



House of Commons  
Health Committee

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# Complaints and Raising Concerns

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**Fourth Report of Session 2014–15**

*Report, together with formal minutes relating  
to the report*

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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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Evidence relating to this report is published on the [inquiry page](#) of the Committee's website.

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<sup>1</sup> 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).



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## Summary

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Most of those who complain about NHS services do not seek financial redress. They do so because they wish to have their concerns and experiences understood and for any failings to be acknowledged and put right so that others do not suffer the same avoidable harm. Where such errors occur, patients and their families deserve to be met with a system which is open to complaints, supports them through the process and which delivers a timely apology, explanation and a determination to learn from mistakes.

The current system for complaints handling however, remains variable. Too many complaints are mishandled with people encountering poor communication or at worst, a defensive and complicated system which results in a complete breakdown in trust and a failure to improve patient safety.

The Committee welcomes the progress made since our last report but in this, our final report on complaints and concerns in this Parliament, we set out an overview of the developments and recommendations to date as well as those expected in 2015. We also make a number of recommendations where we feel further action is required.

As we aim to move to a culture which welcomes complaints as a way of improving NHS services, the number of complaints about a provider, rather than being an indicator of failure, may highlight a service which has developed a positive culture of complaints handling and it will be important for system and professional regulators alike to be able to identify the difference.

Complaint handling remains overly complex and we recommend a single gateway for raising complaints and concerns with clearer, adequately resourced arrangements for advocacy and support.

The removal of primary care complaints handling from local areas has resulted in a disconnection from local knowledge and learning and led to unacceptable delays. We recommend that this is rectified.

There is also a strong case for integrating complaints about health and social care under the same umbrella and this should start with a single rather than separate ombudsmen. There is now no excuse for any health or care organisations not to implement the recommendations of the 'My Expectations' report on first tier complaints as this has clearly set out a user led guide to best practice.

Just as we expect the NHS to respond in a timely, honest and open manner to patients or families raising complaints or concerns, we should expect the same for staff. The treatment of whistleblowers remains a stain on the reputation of the NHS and has led to unwarranted and inexcusable pain for a number of individuals. The treatment of those whistleblowers has not only caused them direct harm but has also undermined the willingness of others to come forward and this has ongoing implications for patient safety. Whilst this committee is clear that professionals have a duty to put patients first and to come forward with their concerns we recommend that those who have suffered harm as a result of doing so and

whose actions are proven to have been vindicated, should be identified and receive an apology and practical redress.



# 1 Introduction

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1. In 2011 the Committee held an inquiry into Complaints and Litigation, and looked in some detail at the working of the NHS complaints system. In its report, it said that

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.<sup>1</sup>

2. It recommended that the Government undertake a review of the NHS complaints system. It also made recommendations about the roles of the Ombudsman, advice and advocacy services, providers and commissioners, and about the co-ordination and monitoring of complaints handling across the NHS. In its response to the Committee's report, the Government accepted that "whilst some NHS organisations respond quickly and effectively to complaints, others are not so effective", and agreed that "the NHS can do more to improve complaints handling."

3. The period since the publication of the Committee's report into Complaints and Litigation has seen the implementation of the Health and Social Care Act 2012; the publication of the Francis report; and, in October 2013, the publication of the Clwyd-Hart Review of the NHS Hospitals Complaints System. The Government provided its formal response to the Francis report in November 2013.

4. As well as complaints and concerns made by patients and members of the public, the Francis report also highlighted the related issue of the way in which complaints and concerns raised by staff within health and care organisations were handled. This is an issue that has featured in much of the Committee's work this Parliament and we considered it important to examine it in this inquiry as another indicator of patient safety concerns alongside complaints.

5. The current inquiry followed up relevant recommendations made in the Committee's 2011 report on Complaints and Litigation, and the commitments made in the Government response. It also examined the treatment of staff who raise concerns about NHS services, and the procedures in place to encourage NHS staff to raise concerns without fear of detriment. Specific issues on which the Committee asked for evidence were:

- Handling of complaints made by patients and families about care received in the health and care sectors, including both primary and secondary care providers;
- Handling of concerns raised by staff about care given in the health and care sectors;

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1 Health Committee, Sixth Report of Session 2010-12, [Complaints and Litigation](#), HC 786-I, para 4

- The extent to which the findings of recent inquiries have been incorporated into the complaints process;
- Support for patients, the public and staff who wish to make complaints or raise concerns;
- The consequences of complaints for care providers and of raising concerns for the employment prospects of staff;
- Openness about complaints and concerns, and accessibility of information;
- The role of commissioners, system regulators and professional regulators with regard to complaints and concerns;
- The operation of the Public Interest Disclosure Act 1998 in relation to health and social care;
- Future plans for improvements in this area.

