns as quickly as possible.⁵⁰

52. PALS staff will routinely:

- provide information about the NHS, the complaints procedures and complaints advocacy,
- help resolve concerns or problems about NHS services, and
- provide information about agencies and support groups outside the NHS.⁵¹

53. Additionally, PALS aims to provide an early warning system for NHS organisations and regulatory bodies by identifying problems or gaps in services and reporting them.⁵² Although PALS are not formally seen as part of the two stage complaints process,⁵³ they do aim to resolve concerns and problems before they become formal complaints. The National PALS Network told us that:

[...] we do not believe that PALS is simply a “gateway to the complaints system” but an integral part of it. If organisations only categorise issues as complaints because a ‘formal’ investigation has been carried out by an investigating officer or complaints manager they are seriously under-counting complaints and undervaluing other means of resolving complaints.⁵⁴

54. Despite this, PALS are not always visible within hospital establishments. Our random and unscientific straw poll of six large Foundation Trust acute hospitals found PALS was not visible in hospital receptions or clearly signposted. **Patient advice and liaison services are crucial, as the first line of contact for many complainants and as teams that can resolve complaints, sometimes on the spot. The Government needs to explore how PALS can have a highly visible presence in hospital receptions and GP surgeries and be well signposted throughout larger NHS buildings.**

48 University of the West of England, *Evaluation of Patient Advice and Liaison Services*, Bristol 2008

49 *Ibid.*

50 “What is PALS”, National PALS Network 24 December 2009, www.pals.nhs.uk

51 *Ibid.*

52 *Ibid.*

53 Ev 80

54 Ev 81

55. As PALS will frequently be a complainant's first point of contact in the complaints system, they are key to the speedy resolution of customer service complaints, as well as signposting complainants to the correct part of the system. During our evidence sessions the Committee has taken a considerable amount of evidence about the role and value of PALS services, some of it suggesting that some change is required. Far from helping to resolve complaints or signpost people, some witnesses have told the Committee that:

We would never suggest it was fobbing off [by PALS], but it does effectively appear to be rather like fobbing off. It does not reach the complaints process. That is our concern.⁵⁵

My sister-in-law did try and go to the PALS office but found them a total waste of time. They would just refer you back to the people that weren't listening to you in the first place. There was no guidance there of what to do really. We had to find our own way.⁵⁶

56. Other witnesses have told us that PALS has a limited role in the eyes of patients because they are not seen as sufficiently independent of the organisation being complained about:

Patients don't see PALS officers as independent because they have an office next to the data protection people who are providing you with your copying, notes or whatever [...] It is very difficult to feel that somebody is dealing with that independently and you are not just being fobbed off by someone.⁵⁷

57. However, in contrast with this Cambridge University Hospitals NHS Foundation Trusts told us that the insider position of PALS can be a strength:

Being on the inside, whilst there is the odd inquirer who will see you are wearing a badge and will not think you are independent, in most places you have the opportunity, through the knowledge you have of the organisation, to win the inquirer over to allow them to give you the chance to work with them.⁵⁸

58. In considering the future of PALS the Committee has had to balance its core role i.e. the speedy resolution of complaints, with the independence that some witnesses have called for. On balance, the Committee finds that PALS should remain a part of the workforce of the organisation being complained about. This "insider" position offers PALS the opportunity to access and influence clinicians and managers that may otherwise be more difficult to achieve.

59. Although they have access to senior staff, the Committee has heard that PALS staff have to be at a sufficiently senior level within the organisation in order to be able to influence clinicians and managers within the NHS.

55 Q 17

56 Q 53

57 Q 18

58 Q 204

[...] in order for PALS to challenge effectively, they have to be senior staff in the organisation so that if they go out to talk to a consultant or a matron they have the credibility and authority to do so.⁵⁹

The Committee sees two key issues within this; the grading of PALS staff and their ability to influence others. The Patients Association told us that:

If we are talking specifically about PALS, they are [...] often of a very junior grade. It absolutely, there, depends on their attitude and how the trust has chosen to place them within, I guess, the power structure of the hospital. But then you can have PALS which just as easily could be one admin officer who works two days a week, who has no ability to influence and who will just be dismissed by the staff.⁶⁰

Reinforcing this point, Cambridge University Hospitals NHS Foundation Trust told us:

From our experience, we see that where PALS staff number literally one man in a broom cupboard, [...] the sheer volume of work that they have to manage is too much to bring about a significant change.⁶¹

60. The Committee does not seek to set a minimum grade for PALS officers in the NHS, but does recommend that the Government commissions a framework that sets out the capabilities required to deliver patient advice and liaison roles. This framework should then be used to support, train and develop PALS officers, as well as to ascertain their current skills and benchmark grades across similar organisations.

61. PALS and complaints management and investigation have been established on a different basis. PALS were established to support and advise complainants and to address complaints as quickly as possible, ideally before they enter the formal system. Complaints management and investigation however have a formal role in administering the complaints system e.g. logging complaints and contacting complainants, as well as in investigating and reporting back to patients and organisations. The Committee took evidence on the integration of PALS and complaints management services. Cambridge University Hospitals NHS Foundation Trust told us:

From our experience, we have had a combined PALS and complaints service since 2001. [...] It has certainly worked as well as it can where the two are brought together.⁶²

62. The National PALS Network (NPN) supports the integration of PALS and complaints management into one complaints pathway with one single point of access:

We also favoured a single local access point for complainants and noted that some trusts had already merged the resources allocated to PALS with what were often known as “formal” complaints departments to form new, integrated teams capable of a person-centred ethos and flexible and proportionate responses to complainants.

59 Q 204

60 *Ibid.*

61 *Ibid.*

62 Q 193

[...] We recommended that the Department worked with NPN and other stakeholders towards the development of a clear pathway and a single, national protocol on complaints handling to provide clear direction to trusts and social care organisations, their staff and the public.⁶³

63. The Committee finds that one single point of access for the entire local resolution of a complaint is valuable and that integration of complaints and advice teams can provide this. The Committee finds that Local Involvement Networks (soon to become Local Healthwatch organisations), as the local voice of patients, should drive forward the improvement of patient advice and complaints services and feed into the commissioning process.

Independent Complaints Advocacy

64. Established in 2003 in response to the Neale and Ayling Inquiries, Independent Complaints Advocacy Services (ICAS) provide:

[...] advocacy support to enable people to use the NHS complaints process. The service helps people know their rights, understand the standards of care, treatment and service they can expect, explore choices and express their views. The service focuses particularly on vulnerable people.⁶⁴

65. ICAS is a statutory service and is available free of charge to anyone who wishes to make a complaint about their NHS funded treatment.⁶⁵ ICAS services are frequently offered remotely, either over the telephone, via self-help materials or through web based-templates for complaints letters, requests for medical records etc. Advocates will sometimes visit complainants in their homes or at another location should this be deemed to be necessary.

66. Although ICAS is available to support complainants at all stages of the NHS complaints process, advocates are unable to offer advocacy where complaints are being pursued with professional regulators such as the General Medical Council. Such complaints are bound to be complex and stressful for complainants. Complainants may find themselves supported by ICAS for one part of a complaint (to the NHS) but not supported to take their claim to the relevant professional regulator. ICAS provider organisations told us:

In our opinion these areas are ones where organizational boundaries and existing processes have been given precedence over patient needs. All could easily be ironed out bringing great benefit to many people whose lives are already complicated.⁶⁶

67. It is a significant anomaly that complaints to a professional regulator cannot be supported by ICAS, even when this forms part of a complaint that is being made to the NHS. The Committee recommends that Government removes this restriction as part of its review of the complaints system.

63 Ev 98

64 Ev 107

65 Health and Social Care Act 2001, Section 12

66 Ev 107

68. The Committee has heard that ICAS provides a very useful service to patients:

ICAS is very valuable for those people that struggle to make complaints in a very real sense, such as writing letters, giving them confidence, going to meetings, all these other things. They do provide a very good service in that regard.⁶⁷

69. However, not all complainants avail themselves of advocacy services. The Department of Health told us in their evidence to the Committee that:

[...] there were about 7,500 cases helped of the 25,600 last year that were referred to independent complaints advocacy.⁶⁸

70. In contrast to this the ICAS provider organisations have told the Committee that for the year 2009–10 they received 12,000 requests for self-help packs and had 14,721 cases that required direct advocacy support.⁶⁹ Whichever statistic is true, the fact remains that a minority of complainants use advocacy services. The Ombudsman has told the Committee that:

Around 10% of the health complaints that I receive have an ICAS or other professional advocate. In my experience complaints that have ICAS involvement are much more likely to be brought to the Ombudsman at the right time and are more likely to be accepted for investigation.⁷⁰

71. Where advocacy is used, advocates play a valuable role at supporting complainants in making effective complaints. The Committee finds that there may well be a business case for further support for ICAS in order to reduce the number of premature complaints received by the Ombudsman. The Committee recommends that Government reviews this proposal as part of its review of the complaints system.

72. The Committee is concerned that some complainants who would benefit from support from ICAS are simply not aware of its existence. Witnesses have told us that some PALS “never mention ICAS or the complaints process”.⁷¹ The organisation Cure the NHS told us:

The problem is that people don’t know that ICAS exist. With regard to the people in Mid Staffordshire, I had not met one person who had contacted ICAS. If they were advertised more, more people would use them and there should be a structure so that we know what their role is.⁷²

The National Audit Office has suggested that awareness of ICAS services is very low. Their report into complaints handling in the NHS states that:

67 Q 19

68 Q 81

69 Ev 111

70 Ev 146

71 Q 19

72 Q 19

[...] 84 per cent of dissatisfied NHS service users who did not complain were unaware of the [ICAS] service.⁷³

73. ICAS services cost the taxpayer over £10m per year⁷⁴ and greater emphasis must be placed of effective marketing and public information strategies. Simple remedies were suggested by some witnesses:

The first thing you need to do is to force the trusts, once again, to put out in their letter when they send out that initial response within the 48 hours that ICAS is available to help support the complainant. Despite all the spotlight being on Stafford, the letters of complaint going out still do not mention ICAS. They mention AvMA but not ICAS. So, even under the spotlight, we still don't have that going out to complainants. They still don't know that body exists.⁷⁵

At the bare minimum, absolutely everybody should be told about it, and not just told about it in a kind of dry paragraph constructed by the trust that is probably not going to be very encouraging, but they need to have the service sold to them, to an extent, to encourage them to use it.⁷⁶

74. The Committee recommends that NHS management is tasked to deliver a significant improvement in patient awareness of and access to the services provided by ICAS. It also recommends that PALS should be expected to refer serious cases to ICAS speedily in order to reduce delays in the process.

75. The Committee will explore further the Government's proposals for ICAS commissioning in the chapter on the proposed health reforms.

73 National Audit Office, *Feeding back? Learning from complaints handling in health and social care*, 2008

74 The Health Service Ombudsman, *Listening and Learning: The Ombudsman's review of complaint handling in the NHS in England 2009–10*, October 2010

75 Q 20

76 Q 22

4 The role of commissioners

76. The Committee notes that the NHS complaints system has only been in place for a little over two years. Whilst we are not proposing a lengthy and disruptive reorganisation at this point, the Committee believes that commissioning authorities (as outlined in our earlier report *Commissioning: further issues*⁷⁷) should be the engines that drive improvement in complaints handling, in the analysis of data and in leading change within the NHS.

A duty of candour

77. The Committee has heard in evidence that the NHS does not always admit when things go wrong, nor does it always offer an explanation. In our first evidence session the Committee heard from three patients. Their stories described how things had clearly gone wrong in their care or that of a relative, but the NHS had not been candid in responding to the concerns they had raised.⁷⁸

78. In his 2003 report, the then Chief Medical Officer called for a formal duty of candour.⁷⁹ This cause has subsequently been taken up by Action against Medical Accidents (AvMA), National Voices and other organisations.⁸⁰ In its White Paper on the NHS, the Government has made a commitment to:

[...] require hospitals to be open about mistakes and always tell patients if something has gone wrong.⁸¹

Further action on this by the Government is pending.

79. The Committee notes that candour is already enshrined in a number of commitments and regulatory frameworks. The NHS Constitution contains a pledge that:

[...] when mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively.⁸²

The Committee has heard in evidence that medical professionals are already subject to a similar duty from their regulator:

They are subject to a duty of candour pursuant to the GMC requirements in any event. I suppose your question is: would a statutory duty of candour make any difference?⁸³

77 Health Committee, Fifth Report of the Session 2010–2012, *Commissioning: further issues*, HC 796-I

78 For example Q 44, 48 and 51

79 The Department of Health, *Making amends. A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS*, July 2003

80 For example see Action against Medical Accidents, "A legal duty of candour", www.avma.org.uk

81 Department of Health, *Equity and Excellence: Liberating the NHS*, Cm 7881, July 2010, p3

82 The Department of Health, *The NHS Constitution*, March 2010

83 Q 350

Others have suggested that what is required is a culture change as opposed to a new statutory framework for candour:

[...] without the culture change, even making it a statutory duty may not make much difference.⁸⁴

In its response to the report of the NHS Future Forum report on the proposed reforms to the NHS the Government has stated that it will introduce a duty of candour: a new contractual requirement on providers to be open and transparent in admitting mistakes.⁸⁵

80. The Committee welcomes the Governments announcement that it will introduce a contractual duty of candour. The Committee does not think that placing further statutory duties on the NHS will produce the shift in culture that is required to ensure that patients get full disclosure of information when things go wrong. The emphasis on the importance of culture change described later in this report may have more impact than further statutory change.

81. However, the Committee believes that service agreements between NHS commissioners and their providers should include a contractual duty of candour to the commissioner. A duty of candour to patients from providers should also be part of the terms of authorisation from Monitor, and of licence by the Care Quality Commission.

82. When commissioning authorities are being authorised by the NHS Commissioning Board they should also be placed under a contractual duty of candour to their populations and to their local Healthwatch organisations.

Setting standards, monitoring improvement

83. How standards for the NHS complaints system are set, measured, monitored and evaluated is a complex matter. In 2009 the Government laid regulations before Parliament that set out in broad terms how the complaints process should work, including the overall framework of what patients should expect e.g. efficient and effective investigation, timely response.⁸⁶ The Regulations also provide that written records be kept of oral complaints, that information on how to make a complaint be publically available and that organisations make their complaints handling reports available on request.⁸⁷

84. Within this framework there is considerable scope for some NHS organisations to develop their own standards for complaints handling. The Committee heard from an ICAS provider organisation that:

All I can say is that every organisation is different. They all have their own variation of standards and reporting. With the best ones, it is reported regularly and to the highest level.⁸⁸

84 Q 357

85 Department of Health, *Government response to the NHS Future Forum report*, Cm 8113, June 2011, p. 39

86 Local Authority Social Services and National Health Service Complaints (England) 2009 (SI 009/302)

87 *Ibid.*

88 Q 202

Echoing this comment, an NHS Foundation Trust told us that:

The Trust board sets the standards in association with the clinical teams as policy and procedure is developed. In our Trust, they are monitored again by the Trust board through the quality assurance board.⁸⁹

85. Arguably this complexity allows NHS organisations to tailor their complaints handling standards to their own local circumstances. However, during the course of this inquiry the Committee tried to establish a view of how different NHS organisations were performing on complaints handling. In order to get a rounded view of this, the Committee had to analyse data from a number of different sources, including the Ombudsman, the Care Quality Commission, Monitor and the NHS Trusts themselves. This complexity was mirrored in evidence to the Committee from the Patients Association:

The barrier to accountability in that respect at the moment is the lack of proper performance measurement of complaints handling. We can't isolate particular Trusts in an effective way and say which ones do their complaints handling well and which ones don't. We have all talked about examples we have seen as good and bad, but we are not able to get any handle on trusts that do well generally and trusts that don't do a good job generally.⁹⁰

86. The Committee finds that in the absence of clear national standards for complaints handling, and with no one organisation taking the lead on assessment of performance, it is extremely difficult to ascertain which organisations are performing well on complaints. There is significant potential for duplication by different regulators and for failing organisations to be overlooked.

87. The Committee strongly advocates that one organisation should be responsible for maintaining an overview of complaints handling in the NHS, setting and monitoring standards, supporting change, and analysis of complaints handling data “in the round” from all sources. The Committee recommends that this responsibility should rest with Healthwatch England in conjunction with local Healthwatch organisations and that it should be resourced at a level which reflects the importance placed in this issue by patients and taxpayers.

88. The Committee has outlined how complaints can be a source of information and intelligence for patients and for healthcare providers – providing them with essential information to address weaknesses in their processes. Complaints are possibly of even greater value and importance to organisations that commission healthcare. However, data quality and the ability of commissioners to obtain the required information are significant issues. The Patients Association told us that:

You can't compare one organisation to another effectively. From a commissioner's point of view, it must be incredibly challenging to know whether you have a real issue with your provider.⁹¹

89 *Ibid.*

90 Q 33

91 Q 15

89. Notwithstanding changes to the Health and Social Care Bill, the NHS Commissioning Board will be mandated to develop model commissioning contracts and can require commissioning authorities to use or have due regard to them.⁹² The Committee concludes that a contractual duty on providers to share complaints data with commissioners would be more effective than further legislation.

90. The Committee thinks that commissioners need to have a much greater focus on complaints handling and on complaints data. We would like to establish the principle that providers must account to their commissioner on complaints handling, and that the commissioner in turn must account to the public and local Healthwatch for the performance of their providers.

91. The Committee recommends that the model commissioning contracts that will be developed by the NHS Commissioning Board must mandate access to comparable complaints data from their provider organisations by commissioners.

Complaints data

92. The commissioning process requires robust and comparable data, sophisticated analysis, and the conversion of these into commissioning plans. Action against Medical Accidents suggested to the Committee that commissioners could and should play a greater role in oversight of complaints from their providers:

why aren't the commissioning organisations being more vigilant about trends in the hospitals or the trusts where they are commissioning their treatment? They should be, I am sure, and that is definitely our view. If there is the idea that HealthWatch will continue to have this advisory role to consortia, then they should be able to say, "The trends here are such and such and therefore what are you going to do about that when you are commissioning that treatment?"⁹³

93. In a later evidence session a Foundation Trust Director of Nursing seemed to echo this point when she told the Committee that complaints data could help to support effective commissioning and to drive up service quality.

[...] but if the information published to commissioners also says, "The services you are commissioning from this organisation are not as good and the complaints response is not as good as that over there, so what is happening about that?", that would be quite an incentive to most providers.⁹⁴

94. The view that commissioners have a role to play and that information needs to be shared more widely has been endorsed by the Department of Health in their evidence to the Committee:

One of the things we will be considering is the role of commissioners potentially in commissioning for information. You are absolutely right that, in terms of trusts

92 Health and Social Care Bill, Clause 16 [Bill 132 (2010–12)]

93 Q 26

94 Q 285

being accountable, it is important that information is available and in the public domain and that there is a commitment to transparency. We need to work through how that will play into the commissioning system with the Commissioning Board and GP consortia.⁹⁵

95. The Committee asked Executive Board members from two Foundation Trusts whether commissioners ever ask about the complaints process as opposed to individual cases. The responses were illuminating:

Helen Thomson: No.

Dr Newbold: No. They would want to know we had a process and policies in place.⁹⁶

Dr Newbold agreed that it was a box-ticking exercise.⁹⁷ Although NHS provider organisations compile complaints data and complete complaints reports, the Committee heard that these data are not always comparable and there is currently no duty on these providers to automatically publish their complaints reports. Rather, these are provided on request.⁹⁸

96. The Committee recommends that providers of NHS care and treatment should be under a contractual duty to report comparable complaints data to their commissioners at a frequency specified by them. Commissioners should in turn share this data with other commissioners, the relevant Healthwatches, and the NHS Information Centre who can in turn share their concerns with Healthwatch England.