We received 120 written submissions. We are grateful to all those who have contributed to the inquiry.

### **Developments since the Committee's 2011 report**

6. Since our 2011 report, there have been significant developments in the form of the second Francis report and actions which flowed from it—the Government's formal responses and the commissioning of the Clwyd/Hart review of acute provider complaints.

7. The Department of Health has set up its cross-service Complaints Programme Board in response to Francis and Clwyd/Hart, the aim being to complete as much of the work as possible by March 2015. This activity appears to have displaced the review of the complaints system which the Government undertook to conduct in response to this Committee's earlier report.

8. We have also seen the October 2014 publication of Healthwatch England's review of the complaints system and the publication by PHSO, the Local Government Ombudsman and Healthwatch England in November 2014 of a service user-led vision for complaints handling,<sup>2</sup> with support from NHS England, Monitor, the Trust Development Authority and the Foundation Trust Network. This work is one of the major items in the Department's Complaints Programme.

9. Changes aimed at improving the culture of complaint handling within providers and across the health and care system are welcome, but they take time to have an effect and are difficult to measure. Meanwhile, the volume of complaints continues to rise. This may reflect increased awareness of complaints procedures and an increased willingness to remark on poor standards of service. While the headline figure may indicate service deterioration, it may also indicate an organisation which welcomes complaints as a means of improving performance. HSCIC data now also indicate (on an experimental basis) the

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2 [My expectations for raising concerns and complaints](#), PHSO, November 2014,

number of complaints upheld: in 2013/14 just over 50% of complaints about all NHS services were upheld, though this figure is subject to significant caveats.

**10. There is no doubt that the landscape has changed significantly since our earlier inquiry. Patient safety and the treatment of complaints and concerns have become high profile issues. There is equally no doubt that we are only at the beginning of a process of change with significant scope for further improvement.**

11. Despite the work undertaken to change the culture of complaints handling across the NHS system, the Committee has received ample evidence from individuals and patient representative organisations of a system which has not responded adequately to address individual complaints. For example, in oral evidence the Foundation Trust Network referred to a CQC in-patient survey where 7 per cent of those surveyed gave a 0 or 1 ranking for the overall quality of their care:<sup>3</sup> this level of assessment of is unacceptable.

12. We understand that many of the issues raised with the Committee had their origins in incidents which occurred before the second Francis report was published. That does not mean that they can be discounted. Ann Clwyd was concerned that many of her recommendations were not being acted upon, and it is important that the health and care system should, through its operations, demonstrate a clear commitment to improving the quality of complaint handling.

13. There have been a number of significant reviews of the complaint system which have urged a change in the culture of the NHS in responding to complaints. There is little firm evidence to date of the moves to change culture having a wholesale positive effect either on the behaviour of NHS providers which give rise to complaints or on the satisfaction of service users about how their complaints have been handled.

**14. We recommend that the Government publish a detailed evaluation of the progress achieved, and work remaining to be undertaken, by the Complaints Programme, in order for the public and our successor Committee in the next Parliament to be able to monitor progress. The Department should also include an evaluation of the operation of the complaints system across the health sector in the light of the post-Francis changes. A review was promised for 2014 but has not been undertaken.**

15. The rest of this report provides an overview of the issues raised with us concerning complaint handling, the role of the Ombudsman, professional regulators and the treatment of staff raising concerns. It is a snapshot of where the complaints system stands now, the progress that has been made and the areas where change is still required.

16. We consider that our analysis in our previous report remains relevant and we are not attempting to re-examine all the issues that we addressed then. **While there have been some improvements there are still too many individual cases which are mishandled, from instances of poor communication to those which end in a complete breakdown in trust between patients, their families and NHS institutions.**

17. As the Committee said in 2011, the issue lies in

...the 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<sup>4</sup>.

18. Reform of the complaints processes in health and social care and the inculcation of a culture of openness and responsiveness is a continuing process and one that needs to be regularly monitored. **We recommend that our successors on the Health Committee in the next Parliament continue this work of monitoring improvement in the complaints process.**

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4 Health Committee, [Complaints and Litigation](#), para 25

## 2 Complaint handling

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### What should good complaint handling look like?