Complaints action plans

97. Once a complaint has been investigated and found to be well made and with cause, NHS organisations will frequently develop an action plan. Action plans aim to prevent the original incident from recurring by making some change to the systems and procedures either within the clinical area or throughout the organisation concerned. Some witnesses to our inquiry have questioned the usefulness of action plans. Some have told us that they were told an action plan was in place, only to be copied into a blank form.⁹⁹ Julie Bailey from Cure the NHS told the Committee that:

What we have found with the public inquiry at Mid Staffordshire is that we have a sack full of action plans, several that have been sent to the Ombudsman, but they were never put into practice. Nobody was there to check on them. We have got action plan after action plan going back 10 years, but they were never implemented. I am sure that is the same throughout the country.¹⁰⁰

95 Q 107

96 Ev 55

97 *Ibid.*

98 For example Q 112 to 114

99 Q 48

100 Q 11

98. The Ombudsman will routinely ask to see action plans and for updates on progress that has been made against them. However, action plans have no statutory force or footing. In oral evidence to the Committee the Department of Health seemed to agree with the need to look again at action plans:

[...] that does leave a gap in the sense that it is easy to write a letter which is then subsequently forgotten. Subject to further consideration, we need to look at whether or not this aspect of the regulations might be strengthened so that if a promise has been given to undertake a certain action then a follow-up letter goes out or, at minimum, it is accepted that the complainant may subsequently write, three to six months later, and say, "I am just checking on how you followed up from this," and expect a reply. It is a fair question.¹⁰¹

99. Following on from this we asked the Minister of State for Health whether following up on implementation of complaints action plans should be the role of the commissioner.

Absolutely. That is a very valid point and we will await your report.¹⁰²

100. Action plans that arise from complaints are a vital part of organisational learning, but they are only of value if they are followed through to implementation.

101. The Committee recommends that providers of NHS care and treatment be put under a contractual duty to report their complaints action plans, and progress against implementing them to their commissioners, and to the complainant. Commissioners, as the focal point for local analysis of complaints, should then share action plans and progress updates with their local Healthwatch.

102. Local Healthwatch should also share complaints action plans and any concerns they have about implementation with Healthwatch England.

101 Q 388

102 Q 389

5 The proposed health reforms

103. A number of the Government's proposed reforms will or could have a significant impact on the health and social care complaints system. These include, among others, proposals for the commissioning of complaints advocacy services by Local Authorities, proposals for the handling of primary care by the successor organisations of PCTs, and proposals for progressing the Information Revolution consultation.

104. The only specific provisions relating to the complaints system within the Health and Social Care Bill relate to information-sharing. It is intended that the Ombudsman will be able to share complaints reports with those she thinks appropriate, such as professional regulators.¹⁰³ **The Committee welcomes the provisions in the Health and Social Care Bill that support information sharing between organisations but would like to see the proposals strengthened in a number of areas relating to the complaints system.**

Complaints advocacy commissioning

105. Independent Complaints Advocacy Services or ICAS are currently commissioned nationally by the Department of Health in three block contracts. Each contract is provided by a separate provider—POhWER (London, West Midlands and East of England), The Carers Federation (North East, North West, Yorkshire and Humberside and East Midlands) and SEAP (South East and South West England).¹⁰⁴

106. The Committee notes that other statutory advocacy services are also in existence. Independent Mental Health Advocates (IMHAs) support people who are detained under the Mental Health Act to understand and exercise their rights. Under Clause 35 of the Health and Social Care Bill IMHA commissioning will pass from PCTs to Local Authorities in 2013.¹⁰⁵ Independent Mental Capacity Advocates (IMCAs) support people who lack capacity and are facing significant decisions. IMCA services have been commissioned by Local Authorities since their inception.

107. The Government is proposing that local Healthwatch organisations will evolve from the current Local Involvement Networks (LINKs) to represent the voice of patients to providers, regulators and commissioners. Healthwatch will retain the powers that LINKs had to comment on service changes, to enter and view services provided by or on behalf of the NHS and input people's views into commissioning.

108. In the White Paper, the Government proposed that local Healthwatch would be funded to provide complaints advocacy services and would be able to refer concerns about services to Healthwatch England which could in turn ask the Care Quality Commission to investigate.¹⁰⁶

103 Health and Social Care Bill Cl. 185

104 "New ICAS contracts awarded to POhWER, Carers Federation and SEAP", National PALS Network, February 2006, www.pals.nhs.uk

105 Health and Social Care Bill, Cl. 35

106 Department of Health, *Equity and Excellence: Liberating the NHS*, Cm 7881, July 2010, para. 2.26

109. Following consultation on this, the Government decided that Local Authorities should decide whether local Healthwatch would provide complaints advocacy, or to commission this from another body. In evidence to the Committee the Department of Health told us that it will double the funding going to Healthwatch specifically to enable it to support advocacy for complainants.¹⁰⁷

110. The Committee has heard evidence that the provision of ICAS across England is inconsistent. Witnesses have told the Committee that ICAS works in different ways in different parts of the country¹⁰⁸ and others have told us that:

The recurring theme here is that the provision over the whole of the country is inconsistent.¹⁰⁹

111. The Department of Health told the Committee that where problems arise “we would expect Healthwatch England perhaps to notify an individual local authority of those problems”.¹¹⁰ The Department went on to remind the Committee that Local Authorities “[...] are not subject to direction from the centre, either within the Department of Health or, indeed, from HealthWatch England within CQC”.¹¹¹

112. From the evidence presented to it the Committee finds that people who use complaints advocacy services see a demonstrable benefit from it. However, existing commissioning arrangements have led to coverage that is neither complete nor consistent.

113. The Committee supports the Government’s proposal for Local Authority commissioning of complaints advocacy. Local Authorities should use their considerable experience in this area to improve consistency of advocacy services across England. Commissioning statutory advocacy services for complaints, mental health and mental capacity could create opportunities to make service improvements and to reduce costs that should be explored by Local Authorities and the Department of Health against the background of a shared commitment to provide an effective advocacy service.

Primary care complaints

114. GPs and other primary care practitioners provide a significant proportion of the daily contacts that the NHS has with the public. As such it is no surprise that complaints about general practice comprised nearly 50% of all complaints about the NHS in England in 2009–10.¹¹² Members of the public may have specific issues about complaining about their GP, and the Committee heard evidence that this is the case:

107 Q 82

108 Q 19

109 *Ibid.*

110 Q 386

111 *Ibid.*

112 The Information Centre for Health and Social Care, *Data on written complaints in the NHS 2009–10, August 2010*

[...] there is a particular bond that you have with your GP. He or she is your first point of call when you are not well. The worry is that if you make a complaint you will be treated differently. Anecdotally maybe, it has happened to a lot of people where they are struck off after making a complaint and people are worried that that is going to happen, especially if it is a rural practice and they have nowhere else to go. Having said that, there are other reasons why people do not complain.¹¹³

115. The final report in the Shipman Inquiry supported the then draft regulations that would allow patients to complain either directly to their GP practice or to the relevant Primary Care Trust (PCT).¹¹⁴ The Department acknowledges that it may be difficult for people to complain directly to their surgery about their GP and such complaints about general practice may now also be made to the PCT that commissions their practice.¹¹⁵

116. As the Health and Social Care Bill stands at the moment, including announcements made after the Governments “pause” and “listening exercise”, PCTs are still due to be abolished in 2013. The Government has not made a formal statement on which organisation will offer an alternative to complaints directly to the GP practice once PCTs are abolished. The Department of Health told the Committee that:

[...] there are occasions, particularly with complex or sensitive cases, where someone wishing to make a complaint may feel that it is appropriate to go to an organisation slightly more distant than the organisation that provided the service. That, therefore, means that, at the moment, the choice is to go to the GP practice, the NHS trust, or, alternatively, to the commissioner of that service. As the Minister has described, in the new framework, if that principle holds, some complaints will go to the GP consortium commissioning the care, if it is in the secondary sector, or, if it is in the primary sector, the complaint will go to the NHS Commissioning Board.¹¹⁶

117. In the Committee’s second report on commissioning, it expressed concern that the Governments proposals for commissioning primary care through the NHS Commissioning Board needed to be reconsidered.¹¹⁷ Commissioning complaints systems through the Board nationally presents similar difficulties. The Government needs to bring forward effective proposals for local commissioning of primary care, of which complaints form a key part.

Information and data sharing

118. The Government’s White Paper on the NHS stated that better information for patients can help to promote better and safer care, improve outcomes and support people

113 Q 206

114 The Shipman Inquiry, *Fifth Report - Safeguarding Patients: Lessons from the Past, Proposals for the Future*, December 2004

115 “GP Complaints”, NHS Choices website, July 2009, www.nhs.uk

116 Q 379

117 Health Committee, Fifth Report of Session 2010–2012, *Commissioning: further issues*, HC 796-I, para. 79

to be more involved in decisions about their treatment and care.¹¹⁸ The Government opened a formal consultation on the “Information Revolution” in 2010, stating that:

Health and adult social care information will be liberated from a closed, bureaucratic system in order to serve patients and the public, and to help drive better care, improving outcomes, innovation and the better use of resources.¹¹⁹

119. It is notable that complaints are only mentioned in the footnotes of the Information Revolution consultation. The consultation closed on 14 January 2011 and the Government’s response is pending. When questioned about this, the Minister of State for Health told the Committee that the Information Revolution consultation was “fairly comprehensive” but did acknowledge that complaints had not been mentioned.¹²⁰ When asked whether it should have, the Minister replied:

No, I don’t. The complaints procedures are dealt with through the measures introduced in April 2009 and if one feels that there are failings or there are improvements that can be made to the way in which complaints operate at present, then that is the right area in which to look to seek to improve and amend, if necessary, not through this. The focus of the Information Revolution is to provide more information across the board so that people can see what is going on within the NHS and within health care in England.¹²¹

120. The Committee finds it striking that the Government did not mention complaints in the Information Revolution consultation and is surprised it does not see how complaints information can help people to “see what is going on within the NHS”.

121. Complaints data can and should be used to support informed decision-making by patients and commissioners, and to drive up the quality of care in the NHS. In its forthcoming report on the Information Revolution the Government should consider how complaints data can help patients to make informed choices about their care.

122. The Committee notes that there is also an issue with how complaints data is collected nationally. All NHS Trusts must return their complaints data to the NHS Information Centre for inclusion in the annual report on NHS complaints, the so-called KO41 central return. However Foundation Trusts do not have to return this information and one in seven declined to supply this information to the Information Centre in 2009–10.¹²²

123. The Department of Health and others query the usefulness of the KO41 data return:

There is a true disagreement as to how effective that information is. What I am arguing is that we need to look to the future. We need to shift the situation with more meaningful data.¹²³

118 Department of Health, *Equity and Excellence: Liberating the NHS*, Cm 7881, July 2010

119 Department of Health, *Liberating the NHS: An information revolution*, October 2010

120 Q 381 to 382

121 Q 383

122 The Information Centre for Health and Social Care, *Data on written complaints in the NHS 2009–10, August 2010*

123 Q 373

In response to this perceived lack of usefulness, the Department of Health, the Ombudsman, the CQC, and Monitor signed a joint statement on how to achieve meaningful, comparable complaints information.¹²⁴

124. The Committee welcomes the joint agreement on complaints information between the Department of Health, the Ombudsman and others, and would like to see clear plans in place for its implementation.