19. Most complainants do not want to become drawn into complex, formalised and adversarial systems in which the NHS adopts an overly defensive approach. Neither do they primarily complain in order to gain financial compensation but in a timely manner to have their concerns and experiences understood, failings acknowledged and apologised for, and an assurance that no one else will endure the detriment they experienced.

20. The Committee noted in its previous report that

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 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.<sup>5</sup>

21. Both parts of the system were criticised in our previous inquiry and there has been no shortage of recommendations for improvements on complaint handling. The Clwyd/Hart review made a wide range of recommendations for Government, professionals, regulators, trusts and Trust boards in this regard.<sup>6</sup> A number of these have been taken forward by the Department of Health through its cross-agency Complaints Programme.

22. In its written evidence, the Department said that

The Department of Health believes it is important to join up the complaints system across the health and social care system to deal more effectively with poor care. To support this work, we have set-up a Complaints Programme Board (CPB). This was established in December 2013 to bring together a range of partners across the care system to implement actions which will lead to improvements in complaints handling as set out in *Hard Truths*, and assist member organisations (for example, the Care Quality Commission) to deal with poor care. Whilst the focus of the Board is on delivery of *Hard Truths* commitments, there is unanimous agreement within the Board that it will look more widely across health and social care to consider complaints in other health and social care settings and to bring about improvements.

The Terms of Reference for the CPB are:

- To implement the Government’s commitments detailed in *Hard Truths*.

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5 Health Committee, [Complaints and Litigation](#), summary.

6 [A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture](#), October 2013, chapter 6.

- To deliver the bulk of the Board's *Hard Truths* work programme by March 2015, with organisational lead responsibility for delivery of each project to be agreed within the group.
- To update the Secretary of State for Health on progress, as appropriate.
- To look more widely across health and social care to consider complaints in other health and social care settings, so as to seek to align complaints handling across care services.

The aim is to complete the work programme by March 2015, although some of the deliverables will not be realised within this time-frame.<sup>7</sup>

23. In evidence, witnesses indicated that a good process,<sup>8</sup> embedded in a supportive culture, had the following features:

- Openness to raising issues: service users should be enabled to raise an issue or to get something put right before a formal complaint is necessary.
- A number of ways to capture what service users are experiencing (a key issue in this regard would be the real-time capture of patient feedback data)
- Dialogue established as soon as possible with the complainant, and a closing of the feedback loop by speaking with the patient afterwards to discuss whether all concerns had been addressed

24. The proposal for a service user-led approach to complaint handling across the health and social care sectors, published by PHSO and others in November 2014, provides a good benchmark for complaint handling. Its intention to focus the system on dealing with complaints from a service users perspective, is welcome. The objective of creating a complaints system properly responsive to service users will not be achieved, however, unless providers across the health and care sector properly embed the culture and values espoused in the report into the culture of their organisations.

25. Witnesses have pointed out that the NHS is not a single organisation, but a system of organisations which have a number of competing interests and claims. Responsibility for ensuring a properly responsive complaints system is distributed widely across the health service:

- Trust Boards and management
- The Care Quality Commission, through hospital inspection programmes
- Commissioners, through e.g. meetings with providers, setting expectations of commissioned services, reviews of quality accounts and analysis of provider complaint data

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7 [CRC 74](#)

8 Eg Q 408

- Healthwatch England
- Local Healthwatch, through independent scrutiny of providers and commissioners and through membership of health and wellbeing boards
- The Health Service Ombudsman, setting standards for the health sector through her investigations of complaints and her published reports
- The Local Government Ombudsman, operating similarly for the local authority care sector
- Professional regulators such as the GMC and the NMC

The onus is therefore on individual providers to ensure that a rigorous focus on effective and user-focused complaint handling is maintained.

26. Transparency is an important element of a successful complaints process. One strand of work being undertaken through the Complaints Programme is designed to improve the collection and collation of complaints data in comparable formats by HSCIC. It is of course beneficial to have uniform datasets which can provide insight into comparative trends in complaints data, but these datasets are unlikely to be of great help to the general public in assessing how a Trust is doing on its complaint handling. Sir Robert Francis QC suggested to us that Trusts should be required to publish anonymised summaries of complaints against them, what had happened about the complaint and what the learning from it was, which would lead to greater public understanding of the nature of complaints being made against a Trust and how they were being handled:

We need to move beyond figures in broad categories, which are pretty useless to man or beast. I think there could be an obligation—obviously anonymised—to publish in summary form what the complaint was, what happened about it and what the trust’s learning from it is. If you did that in summary form...then everyone locally is going to say, “This trust is really not handling complaints very well,” or, “It is doing them differently from the place down the road.”<sup>9</sup>

**27. We recommend that Trusts be required to publish at least quarterly, in anonymised summary form, details of complaints made against the Trust, how the complaints have been handled and what the Trust has learnt from them.**

### Complaint handling by providers

28. The handling of complaints by a provider—openness to complaints, processes for handling them, impetus in having them resolved, and sincerity of resolution—is a key factor for a well-functioning health and care system. The ‘toxic cocktail’ of service users reluctant to complain and providers reluctant to listen must be avoided at all costs, as it inevitably leads to a spiral of decline in service quality. Patients must be empowered to give

constructive feedback on services which they believe are substandard. Anna Bradley, Chair of Healthwatch England, told us that

One in three [patients and carers] says that they have had personal experience, or know someone who has had personal experience, of a really quite serious incident, but only half of them have done anything about it... One in four of them says they did not do anything about it because they did not think anyone would be interested. Three in five said they did not know how to do anything about it. One in two said no one would do anything about it anyway and they did not trust that they would get a decent response. As we also know, very many people...just feel too vulnerable.<sup>10</sup>

29. As this shows, the complaints process is seen as complex and difficult to navigate, and can prove off-putting. A great deal of evidence was received on the necessity to simplify the system and create a single route for the service user to make a complaint and be properly signposted, as Healthwatch proposed in its paper *Suffering in Silence* published in October 2014:

*Recommendations for wholesale reform:*

- A ‘no wrong door’ policy, so that wherever a complaint is raised it is the system, not the complainant, that is responsible for routing it to the appropriate agency to get it resolved.
- The Government to explore the scope for online platforms to provide a well-publicised point of access for complaints, enable greater consumer choice, and allow anonymity where required.
- A review of PALS and NHS Complaints Advocacy arrangements, with a view to establishing a new, easily accessible and consolidated complaints advocacy and support offer that is:
  - Available to all users of health and social care regardless of age, condition or where they live.
  - Independent and acts only in the interests of the individual.
  - Well-publicised and easily recognised by everyone so that when they need help they know who to turn to.
  - Underpinned by a set of new national standards to ensure everyone is able to access high quality support.
- Healthwatch England to be given the power to act as a ‘super-complainant’ on behalf of groups of consumers on national issues.<sup>11</sup>

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10 Q22

11 [Suffering in silence](#), Healthwatch England, October 2014



30. In its 2011 report, the Committee recommended stratifying the complaints system to, for example, separate out customer service complaints from complaints about clinical treatment. The evidence given to us in the course of this inquiry, however, from Healthwatch England, Which? and PHSO, has suggested a single system for all complaints, with proper signposting both to the access point and then from the access point to the appropriate places throughout the system. An emphasis on early identification and resolution of customer service complaints by providers would reduce the need for such complaints to enter the system: at present an issue addressed within 24 hours of being raised need not enter the formal complaints process.

**31. We agree that the onus should be on the system to help a complainant. People should not be forced to search out the most appropriate way to raise concerns. We recommend that the complaints system be simplified and streamlined by establishing a single 'branded' complaints gateway across all NHS providers. This should be available online, but not exclusively so. There should be adequate resourcing to enable complaints to be examined, identified, and directed speedily to the appropriate channel.**

32. Evidence from other witnesses confirms that good practice does exist, but indicates this good practice is not the norm. The Healthwatch and Public Involvement Association (HAPIA) told the Committee that

The best hospitals value complaints, demonstrate a good sensitive inclusive investigation process; carry out the investigation quickly; meet with the complainant if appropriate and ensure that the response is provided within a reasonable time frame. In practice this is rare.<sup>12</sup>

In particular, HAPIA says that instances of face to face meetings with service users to discuss the outcome of complaints are few and far between.

33. The organisations that we spoke to were very clear about what constitutes good practice. We agree with Rob Webster of the NHS Confederation, who told us:

There is a simple golden thread through complaints, which I think most people know and is good practice, which is that you always say sorry, explain what you think has happened, and describe why it is not going to happen to anybody else.<sup>13</sup>

34. He went on to say:

We see in most organisations that that is widely understood and, whether it is a front-line member of staff or the chief executive who is responding, that is what they should do. The personal touch is incredibly important, and in many trusts it will be the chief executive who signs off all the formal complaints.

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12 [CRC 109](#)

13 Q 408

As part of the good practice, certain things should happen almost immediately. In my own trust I used to have a standard, which was that you get an acknowledgment within 72 hours and we will ask you personally, “What do you want to get out of this complaint? How long do you want it to take? What do you want to happen with it?” You will have personal contact, and then you will get a response from the chief executive, which will not be a standard format: it will be about you and those three things—the apology, explaining what has happened and why it will not happen to somebody else.

35. Professor Sir Mike Richards, the Chief Inspector of Hospitals, told us about CQC’s experience of complaints handling through inspection:

Some places are doing this well, some are doing it less well, and most have room for improvement in how they are managing complaints. I do not think you will be surprised about that, but that is certainly what we are finding. But through that we will also be able to say, “This is what we see as good practice,” and there will hopefully be some places that we will be able to say are outstanding in how they manage complaints...

Sometimes it is about the care and treatment [people] have received. Quite often it is about staff attitudes. Sometimes it is about administrative failings. Very often it is about car parking...But one of the things that I think is also important is to be able to ask a trust, “Is it the same now as it was a year ago?”, seeing if they have moved on. In one trust I remember a lot of complaints had been about ward 12, and, actually, those complaints had now ceased. Why? It was because they had really taken them on board and had sorted out the problems that there were on ward 12.<sup>14</sup>

36. Witnesses were generally agreed that it is the Trust Board and management which have the lead responsibility for setting an open culture in which complaints can be received and dealt with constructively. The Department of Health has set out several expectations, such as prominent displays of information on the ward about how to complain, but it cannot in the normal course of events intervene in the system to force a Trust to change its practices: it could not, for example, force a Board to appoint a senior non-executive director to review complaints made to the Trust.

37. Day to day responsibility for assuring the public about the quality of services in providers, including the handling of complaints, appears to rest with the CQC. Professor Sir Mike Richards described<sup>15</sup> the range of tools (including information gathering, listening exercises and the use of intelligence) which the CQC can use to assure itself that a provider has good systems for handling complaints, supported by an open and responsive culture. He told us

I can confirm that it is very high on our priority list. There is absolutely no doubt about that. As we have been doing our initial inspections, we have been trying to build our concerns handling, if you like—how we look at

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14 Qs 283, 286

15 Qs 271-78

concerns, whether they are staff concerns or patient and public concerns—into every step of our process.<sup>16</sup>

38. The knowledge that the CQC takes the adequacy of complaint handling seriously ought to encourage Boards to review their arrangements, consider the openness of their culture to complaints and raise their game: there should be no room for complacency even in trusts which consider themselves to be high performers.

39. The CQC exercises ‘soft power’ through its well-publicised standards, which should encourage all Trusts to prioritise complaint handling and related issues of governance as they know they will be held to account on these issues at inspection. It also exercises ‘hard power’ through its power to put Trusts into special measures, whereupon the Trust Development Authority or Monitor can take steps to change or remove the Board if they consider it necessary to improve performance.

40. The CQC is unable to investigate individual cases raised with it, though it has in the past undertaken to this Committee to use such material as ‘free intelligence’. There is though a risk of the CQC, through its inspection activity, being seen as the body which can examine a provider in respect of an individual complaint raised. As the reformed health and care system joins up, and services and complaints systems become, we hope, more integrated, the risk of inappropriate signposting to the CQC is clearly increased. The CQC should therefore continue to make it clear that it cannot in general investigate complaints made to it about NHS or social services. Its report *Complaints Matter*, published in December and which we discuss later, in paragraph 60, is a potential helpful step in that direction.

41. It is clear that the Chief Inspector of Hospitals takes complaint handling in Trusts seriously and he has taken up the challenge given to him by Ann Clwyd to make complaint handling standards a priority. We welcome the efforts of the CQC in this area.

**42. The relationship between the provider and the commissioner is, in our view, key to determining the day-to-day quality of services provided under NHS contracts. It is the commissioner which is best placed to work constructively with the provider on delivering improvements. We do, however, expect the CQC to examine the culture of complaints handling by providers.**

### **Role of commissioners in complaints, and handling of complaints by commissioners**

43. In this inquiry we have found little if any evidence of an active role for commissioners in handling complaints from service users or holding providers to account for the complaints systems they use.