125. However, the Committee remains very concerned that participation in the agreed protocol by Foundation Trusts remains voluntary. The Committee believes this communicates an unacceptable message about the prevailing culture towards complaints, and in particular towards the duty of candour which we believe that all providers of NHS care should respect towards their commissioners and the wider public. We propose that participation in the agreed reporting protocol for complaints should be a condition of the award of any NHS service contract to either public or private sector provider.

126. Although Foundation Trusts are excluded from mandatory returns of complaints data, all NHS providers are required to produce an annual report on their complaint handling performance and to make this available on request.¹²⁵ These reports must include numerical and subject data, the numbers of complaints referred to the Ombudsman and actions taken to remedy complaints.¹²⁶ At present there is no guidance on how organisations must present their complaints reports, nor is it required that these reports be published in print or online¹²⁷ making accessibility by the public difficult to achieve. In evidence to the Committee, Cure the NHS told us:

But we have an ideal opportunity at the moment to force foundation trusts to publish all their data. Now is the time. Instead of allowing them to have closed board meetings, we should force them to have all their evidence in public so that they issue all the complaints, all the serious untoward incidents, their infection rates, and their staffing levels. This is what we should be doing. If all of that information was out in the public arena, then the public would have a choice. They will know if that hospital is safe.¹²⁸

127. The withholding of NHS complaints reports from the public until they are specifically requested runs counter to the principles of the Information Revolution. The Government must take action on this and ensure that complaints reports and serious untoward incident reports are automatically returned to commissioners who can then publish a rounded view on NHS-funded providers. These reports must also be automatically published by local Healthwatch organisations.

124 The Health Service Ombudsman, *Driving improvement and learning from NHS complaints information*, March 2011

125 Local Authority Social Services and National Health Service Complaints (England) 2009 (SI 009/302)

126 *Ibid.*

127 *Ibid.*

128 Q 13

6 Complaints cultures

128. The Committee has investigated the structures and processes that support complaints and complainants in the NHS. We have been reminded throughout this process that having the right complaints handling systems, processes and structures is only part of the story. The cultures surrounding complaints within organisations and the broader public cultures are also key to understanding the response to complaints from the NHS and why so few people actually complain.

Patient complaints

129. In the broader context, it appears that UK residents are finding it easier to make complaints about poor service. The National Complaints Culture Survey has shown an increase in the numbers of people willing to make a complaint, from 50% in 2001 to 75% in 2010.¹²⁹ Despite this rise in the willingness to complain about service, complaining about healthcare is an entirely different matter. The National Audit Office report into complaints in the NHS and Social Care states that:

Only five per cent of people who had been dissatisfied with NHS services made a formal complaint. Sixteen per cent made an informal complaint to which they did not expect a written response, but 79 per cent did not complain at all. Most commonly, people did not complain because they lacked confidence in the system: 32 per cent who did not complain formally stated that they thought nothing would be done as a result of their complaint, whilst six per cent did not feel their complaint would be looked at with sufficient independence or fairness.¹³⁰

130. The Committee heard evidence that people do not wish to:

[...] “make a fuss about that because they have been really nice to me.” This is the sort of barrier to making a complaint that we get.¹³¹

We have also heard from a complaints manager that people have low confidence in the system:

They think it will be a waste of time if they complain. We have had people say, “I am really shocked that you phoned me,” or, “Gosh, you wrote to me straight away to acknowledge it.” People have such low expectations of the process that they are surprised with anything quite positive that you do for them.¹³²

131. The Committee agrees with the findings of this report and would add that fear of reprisal from the healthcare professional or organisation concerned will also be a significant factor in patients not complaining about the NHS. An NHS complaints manager told us:

129 Institute of Customer Service, National Complaints Culture Survey, 2010

130 National Audit Office, *Feeding back? Learning from complaints handling in health and social care*, 2008

131 Q 206

132 Q 206

One of the reasons has to be that people feel afraid of what will happen next time they come into hospital. That is something we need to recognise. Sometimes, if something has gone wrong in healthcare, it is a very distressing experience and people do not always want to face that again through the process.¹³³

132. This is perhaps most pronounced in primary care where there are often longstanding relationships between clinicians and patients that could be disrupted by complaints. Patients in rural areas may well be concerned that they could be removed from a practice register for making a complaint.

133. There are significant cultural barriers to complaining about healthcare in England, not least because of the position that the NHS has within the national psyche. Added to this are fears that complaints will prejudice future care and that the complaints system will prove to be ineffective at resolving complaints to their satisfaction.

134. Although the majority of written complaints recorded in the NHS in 2009–10 related to “all aspects of clinical care”,¹³⁴ the Committee thinks that it is reasonable to assume that a great number of complaints that are not written down or reported are related to customer care issues e.g. cold food, staff attitude etc. Effective processes could and should detect and deal with such complaints whilst the person is still using the service.

135. The Committee sees great value in providers constantly viewing the comments left about them on websites such as Patient Opinion and NHS Choices. The NHS can also do more to enable patients to make a complaint in an anonymous manner that can lead directly to service changes. **The Committee strongly supports the use of tools that allow patients to give feedback anonymously and that can demonstrate that changes have been made to service provision based on feedback received.**

136. The Committee urges the Government to pilot how “real-time” feedback can be captured by using existing technology, for example patient bedside technology, that can capture immediate customer care issues, lead to an immediate response and be fed into analyses of broader complaints trends.

Staff cultures

137. The Committee endorses the view that the NHS workforce is skilled and capable of delivering world-class healthcare. As with any workforce, however, performance issues will from time to time arise and must be dealt with.

138. An open culture around complaints amongst staff is essential. Patients must feel that their complaints are heard, staff must feel supported to report errors and problems, and organisations must be able to use feedback to learn, with the principal aim of creating a safe patient environment. In its report into Patient Safety, the previous Health Committee noted:

¹³³ *Ibid.*

¹³⁴ The Information Centre for Health and Social Care, *Data on written complaints in the NHS 2009–10, August 2010*

Attempts to improve patient safety should not focus on punishing individuals for errors, but on removing "error-provoking" aspects of care-delivery systems. This entails moving away from a "blame culture", in which incidents are analysed to attribute blame to individuals. Such a culture encourages covering up incidents and fails to identify underlying causes and learn lessons that could prevent repetition of incidents. Instead, individuals should not fear being unfairly made to shoulder the blame for incidents (this has been termed a "fair blame culture"). Greater openness about, and reporting of, incidents, combined with determined searching for systemic faults, enables lessons to be learned and implemented with tangible improvements in safety. In this respect, healthcare needed to catch up with other safety-critical industries, such as civil aviation, where this approach has become well established.¹³⁵

139. Several witnesses have recounted their experiences in the NHS, some of which are wholly unacceptable. Mrs. Nicola Monte told us about an experience she had whilst being barrier-nursed in Stafford Hospital:

[...] on a later admission that nurse came back into my room—I was in an isolation room again—and she sort of said to me, “I have been off sick because of you complaining about me. Do you realise the suffering you have caused me?”¹³⁶

Whilst this “victim culture” amongst some members of NHS staff who are being complained about is wholly unacceptable, it is not entirely without a basis. As the Action against Medical Accidents told us, staff are occasionally scapegoated for system failures, sometimes leading to disciplinary action:

People who complain, by and large, want something to stop and someone else not to suffer. Instead, however, the sort might be, “Nurse so and so did it. We have disciplined her.” The complainant might reasonably respond, “That is not what we wanted when we complained. We didn’t want you to say that somebody has been victimised.”¹³⁷

140. The Nursing and Midwifery Council told us that 40% of complaints about nurses and midwives come directly from employers, yet the majority of these could and should have been resolved locally by employers.¹³⁸ This suggests that some NHS employers may not be looking at complaints as failures in systems, and may be too quick to pass on complaints about their employees to professional regulators without using their own performance management systems first.

141. The Committee is reminded that the Chief Medical Officers report in 2000 suggested that the NHS move towards a culture based on “fair blame”,¹³⁹ yet some of what we have heard suggests that this may still be some way from being the dominant culture within the

135 Health Committee, *Patient Safety*, Sixth Report of Session 2008-09,, HC 151

136 Q 63

137 Q 3

138 CAL 63

139 Department of Health, *An organisation with a memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer*, June 2000

NHS. In the context of complaints blame is significant as it can lead staff to cover up incidents that could have patient safety implications.¹⁴⁰

142. There remains some way to go before a culture is created throughout the NHS that is open to complaints, sees these in the light of systemic weaknesses and supports staff. Providers of NHS care and treatment must have clear policies for how they draw the line between system faults, practitioner faults and issues that will be referred to professional regulators.

143. Staff training in complaints is a relatively straightforward intervention that could have a significant impact on the systems, processes and cultures within the NHS. However, the National Audit Office has reported that only one quarter of NHS organisations and Local Authorities make training in complaints handling mandatory for front line staff.¹⁴¹ The Committee has heard evidence of complaints data being used in the appraisal and revalidation processes for Consultants and GPs.¹⁴² **The Committee recommends that NHS organisations offer patient or user satisfaction training that includes basic “customer care”, patient safety and how complaints should be responded to when received by front line staff. Complaints data should be fed back to teams and individual practitioners to support learning, appraisal and changes in practice.**

144. The Committee has also heard from witnesses who have sought resolution of their complaints at a local level, only to be frustrated by the lack of engagement by staff in the investigation or resolution process. In her memorandum of evidence, Mrs. Dee Speers told us that in some cases managers had left the organisation concerned at a crucial point in the investigation into her complaint, making full investigation and local resolution difficult to achieve. **The Committee takes the view that NHS staff should fully support complaints investigations and local resolution, even when they have left the organisation concerned. The Committee recommends that the Government explore the potential for placing staff under a duty to supply information and attend local resolution meetings, even if they have left the organisation concerned.**

Executive Board cultures

145. The National Director of Patient and Public Experience at the Department of Health told the Committee that there is a correlation between handling complaints effectively and the quality of care provided by an organisation.