44. In previous reports on commissioning the Committee has recommended that commissioners take an active role in driving up standards in complaints handling.<sup>17</sup> This could be done through active monitoring of the services delivered under contract,

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16 Q 278

17 Health Committee, [Complaints and Litigation](#), para 90

examination of provider board policies, quality accounts and reports on complaint handling, collaboration with local Healthwatch and CQC on complaint intelligence, and the use of qualitative and quantitative provider complaints data to analyse trends and indicate areas for improvement.

45. The lack of evidence of commissioner engagement in complaints processes is of some concern. CCGs, or commissioning support units (where these functions have been outsourced), must ensure that they have the capacity and the capability to monitor how the providers from whom they commission services deal with complaints, and must use the commissioning process to require high standards in complaint handling. Commissioners themselves have a role in the complaints process, and are required to handle complaints not only about the services that they commission on behalf of their populations from providers but also about the exercise of any of their own functions.

46. We have to assume that levels of public awareness of CCGs, and of their function in relation to complaints, is low: it is to a provider that a service user is most likely to complain. Since complaining to a commissioner is apparently not often done, it is difficult to assess the impact on the system which complaints by this route have. The commissioner route may well be inadequately signposted within most health economies. While it is difficult to see why a provider would encourage a complainant to take a complaint to a commissioner, rather than handling it directly, there is a case for better publicity and better signposting for complaints which are best made to commissioners.

**47. We recommend that the system for service users to make complaints to commissioners about NHS services should be integrated into a single complaints system. Commissioners need to take a far greater role in holding providers to account for delivering a well-functioning complaints system.**

### Complaints handling in primary care

48. NHS England is the commissioner of primary care and is the body to which complaints about GP practices and other primary care services are directed. There has been concern about the use by NHS England of out of area services to handle GP complaints raised locally. In written evidence we were told about the example of primary care complaints from Devon, Cornwall and the Isles of Scilly which are now passed to a call centre in Leeds and dealt with by a commissioning support unit in NW London. This illustrates the opportunity for confusion, dissatisfaction of service users, unacceptable delays and breakdowns in working relationships.

49. Dr Sam Barrell, who told us about these problems, wrote that

Because this arrangement had a “soft launch” it fell to local CCGs to communicate the change in the service to providers, practice managers and other parties. This did create confusion and effectively created a two-flow process, because complaints about the majority of services could be handled locally by the CCG, but complaints about primary care had to be handled at a national level in London. This led to dissatisfaction for patients and those using services, but also for NHS staff who had been unaware of the changes to their roles. Some relationships were undermined, and the abrupt change of

thinking compromised some of the solid foundations laid by PCTs on which CCGs had planned to build.

The confusion was compounded when it came to multiagency complaints that included a primary care element. In these types of complaints, input was required from NHS England; however, we had no knowledge of any process or timeframes that NHS England was adhering to. Locally in Devon we had some 20 complaints severely delayed by this new system. This had a clear impact on clients and, as a result, referrals to the Parliamentary and Health Service Ombudsman increased from on average one complaint a month to three complaints for each of the months of May, June and July 2013. They were referred because of the unacceptable delay. Additionally, the Ombudsman service did not appear to be aware of the changes to the handling of primary care complaints, which led to further confusion and lack of clarity in terms of the responsible organisation.<sup>18</sup>

50. In the light of that evidence, it is not surprising that in its submission HAPIA describes primary care complaints as a ‘complete and utter mess’ and ‘a perverse way of running a system’.<sup>19</sup>

51. NHS England accepts that it initially did not have adequate capacity to handle complaints, and that there was higher than expected demand: it says its service has now improved.<sup>20</sup> It maintains that its centralised approach to complaint handling is appropriate in certain circumstances and brings benefits, but it has the arrangements under review.<sup>21</sup> Neil Churchill, NHS England’s Director for Improving patient Experience, told us in correspondence:

Your challenge about whether our approach is sufficiently local to optimise patient satisfaction and learning from complaints is nevertheless well made. We are certainly open to ideas about how we can organise our complaints handling differently if this will benefit patients. However, this will need to be in the context of the further 15% cut in our running costs from next April, which will inevitably mean reductions in the number of staff in our local teams. It may be the case, for example, that the greater involvement of Clinical Commissioning Groups (CCG(s)) in complaints will help drive improvements in clinical practice or the administrative systems used by GPs, dentists and optometrists. As you know, NHS England is currently exploring co-commissioning of primary care with CCGs and as part of that we are certainly prepared to design, pilot and evaluate a different approach to complaints management in partnership with a CCG, or a cluster of CCGs. This will enable us to measure levels of patient satisfaction, learning from complaints and value for money against our existing models of delivery. We