The evidence suggests that trusts that are good at dealing with complaints also are very good at providing decent quality outcomes for patients. So there is a link between quality and complaints handling and their ability to address things properly.¹⁴³

140 Health Committee, Sixth Report of the Session 2008-09, Patient Safety report, HC 151

141 National Audit Office, *Feeding back? Learning from complaints handling in health and social care*, 2008

142 Q 213–214

143 Q 117

As the Executive Boards of NHS organisation set the tone for their workforce, they are key to the creation of an open complaints culture within the NHS, and to the provision of high quality care and treatment.

146. The National Audit Office has recommended that complaints be seen by the Boards of NHS organisations as a key indicator of service user experience.¹⁴⁴ However, the NAO also found that under half of the NHS organisations they interviewed analysed trends in complaints in a systematic manner, and that the Boards of NHS organisations were not universally focused on achieving good outcomes from complaints.¹⁴⁵ Through the use of narrative data, patient presentations and hard statistics at their Board meetings, some NHS organisations are being sophisticated at learning from complaints and making systemic changes, and this approach was endorsed by the Department of Health and others:

The best boards will often use patients' stories of things that have gone wrong, literally stories or videos at board meetings that convey a sense of the richness.¹⁴⁶

One of the techniques that I have come across that seems to be very effective is that some trusts will bring, when the patient or the complainant wants to, patients to the board to talk to them firsthand about the impact the poor care had on them or their family, and that seemed to be very effective at engaging the board.¹⁴⁷

147. However, it is difficult to ascertain whether or not this is a routine approach in Foundation Trusts as it is estimated that only a quarter of FT Boards meet in public¹⁴⁸ and there is a high degree of variability in how NHS organisations respond to complaints.¹⁴⁹ On 14 June, in its response to the NHS Future Forum report, the Government announced that “we will therefore amend the Bill to require all foundation trusts to hold their board meetings in public”.¹⁵⁰

148. The Committee finds that Foundation Trust Boards meeting in private runs counter to the creation of an open culture within the NHS. We very much welcome the Governments announcement that it will end Foundation Trust secrecy by ensuring that the Boards of these organisations will meet in public. The Committee urges the Government to work with the Foundation Trust regulator Monitor to ensure that open meetings are the default position for all matters where confidentiality or commercial sensitivity are not at stake, and that resolutions to meet in private are used judiciously and sparingly.

149. Two Foundation Trusts described to us their processes for assessment of the openness of their organisational cultures. Calderdale and Huddersfield NHS Foundation Trust described to us a process of “taking the temperature” of their culture:

144 National Audit Office, *Feeding back? Learning from complaints handling in health and social care*, 2008

145 *Ibid.*

146 Q 106

147 Q 35

148 “Private Board meeting risks spelled out”, *Health Service Journal*, 2 April 2009

149 Q 49

150 Department of Health, *Government response to the NHS Future Forum report*, Cm 8113, June 2011, p. 36

Yes, we have done that [undertaken an independent assessment of organisational culture]. You can do a cultural survey and get information back that says you have a nice open culture, but what you can find is that you have wards and departments, for example, that might have their own culture. It is really important that you get underneath the skin of the organisation and that boards do that.¹⁵¹

Heart of England NHS Foundation Trust highlighted their approach to receiving feedback on the culture of the organisation:

Boards need to take soundings, so within an organisation one recognises where complaints are managed well and where they are managed less well. We survey all wards and clinical areas every month. Every month, 15 patients answer a dozen questions about their care. That comes to the board on a monthly basis so that we can chart every single clinical error across all three hospitals and we can see who is improving and who is not.¹⁵²

150. The Committee supports an annual “open culture-check” by NHS organisations. This could utilise existing data from staff surveys, patient feedback and complaints data and cross-references these data with an external peer review by a similar but independent organisation.

151 Q 255

152 *Ibid.*

7 Litigation

151. All healthcare interventions carry some form of risk. In many cases the risks are negligible and outcomes are as expected. In its patient safety inquiry, the previous Health Committee heard evidence from international studies that suggest that about 10% of all patients who are admitted to hospital suffer some form of harm.¹⁵³

152. The existing clinical negligence framework in England is based on tort i.e. a breach of a civil duty to a person or persons must be established. In order to successfully bring a case against the NHS, a claimant must prove that the practitioner or organisation failed to adhere to accepted standards of care and treatment, cannot justify the logic of their approach and that the mode of treatment would not be endorsed by similarly competent practitioners.¹⁵⁴

“No-fault” compensation schemes

153. The costs of litigation against the NHS are increasing year on year. The NHSLA has told the Committee that between 2007–08 and 2009–10 their total payments have risen by nearly 25%, from £633m to £787m.¹⁵⁵ Claimant and NHSLA legal costs are both growing, though claimants legal costs are growing at a much faster rate than those of the NHSLA.¹⁵⁶ The Committee has heard in evidence that because of its contracting arrangements the NHSLA is able to negotiate significantly lower rates from its legal representatives than claimants can achieve.

154. The Committee has taken evidence on compensation systems that are not based on qualifying liability in tort, also known as “no-fault” compensation schemes, and the Committee has reviewed the proposals being considered by the Scottish Government for the introduction of such a system.

155. Patients who are undergoing treatment must first consent to it, having been fully informed of the risks involved.¹⁵⁷ When things do go wrong, patients can and do resort to litigation in order to establish full disclosure of the facts and to seek apology and redress.

156. The Committee has heard in evidence that “no-fault” compensation schemes could increase the costs of settling claims against the NHS by between 20%¹⁵⁸ and 80%.¹⁵⁹ Furthermore, as claims would increase at a time when NHS resources are already under strain, the “pot” of compensation would be likely to be fixed, meaning that the amount payable to the most severely injured persons would be less than at present.

153 Health Committee, *Patient Safety*, Sixth Report of Session 2008–09, HC 151

154 *Bolitho v City and Hackney Health Authority* [1998] A.C. 232, *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 583

155 Ev 90

156 Ev 162

157 Although some of this is enshrined in statute e.g. the Mental Capacity Act, most consent to treatment law has been established by case law.

158 Scottish Government, *No Fault Compensation Group Report*, February 2011

159 Ev 85

157. The evidence suggests that “no-fault” compensation schemes may increase the volume of cases seeking compensation from the NHS whilst reducing the compensation available to those most in need. **The Committee believes that the existing clinical negligence framework based on qualifying liability in tort offers patients the best opportunity possible for establishing the facts of their case, apportioning responsibility for errors, and being appropriately compensated.**

Indemnity Schemes

158. The NHS Litigation Authority (NHSLA) was established in 1995. For the purposes of this report, its principal aim is to:

[...] minimise the overall costs of clinical negligence...to the NHS and thus maximise the resources available for patient care by defending unjustified actions robustly [and] settling justified actions efficiently.¹⁶⁰

159. It discharges this function by administering schemes that help NHS bodies to pool the costs of liabilities to third parties for loss, damage or injury arising out of the discharge of their functions. It also seeks to support the NHS to improve its risk management practices.

160. The key scheme operated by NHSLA is the Clinical Negligence Scheme for Trusts (CNST). CNST provides an indemnity to members and their employees in respect of clinical negligence claims arising from events which occurred on or after 1 April 1995. CNST is often seen as an in-house mutual insurer, with the costs of the scheme being met by membership contributions based on the projected liabilities for a given year.¹⁶¹

161. GPs and dentists are not covered by CNST and instead procure their own indemnity cover. For example, the Medical Protection Society is a mutual not-for-profit organisation that offers professional indemnity to approximately 50% of GPs and 70% of dentists in the UK.

162. In 1998 the NHSLA and other interested parties negotiated a pre-action protocol that governs how medical negligence claims are handled and the timeframe within which each element must be addressed e.g. the sharing of medical records between the NHS and the claimant or their representatives. Under the protocol, the NHS must respond to any offer to settle a claim and alternative dispute resolution may also be used.¹⁶² Some evidence provided to the Committee suggests that not all parties are happy with how it operates. The Association of Personal Injury lawyers have told us that:

There is currently limited access to justice for lower value clinical negligence claims. Proposed changes to the pre-action protocol will reduce areas for potential dispute and reduce costs.¹⁶³

160 The National Health Service Litigation Authority, NHSLA Framework Document

161 *Ibid.*

162 Clinical Disputes Forum, Pre-Action Protocol for the Resolution of Clinical Disputes, December 1998

163 Ev 125

In its submission to the Committee, the Department of Health told us:

There is no effective control over pre-issue costs; certain pre-action protocols lead to magnification of these costs and duplication of effort.¹⁶⁴

163. Although the pre-action protocol for clinical disputes has been amended over time, the Committee takes the view that it is now time for this to be revised, with a view to reducing costs and duplication within the process.

164. As part of its review of all “Arms Length Bodies” (ALB) the Government found that whilst there was a strong case for risk pooling between NHS organisations that there may be potential efficiencies to be gained from the NHSLA. The Government commissioned an “industry review” of the NHSLA that may recommend that some other organisational form may be more appropriate.¹⁶⁵ The Committee has heard in evidence that the NHSLA offers good value for money to the NHS in how it keeps the costs of legal fees down, but accepts the general principle of reviewing all ALBs to secure better value for the tax payer.

165. Deputy NHS Chief Executive David Flory told the Committee that the industry review of the NHSLA would make an initial report “before Easter”. With considerable change already underway in the Department of Health, NHS and the ALB sector, the Committee thinks that distracting the NHSLA from its core task of keeping the costs of litigation down for the NHS could be jeopardised by prolonged uncertainty. **The Committee believes that the Government is in possession of the industry review report of the NHS Litigation Authority. In order to prevent further uncertainty the Committee suggests that it complete the review process and make its conclusions known as soon as possible.**

Claims Management Companies

166. Claims Management Companies (CMCs or “claims farmers”) have been a facet of the legal services industry for over ten years, and have been regulated by the Ministry of Justice since 2007. There are over 3000 CMCs operating in the UK and the Ministry of Justice estimates that approximately 1000 companies seek authorisation to enter the market each year.¹⁶⁶ CMCs operate by collecting claims, assessing their contestability and likely value and then either charging a fee to individual personal injury lawyers or to practices for claims that are passed on to them. CMCs sometimes hold auctions for batches of claims of a particular type.

167. Through their advertising activities CMCs could be seen to increase public awareness of the routes to legal redress available. However, the Committee heard in evidence that:

I think it is odious, but they sell their claims on. They don’t sell them on the basis of merit. They sell them on the basis of who is on whose panel.¹⁶⁷

164 Ev 82

165 Department of Health, *Liberating the NHS: Report of the arms-length bodies review*, July 2010

166 Ministry of Justice, *Claims management regulation*, July 2009

167 Q 146

168. This can lead to a situation where CMCs sell claims to the highest bidder and not to the best qualified solicitor. Lord Young of Graffham has been undertaking a review of compensation culture in the UK. In his report he states that:

Such companies then proceed to auction any claim that appears well founded to the solicitor who will pay the most. Quite apart from encouraging litigation in circumstances when it might not otherwise occur, claims go to the solicitor who pays the most, rather than the one most suitable for the client – sometimes even if their practice is far away from their client.¹⁶⁸

169. CMCs offer immediate cash payments or inducements to persons who wish to make a claim, as highlighted again by Lord Young:

[...]many adverts entice potential claimants with promises of an instant cheque as a non-returnable bonus once their claim is accepted – a high pressure inducement to bring a claim if ever there was one.¹⁶⁹

Leigh Day and Co., a personal injury law firm, described them to us as “unscrupulous”.¹⁷⁰

170. The NHSLA has stated that the activities of CMCs have directly contributed to the increase in the numbers of claims being brought against the NHS.¹⁷¹ The NHSLA told us:

A further concern is that uplifts in costs make claims farming an attractive proposition. We believe that this has been a major factor in increasing numbers of new clinical negligence claims by 10% over each of the last two years. The projection for 2010/11 is for an even higher increase.¹⁷²

171. The code of conduct for CMCs states that they must not engage in face to face “cold calling”, or in any form of high pressure selling, and must give written information on how you can pursue a claim and the costs involved before a contract is agreed.¹⁷³ This does not prohibit advertising in hospitals, on TV and radio, nor does it seem to prohibit “cold calling” by telephone.

172. The Committee is concerned about the activities of Claims Management Companies or “claims farmers”; in particular it is concerned that they encourage people to go straight to litigation rather than use the complaints resolution mechanisms, that the bidding process may not lead to the cases being passed to the advisers best able to resolve the claim, and that they unduly contribute to the rising costs of litigation to the NHS. The Committee therefore proposes that the Government review the regulatory structure within which these businesses operate in order to ensure that patient and taxpayer interests are properly safeguarded.

168 *Common Sense, Common Safety, A report by Lord Young of Graffham to the Prime Minister*, October 2010

169 *Ibid.*

170 Ev 165

171 Ev 91

172 *Ibid.*

173 *Ibid.*

The proposed civil justice and legal aid reforms

173. Persons pursuing a claim against the NHS often use a conditional fee arrangement (CFA), a commonly used type of ‘no win no fee’ arrangement where solicitors are not paid if they do not win. As part of CFAs, claimants will typically obtain “After the Event” (ATE) insurance. ATE insurance is designed to cover legal fees in the event that their claim is not successful. On top of their costs, solicitors can also charge an additional “success fee” if they are successful, and these can be up to 100% of the base costs. Success fees and the full cost of ATE premia may at the moment be recovered from a losing defendant (in this case the NHS).

174. Lord Justice Jackson’s review of civil litigation costs had two key objectives; to keep the costs of civil litigation down but also maintain access to justice.¹⁷⁴ The report found that whilst CFAs did improve access to justice for cases that are not legally aided that they are “the major contributor to disproportionate costs in civil litigation in England and Wales.”¹⁷⁵ Lord Jackson recommended that success fees or ATE premia no longer be recoverable from the defendant (in this case the NHS) and that they instead be negotiated by the claimant and their solicitor and recovered from their settlement.¹⁷⁶ To compensate for this, payments for general damages in personal injury cases should be uplifted by 10% and the success fees recoverable from a claimant’s settlement should be capped at 25% of a settlement.¹⁷⁷ The Government’s response was to accept these proposals.¹⁷⁸

175. In November 2010, the Government also began to consult on reform of the legal aid system in England and Wales.¹⁷⁹ The key proposal is to end Legal Help and Representation to support actions for clinical negligence, as CFAs are available in most cases.¹⁸⁰

176. The Committee also notes that Lord Jackson’s review of civil litigation costs also stated that:

Legal aid is still available for some key areas of litigation, in particular clinical negligence [...] It is vital that legal aid remains in these areas. However, the continued tightening of financial eligibility criteria, so as to exclude people who could not possibly afford to litigate, inhibits access to justice in those key areas. In my view any further tightening of the financial eligibility criteria would be unacceptable.¹⁸¹

Furthermore, Lord Jackson continues:

174 Right Honourable Lord Justice Jackson, *Review of Civil Litigation Costs; Final Report*, December 2009

175 *Ibid.*

176 *Ibid.*

177 *Ibid.*

178 *Ibid.*

179 Ministry of Justice, *Proposals for the reform of legal aid in England and Wales*. Cm 7967, November 2010

180 *Ibid.*

181 Right Honourable Lord Justice Jackson, *Review of Civil Litigation Costs; Final Report*, December 2009

I do, however, stress the vital necessity of making no further cutbacks in legal aid availability or eligibility. The legal aid system plays a crucial role in promoting access to justice at proportionate costs in key areas.¹⁸²

177. The Committee also notes that that Action against Medical Accidents has stated that:

The Ministry of Justice is seeking to save £17 million by taking clinical negligence out of scope for legal aid. We would estimate that at least that amount might be saved for the NHS if access to legal aid was increased for all clinical negligence cases, rather than most claimants being forced to use a CFA.¹⁸³

178. The Government response to its consultation states that it accepts the concerns of stakeholders about the high cost of initial disbursements in clinical negligence cases. To mitigate against this, the Government is proposing that ATE premia will be recoverable in clinical negligence cases only. It will also develop a new, more narrowly-drawn “exceptional funding scheme” for cases where failure to fund a legal case would result in a breach of the right to legal aid under the Human Rights Act 1998 or European Union law. The Government does accept however that:

there may be particularly complex cases where [...] it may be difficult to find a CFA, but the exceptional funding scheme for out of scope cases will ensure that individual cases of this type continue to receive legal aid.¹⁸⁴

179. The Committee notes that the Government supports the recoverability of “after the event” insurance premia in clinical negligence case to mitigate against the high costs incurred in the early stages of such cases. The proposal to end the recoverability of success fees from the defendant, in this case from the NHS, remains in place. The Committee is concerned that this could impact negatively on some of the most seriously injured or disabled claimants, both by reducing the value of final settlements (after erosion by fees) and by undermining access to justice.

180. The Committee considers that preservation of access to justice will be the yardstick by which these proposals will be judged by the public and that the Government must take care to gauge its proposals against this measure.

Timely resolution of smaller claims

181. The NHS Redress Act 2006 allows the Secretary of State for Health to establish a scheme to apply to cases involving liabilities in tort arising out of hospital care provided as part of the NHS in England.¹⁸⁵ The scheme would enable the development of a redress package where there has been a less severe, lower monetary value case of clinical negligence proven against the NHS. Under the Act a redress package must include compensation, an explanation of what happened, an apology and a description of action taken to prevent recurrence. The redress scheme would be voluntary and participants would waive the right

182 *Ibid.*

183 Ev 152

184 Ministry of Justice, *Legal Aid Reform in England and Wales; the Government Response*, Cm 8072, June 2011, para. 37

185 Department of Health, *NHS Redress*, a statement of policy, 2005

to future legal action against the NHS on this particular complaint. Despite its successful passage through Parliament in 2006, the regulations to enact the NHS Redress scheme have not been brought into effect in England. In his review of legal costs Lord Justice Jackson has lent his support to implementation of the NHS Redress Act, stating that the scheme:

[...] is a sensible one, which will facilitate the early and economic resolution of lower value clinical negligence claims in respect of hospital treatment [...]The proposed redress scheme is one which will promote access to justice at proportionate cost.¹⁸⁶

182. The Government has stated that the NHS Redress Act scheme:

[...] missed an opportunity to improve fundamentally the way that clinical negligence claims are handled. It should have focused on improving the fact-finding phase prior to pursuit of a claim in order to facilitate faster resolution of claims and leaving it to the parties concerned, or ultimately the courts, to determine cases not resolved by the fact-finding.¹⁸⁷

The Department is also working with the Ministry of Justice on another of Lord Young's recommendation to explore whether the Road Traffic Accident scheme could be extended to low value clinical negligence claims.¹⁸⁸

183. The Ministry of Justice Road Traffic Accident (RTA) Scheme came into effect on 1 April 2010 and applies to persons injured in RTAs where claims are likely to be valued between £1000 and £10,000. The scheme aims to compensate people quickly using an online portal and "front-loads" solicitors fees, ensuring that sufficient work is undertaken early in the process to enable early resolution, ideally through negotiation.

184. The NHSLA has been tasked by the Government with development of the proposed voluntary scheme, under the umbrella of CNST.¹⁸⁹ The Committee notes that the NHSLA estimates that approximately 3000 claims will be processed through this system, nearly half of the total amount of claims received by it in 2009–10.¹⁹⁰

185. The Medical Protection Society, whilst endorsing the principle of speedy resolution of claims has concerns about the extension of the RTA scheme:

It is important to note that a low value clinical negligence claim can be as complex as a high value claim. We appreciate that a claimant can only establish that he or she has a claim with the assistance of a lawyer and that there must be costs associated with this. Those costs would be considerably more than the RTA scheme currently allows.¹⁹¹

186. The Committee welcomes the development of a rapid resolution process for lower value clinical negligence claims against the NHS, as this will speed up admissions of

186 Right Honourable Lord Justice Jackson, *Review of Civil Litigation Costs; Final Report*, December 2009

187 Ev 83

188 *Ibid.*

189 Ev 92

190 NHS Litigation Authority, *NHSLA report and Accounts 2009–10*, June 2010

191 CAL 12

liability and access to redress for patients, and reduce costs for the NHS. The Committee would like to see evidence of how the complexity of low monetary value claims will be managed whilst costs are reduced.