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18 [CRC 111](#)

19 [CRC 109](#)

20 [CRC 115](#)

21 *ibid*

will be delighted to talk to Dr Barrell about how we might design such a pilot and would be happy to inform you and the Committee about the results.<sup>22</sup>

**52. The Committee is concerned about the effects of centralising complaint handling in primary care by NHS England. We do not believe that primary care complaints should be investigated in a different region. This has led to fragmentation and disconnection from local knowledge and impaired the ability to deliver a timely response and learn from complaints. We recommend NHS England reports on progress on providing a primary care complaints system that is responsive to patients in a timely manner and which results in local learning and improvement.**

### Complaint handling in social care

53. The complaints system in social care is functionally separate from the complaints system in health care, though each is governed by the same set of regulations: complaints about care homes arising from the social services function of a local authority follow a different route from complaints about NHS providers. HAPIA call for a ‘consistent easily-understood system across the country’<sup>23</sup> which uses common terminology and clear and unambiguous approaches to complaint handling. In written evidence, Which? sets out some of the anomalies of the current position, with separate systems for local health and care complaints. At the second tier, the situation becomes more complicated:

At the second tier, there are several ombudsmen and other bodies operating in the same space, with overlapping coverage that varies depending on how the service is funded and which part of government has oversight. As well as making the system more complex for the user to navigate, this also increases the risk that systemic problems are overlooked or fall through the gaps.

For example, an individual with a complaint about a nursing home could potentially take their complaint to two or three different ombudsmen depending on who the responsible department is and how their place at the home is funded. If it were a social care issue they would need to go to the Local Government Ombudsman (LGO), but if it related to a health matter they would need to approach the Parliamentary and Health Services Ombudsman (PHSO). If the complaint straddled both of these issues, it would fall under the remit of both ombudsmen, and the user would need to decide which to go to. If it was regarding a health matter that was privately-funded, they would not have any access to PHSO.<sup>24</sup>

54. The solution that Which? and others propose is, as we have discussed earlier, a single access point:

The Government should establish a ‘one-stop’ telephone and web complaints portal for public services along the lines of the Complaints Wales service, run up by the Welsh Public Services Ombudsman. Its functions would include

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22 [CRC 115](#)

23 [CRC 109](#)

24 [CRC 85](#), paras 19 and 20.

signposting people to the right body for first-tier complaints, directly sending their complaint to providers and commissioners if they wish, and acting as a gateway for second-tier complaints, directly sending people's complaints to the relevant ombudsman service.

Behind this one-stop portal there should sit a rationalised set of public services ombudsmen with consistent powers and processes that would mirror the regulatory landscape...<sup>25</sup>

**55. On the evidence we have heard there is a strong case for working towards the integration of social care complaints into a single complaints system. As a first step we consider there should be a single health and social care ombudsman.**

### ***Complaints to the regulator***

56. The Relatives and Residents Association<sup>26</sup> are critical of CQC's approach to issues raised with them by individuals. They note that CQC seeks feedback and yet says that it cannot address individual complaints. The RRA are also concerned that the information that is provided is not being used to pick up on poor care generally:

This continuing misguided policy means that a great deal of important intelligence, often needing urgent investigation and, sometimes enforcement, is missed or lost. This also means a further loss of trust by relatives and the general public in CQC's efficacy.<sup>27</sup>

57. The CQC itself insists that this information is used;

Information from people who use care services about the quality and safety of their care, including their concerns and complaints, is a vital source of information for our new surveillance model. We will make systematic use of people's views and experiences, including complaints and views of staff, along with information from local and national data and intelligence sources, previous inspections, and from local authority overview and scrutiny committees. We will place more emphasis on the content and trends in complaints made and will consider how complaints are handled and responded to by providers when we carry out inspections. We will also make sure we understand the reality of people's individual experiences of care, including working closely with local Healthwatch and local voluntary groups.<sup>28</sup>

58. David Behan emphasised this point in oral evidence:

...we do not have the ability to adjudicate complaints and work towards resolving them. But...the intelligence that we gather from people who raise

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25 Ibid para 28

26 [CRC 105](#)

27 CRC 105, para 9.

28 [CRC 95](#) para 15

concerns is absolutely essential to us so that we can assess whether their complaint is something that has affected just them or whether there is a pattern of complaints coming from, say, maternity care, and if there was that would then inform our inspection plans.<sup>29</sup>