Conclusions and recommendations

The NHS complaints system

1. The Committee welcomes the improving level of satisfaction with the local resolution process for complaints, but finds that the Government can still do more to improve patient experience of the complaints system. (Paragraph 13)
2. The Committee is clear that the current two-stage model of the complaints system has the potential to give speedy resolution of, and earlier learning from, complaints. However, there is still a considerable amount of work to do in order to fully implement the system throughout England. (Paragraph 16)
3. The Committee takes the view that the two year period since implementation of the new system should give the Government sufficient data to undertake a review and to make improvements. The Committee endeavours to support this process with this report. (Paragraph 17)
4. The NHS complaints statistics show an increase of 13.4% in complaints between 2008–09 and 2009–10. This is comparison of data between two distinct complaints systems is unreliable. Furthermore, the growing number of people treated by the NHS, the stricter reporting arrangements, more information about how to complain and a general improvement in consumer rights awareness may have added to the volume of complaints that the NHS receives. (Paragraph 24)
5. In particular we are concerned about the number of individual cases where complainants did not feel the NHS was sufficiently responsive to their concerns. It is in this variable individual experience, rather than in movements in the headline totals, that the Committee feels that there is a real issue which the NHS needs to address. (Paragraph 25)
6. Customer service complaints often can and should be resolved immediately by the person receiving the complaint apologising and rectifying the issue, be they a clinician, a PALS officer or any other employee of the NHS. Due to the nature of these types of complaints, admitting that there was a problem, dealing with it and apologising will save time and resources that can be diverted to prompt and effective investigation and resolution of more serious and complex cases. (Paragraph 28)
7. It will always be difficult for a single complaints system to manage complaints about the great diversity of issues that occur on a daily basis. In its review of the complaints system in England, the Government should consider carefully the development of separate systems for investigation and resolution of customer care complaints and more serious complaints about clinical issues. A stratified set of standards relating to each part of the system should also be considered. (Paragraph 31)
8. The Committee recommends that in all cases where serious untoward incidents are being investigated, whether or not a complaint has been made, those directly affected should always be included as full participants in the process. (Paragraph 36)

9. We recommend that the Ombudsman urgently reviews the manner in which data on complaint handling by her office is communicated to the public as she appears to be significantly more actively engaged in reviewing NHS complaints than is obvious from the published data. (Paragraph 48)
10. The terminology “no worthwhile outcome” which arises from the Health Service Commissioners Act is being used in communication with complainants. Several have told us that their complaints were rejected because “no worthwhile outcome” could be achieved. The Committee recommends that the Ombudsman urgently reviews the use of this terminology in correspondence as it appears significantly to undermine public confidence in the complaints handling process. (Paragraph 49)
11. Many people see the role of the Ombudsman as a general appeals process for the complaints system, but the remit under the Health Service Commissioners Act is much narrower than that. The Committee is of the view that a complainant whose complaint is rejected by the service provider should be able to seek independent review. The legal and operational framework of the Ombudsman’s office should be reviewed to make it effective for this wider purpose. (Paragraph 50)

Advice and advocacy services

12. Patient advice and liaison services are crucial, as the first line of contact for many complainants and as teams that can resolve complaints, sometimes on the spot. The Government needs to explore how PALS can have a highly visible presence in hospital receptions and GP surgeries and be well signposted throughout larger NHS buildings. (Paragraph 54)
13. In considering the future of PALS the Committee has had to balance its core role i.e. the speedy resolution of complaints, with the independence that some witnesses have called for. On balance, the Committee finds that PALS should remain a part of the workforce of the organisation being complained about. This “insider” position offers PALS the opportunity to access and influence clinicians and managers that may otherwise be more difficult to achieve. (Paragraph 58)
14. The Committee does not seek to set a minimum grade for PALS officers in the NHS, but does recommend that the Government commissions a framework that sets out the capabilities required to deliver patient advice and liaison roles. This framework should then be used to support, train and develop PALS officers, as well as to ascertain their current skills and benchmark grades across similar organisations. (Paragraph 60)
15. The Committee finds that one single point of access for the entire local resolution of a complaint is valuable and that integration of complaints and advice teams can provide this. The Committee finds that Local Involvement Networks (soon to become Local Healthwatch organisations), as the local voice of patients, should drive forward the improvement of patient advice and complaints services and feed into the commissioning process. (Paragraph 63)
16. It is a significant anomaly that complaints to a professional regulator cannot be supported by ICAS, even when this forms part of a complaint that is being made to

the NHS. The Committee recommends that Government removes this restriction as part of its review of the complaints system. (Paragraph 67)

17. Where advocacy is used, advocates play a valuable role at supporting complainants in making effective complaints. The Committee finds that there may well be a business case for further support for ICAS in order to reduce the number of premature complaints received by the Ombudsman. The Committee recommends that Government reviews this proposal as part of its review of the complaints system. (Paragraph 71)
18. The Committee is concerned that some complainants who would benefit from support from ICAS are simply not aware of its existence. (Paragraph 72)
19. The Committee recommends that NHS management is tasked to deliver a significant improvement in patient awareness of and access to the services provided by ICAS. It also recommends that PALS should be expected to refer serious cases to ICAS speedily in order to reduce delays in the process. (Paragraph 74)

The role of commissioners

20. The Committee notes that the NHS complaints system has only been in place for a little over two years. Whilst we are not proposing a lengthy and disruptive reorganisation at this point, the Committee believes that commissioning authorities (as outlined in our earlier report Commissioning: further issues) should be the engines that drive improvement in complaints handling, in the analysis of data and in leading change within the NHS. (Paragraph 76)
21. The Committee welcomes the Governments announcement that it will introduce a contractual duty of candour. The Committee does not think that placing further statutory duties on the NHS will produce the shift in culture that is required to ensure that patients get full disclosure of information when things go wrong. The emphasis on the importance of culture change described later in this report may have more impact than further statutory change. (Paragraph 80)
22. However, the Committee believes that service agreements between NHS commissioners and their providers should include a contractual duty of candour to the commissioner. A duty of candour to patients from providers should also be part of the terms of authorisation from Monitor, and of licence by the Care Quality Commission. (Paragraph 81)
23. When commissioning authorities are being authorised by the NHS Commissioning Board they should also be placed under a contractual duty of candour to their populations and to their local Healthwatch organisations. (Paragraph 82)
24. The Committee finds that in the absence of clear national standards for complaints handling, and with no one organisation taking the lead on assessment of performance, it is extremely difficult to ascertain which organisations are performing well on complaints. There is significant potential for duplication by different regulators and for failing organisations to be overlooked. (Paragraph 86)

25. The Committee strongly advocates that one organisation should be responsible for maintaining an overview of complaints handling in the NHS, setting and monitoring standards, supporting change, and analysis of complaints handling data “in the round” from all sources. The Committee recommends that this responsibility should rest with Healthwatch England in conjunction with local Healthwatch organisations and that it should be resourced at a level which reflects the importance placed in this issue by patients and taxpayers. (Paragraph 87)
26. The Committee thinks that commissioners need to have a much greater focus on complaints handling and on complaints data. We would like to establish the principle that providers must account to their commissioner on complaints handling, and that the commissioner in turn must account to the public and local Healthwatch for the performance of their providers. (Paragraph 90)
27. The Committee recommends that the model commissioning contracts that will be developed by the NHS Commissioning Board must mandate access to comparable complaints data from their provider organisations by commissioners. (Paragraph 91)
28. The Committee recommends that providers of NHS care and treatment should be under a contractual duty to report comparable complaints data to their commissioners at a frequency specified by them. Commissioners should in turn share this data with other commissioners, the relevant Healthwatches, and the NHS Information Centre who can in turn share their concerns with Healthwatch England. (Paragraph 96)
29. Action plans that arise from complaints are a vital part of organisational learning, but they are only of value if they are followed through to implementation. (Paragraph 100)
30. The Committee recommends that providers of NHS care and treatment be put under a contractual duty to report their complaints action plans, and progress against implementing them to their commissioners, and to the complainant. Commissioners, as the focal point for local analysis of complaints, should then share action plans and progress updates with their local Healthwatch. (Paragraph 101)
31. Local Healthwatch should also share complaints action plans and any concerns they have about implementation with Healthwatch England. (Paragraph 102)

The proposed health reforms

32. The Committee welcomes the provisions in the Health and Social Care Bill that support information sharing between organisations but would like to see the proposals strengthened in a number of areas relating to the complaints system. (Paragraph 104)
33. From the evidence presented to it the Committee finds that people who use complaints advocacy services see a demonstrable benefit from it. However, existing commissioning arrangements have led to coverage that is neither complete nor consistent. (Paragraph 112)

34. The Committee supports the Government's proposal for Local Authority commissioning of complaints advocacy. Local Authorities should use their considerable experience in this area to improve consistency of advocacy services across England. Commissioning statutory advocacy services for complaints, mental health and mental capacity could create opportunities to make service improvements and to reduce costs that should be explored by Local Authorities and the Department of Health against the background of a shared commitment to provide an effective advocacy service. (Paragraph 113)
35. In the Committee's second report on commissioning, it expressed concern that the Government's proposals for commissioning primary care through the NHS Commissioning Board needed to be reconsidered. Commissioning complaints systems through the Board nationally presents similar difficulties. The Government needs to bring forward effective proposals for local commissioning of primary care, of which complaints form a key part. (Paragraph 117)
36. The Committee finds it striking that the Government did not mention complaints in the Information Revolution consultation and is surprised it does not see how complaints information can help people to "see what is going on within the NHS". (Paragraph 120)
37. Complaints data can and should be used to support informed decision-making by patients and commissioners, and to drive up the quality of care in the NHS. In its forthcoming report on the Information Revolution the Government should consider how complaints data can help patients to make informed choices about their care. (Paragraph 121)
38. The Committee welcomes the joint agreement on complaints information between the Department of Health, the Ombudsman and others, and would like to see clear plans in place for its implementation. (Paragraph 124)
39. However, the Committee remains very concerned that participation in the agreed protocol by Foundation Trusts remains voluntary. The Committee believes this communicates an unacceptable message about the prevailing culture towards complaints, and in particular towards the duty of candour which we believe that all providers of NHS care should respect towards their commissioners and the wider public. We propose that participation in the agreed reporting protocol for complaints should be a condition of the award of any NHS service contract to either public or private sector provider. (Paragraph 125)
40. The withholding of NHS complaints reports from the public until they are specifically requested runs counter to the principles of the Information Revolution. The Government must take action on this and ensure that complaints reports and serious untoward incident reports are automatically returned to commissioners who can then publish a rounded view on NHS-funded providers. These reports must also be automatically published by local Healthwatch organisations. (Paragraph 127)

Complaints cultures

41. There are significant cultural barriers to complaining about healthcare in England, not least because of the position that the NHS has within the national psyche. Added to this are fears that complaints will prejudice future care and that the complaints system will prove to be ineffective at resolving complaints to their satisfaction. (Paragraph 133)
42. The Committee strongly supports the use of tools that allow patients to give feedback anonymously and that can demonstrate that changes have been made to service provision based on feedback received. (Paragraph 135)
43. The Committee urges the Government to pilot how “real-time” feedback can be captured by using existing technology, for example patient bedside technology, that can capture immediate customer care issues, lead to an immediate response and be fed into analyses of broader complaints trends. (Paragraph 136)
44. The Committee endorses the view that the NHS workforce is skilled and capable of delivering world-class healthcare. As with any workforce, however, performance issues will from time to time arise and must be dealt with. (Paragraph 137)
45. There remains some way to go before a culture is created throughout the NHS that is open to complaints, sees these in the light of systemic weaknesses and supports staff. Providers of NHS care and treatment must have clear policies for how they draw the line between system faults, practitioner faults and issues that will be referred to professional regulators. (Paragraph 142)
46. The Committee recommends that NHS organisations offer patient or user satisfaction training that includes basic “customer care”, patient safety and how complaints should be responded to when received by front line staff. Complaints data should be fed back to teams and individual practitioners to support learning, appraisal and changes in practice. (Paragraph 143)
47. The Committee takes the view that NHS staff should fully support complaints investigations and local resolution, even when they have left the organisation concerned. The Committee recommends that the Government explore the potential for placing staff under a duty to supply information and attend local resolution meetings, even if they have left the organisation concerned. (Paragraph 144)
48. The Committee finds that Foundation Trust Boards meeting in private runs counter to the creation of an open culture within the NHS. We very much welcome the Government's announcement that it will end Foundation Trust secrecy by ensuring that the Boards of these organisations will meet in public. The Committee urges the Government to work with the Foundation Trust regulator Monitor to ensure that open meetings are the default position for all matters where confidentiality or commercial sensitivity are not at stake, and that resolutions to meet in private are used judiciously and sparingly. (Paragraph 148)
49. The Committee supports an annual “open culture-check” by NHS organisations. This could utilise existing data from staff surveys, patient feedback and complaints

data and cross-references these data with an external peer review by a similar but independent organisation. (Paragraph 150)

Litigation

50. The Committee believes that the existing clinical negligence framework based on qualifying liability in tort offers patients the best opportunity possible for establishing the facts of their case, apportioning responsibility for errors, and being appropriately compensated. (Paragraph 157)
51. Although the pre-action protocol for clinical disputes has been amended over time, the Committee takes the view that it is now time for this to be revised, with a view to reducing costs and duplication within the process. (Paragraph 163)
52. The Committee believes that the Government is in possession of the industry review report of the NHS Litigation Authority. In order to prevent further uncertainty the Committee suggests that it complete the review process and make its conclusions known as soon as possible. (Paragraph 165)
53. The Committee is concerned about the activities of Claims Management Companies or “claims farmers”; in particular it is concerned that they encourage people to go straight to litigation rather than use the complaints resolution mechanisms, that the bidding process may not lead to the cases being passed to the advisers best able to resolve the claim, and that they unduly contribute to the rising costs of litigation to the NHS. The Committee therefore proposes that the Government review the regulatory structure within which these businesses operate in order to ensure that patient and taxpayer interests are properly safeguarded. (Paragraph 172)
54. The Committee notes that the Government supports the recoverability of “after the event” insurance premia in clinical negligence case to mitigate against the high costs incurred in the early stages of such cases. The proposal to end the recoverability of success fees from the defendant, in this case from the NHS, remains in place. The Committee is concerned that this could impact negatively on some of the most seriously injured or disabled claimants, both by reducing the value of final settlements (after erosion by fees) and by undermining access to justice. (Paragraph 179)
55. The Committee considers that preservation of access to justice will be the yardstick by which these proposals will be judged by the public and that the Government must take care to gauge its proposals against this measure. (Paragraph 180)
56. The Committee welcomes the development of a rapid resolution process for lower value clinical negligence claims against the NHS, as this will speed up admissions of liability and access to redress for patients, and reduce costs for the NHS. The Committee would like to see evidence of how the complexity of low monetary value claims will be managed whilst costs are reduced. (Paragraph 186)

Formal Minutes

Wednesday 22 June 2011

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper
Andrew George
Grahame M Morris
Chris Skidmore

David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Draft Report (*Complaints and Litigation*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 186 read and agreed to.

Resolved, That the Report be the Sixth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence to be published.

[Adjourned till Tuesday 28 June at 10 am

Witnesses

Tuesday 1 February 2011

Page

Julie Bailey, Cure the NHS, **Catherine Hopkins**, Legal Director, Action against Medical Accidents, and **Kieran Mullan**, Director of Strategy and Engagement, The Patients Association.

Ev 1

Mrs Dee Speers, **Mrs Nicola Monte** and **Debra Hazeldine**.

Ev 13

Tuesday 15 February 2011

Ann Abraham, Parliamentary and Health Service Ombudsman, **James Johnstone**, Director of Customer Service and Assessment, Parliamentary and Health Service Ombudsman, **Paul Streets**, National Director of Patient and Public Experience, and **Chris Bostock**, Head of User Experience, Department of Health.

Ev 20

David Flory CBE, Deputy NHS Chief Executive, **Stephen Walker CBE**, Chief Executive, NHS Litigation Authority, and **Sarah Albon**, Director for Civil, Family and Legal Aid Policy, Ministry of Justice.

Ev 32

Tuesday 26 April 2011

Lee Bennett, Assistant Director of Patient Experience and Public Engagement, and Complaints Manager, Cambridge University Hospitals NHS Foundation Trust, **Anne-Marie Ledson**, Team Leader, ICAS Yorkshire and Humberside, and **Helen Marshall**, Risk Manager and Complaints Lead, Calderdale and Huddersfield NHS Foundation Trust.

Ev 41

Dr Mark Newbold, Chief Executive, Heart of England NHS Foundation Trust, and **Helen Thomson**, Executive Director for Nursing and Deputy Chief Executive, Calderdale and Huddersfield NHS Foundation Trust.

Ev 51

Tuesday 10 May 2011

Desmond Hudson, The Law Society of England and Wales, **Muiris Lyons**, The Association of Personal Injury Lawyers, **Carole Ayre**, Browne Jacobson LLP, and **Nicola Wainwright**, Leigh Day & Co Solicitors.

Ev 59

Rt Hon Simon Burns MP, Minister of State, and **Chris Bostock**, Head of User Experience, Department of Health.

Ev 69

List of printed written evidence

1	Department of Health	Ev 79
2	Department of Health supplementary	Ev 84
3	Department of Health supplementary	Ev 84
4	Dee Speers	Ev 86
5	Dee Speers further	Ev 87
6	Dee Speers supplementary	Ev 88
7	NHS Litigation Authority	Ev 89
8	NHS Litigation Authority supplementary	Ev 92
9	National PALS Network	Ev 97
10	The Law Society of England and Wales	Ev 100
11	Cure the NHS	Ev 104
12	Independent Complaints Advocacy Service	Ev 107
13	Independent Complaints Advocacy Service supplementary	Ev 111
14	Independent Complaints Advocacy Service further	Ev 114
15	Association of Personal Injury Lawyers	Ev 124
16	Browne Jacobson LLP	Ev 142
17	Health Service Ombudsman	Ev 145
18	Action against Medical Accidents	Ev 149
19	Leigh Day & Co Solicitors	Ev 152
20	The Patients Association	Ev 157
21	The Patients Association supplementary	Ev 159
22	Health Service Ombudsman supplementary	Ev 161
23	Association of Personal Injury Lawyers supplementary	Ev 162
24	Browne Jacobson LLP supplementary	Ev 163
25	Sands	Ev 164
26	Miss Andrea Burke (CAL 46)	
27	Nursing and Midwifery Council (CAL 63)	
28	Medical Protection Society (CAL 12)	

List of additional written evidence

(published in Volume III on the Committee's website www.parliament.uk/healthcom)

1	Patient Opinion
2	Miguel Cubells
3	S Ramskill
4	The Royal College of Radiologists
5	Centre for Effective Dispute Resolution
6	National Children's Bureau
7	HealthCare Resolutions
8	Independent Healthcare Advisory Services

- 9 Jan Middleton
- 10 Hill Dickinson LLP
- 11 Terry Leigh PhD
- 12 Mr Cedric Maddox
- 13 General Medical Council
- 14 Arthur Briggs
- 15 Mr and Mrs Cowling
- 16 Anne Ward Platt
- 17 Gerry Ferguson
- 18 Medical Defence Union
- 19 The Carers Federation
- 20 Care Quality Commission
- 21 SEAP
- 22 Jane and Dennis Bannister
- 23 Martin Jeremiah
- 24 Mencap
- 25 National Voices
- 26 Ros Phillips
- 27 NALM
- 28 NHS Confederation
- 29 Lord Dunboyne
- 30 Colin Yeo
- 31 Charlotte Radford

List of unprinted written evidence

The following memoranda have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Parliamentary Archives, and are available to the public for inspection. Requests for inspection should be addressed to The Parliamentary Archives, Houses of Parliament, London SW1A 0PW (tel. 020 7219 3074). Opening hours are from 9.30 am to 5.00 pm on Mondays to Fridays.

Ms Manuela Manuel
Jeffrey Williams
Sam Smith
Jan Ooms
Ann Reeves
James Titcombe
Francis Biard
Mr William Cassie Powell
Gary O'Mara
David de Grothier
David Eaton
Martin James Wildman
Anonymous

Miss Donna McCallum
Mr Johnstone
Mr Leslie Smith

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786