59. There has now been a further development, with the CQC publishing its report *Complaints Matter*. This reiterates many of the points made in the CQC written and oral evidence about its use of complaints as intelligent monitoring of the system, but also sets out how it will from now on look at the way an organisation deals with complaints as part of its inspection process:

In October 2014 we introduced a mandatory key line of enquiry for inspections of hospitals, mental health services, community healthcare services, GP practices, out-of-hours services and adult social care services. This looks at how well complaints and concerns are handled. This assessment forms part of our judgement and rating of an organisation's responsiveness. For consistency in all inspections, this will apply to dentists, independent hospitals and ambulance services from April 2015.

New and robust methods help inspection teams to understand how well providers listen to people's concerns and learn from them to improve quality.

Before a CQC inspection, we gather information relating to complaints and concerns, including details from partners such as the health and social care ombudsmen, local authorities, Healthwatch England and complaints advocacy services.

We request a range of information from providers before we inspect, such as a summary of complaints from the last 12 months and how these were resolved.

We ask what people who use services think about the way complaints and concerns are handled, using surveys, comment cards, and conversations during inspections, often led by CQC's Experts by Experience.

During site visits, our inspectors review a sample of complaints files to understand if these have been handled in a way that matches the good practice we expect to see.

On large inspections (in hospitals, mental health services and community healthcare services), we are introducing a lead inspector for complaints and staff concerns to draw evidence together.

Our inspection reports now include a description of the provider's handling of complaints. And the new fundamental standards include requirements around complaints handling as well as the new duty of candour. Where we find breaches of these standards, we will use our range of enforcement



powers: warning notices, suspending or cancelling registration and ultimately prosecution. We will work with partners to encourage improvement.<sup>30</sup>

60. This move by CQC to make examination of complaints processes part of its inspection model is very welcome. In time, this should lead to a significant increase in the attention that organisations pay to the way in which they handle complaints and therefore to an improvement in quality. It does not resolve the problem of how individual complaints raised with CQC can be addressed, but it may provide the impetus for the degree of system-wide improvement that the Committee and many others wish to see.

61. The *Complaints Matter* report also addresses the issue of concerns raised by staff. It says that

We expect complaints and concerns to be used to improve the quality of care, and that employees who raise concern are valued, respected and protected. Reprisals such as victimisation or bullying are unacceptable.

In every inspection and as part of assessing an organisation's leadership, CQC will look at processes in place to handle staff concerns.<sup>31</sup>

We look at issues connected with staff raising concerns in the final section of this report.

## Complaint advocacy services

62. Advocacy services can play a significant role in helping people to raise complaints and concerns about care and related issues. The problem that has been expressed to us is that those services are fragmented and difficult to find. Robert Francis told us:

I am concerned at what is or is not happening with advocacy services and the support network. It does seem to be more fragmented even than it was at the time I looked at it. I am concerned about how that is funded and what is happening with the money around that, but most importantly I think it is becoming more difficult than it was for people to find what is the advocacy service. I recently had an experience where a letter arrived and I thought the answer to it would be to put the individual in touch with the advocacy service appropriate for the particular hospital that the complaint was about. I am afraid I spent 20 minutes on the internet and was none the wiser. If I could not find it, then I don't know how a member of the public was expected to, so I think there is work to be done there.<sup>32</sup>

63. One arm of the advocacy arrangements is the Patient Advice and Liaison Service. As we noted in our previous report:

Patient Advice and Liaison Services (PALS) were established across the NHS between 2000 and 2002 and aim to ensure that the NHS:

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30 [Complaints Matter](#), CQC, 8 December 2014, summary

31 *ibid*

32 Q 25

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

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.

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.

Although PALS are not formally seen as part of the two stage complaints process, 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.<sup>33</sup>

64. The picture on PALS services in NHS Trusts is very mixed. They can work well, but are not equipped to deal with complex cases and are seen by many as lacking independence as in some places they are part of the complaints system as well as acting as advocates. As Healthwatch England told us:

Some people have told us that they are very happy with advocacy services, specifically mentioning that PALS helped to sort out their problem and gave them confidence in the complaints system. However, other people have told us that advocacy can be hard to access and of poor quality, and told us about bad experiences they had with PALS.<sup>34</sup>

At the time of our earlier inquiry, advocacy was provided through the Independent Complaints Advocacy Service (ICAS). Although the experience of the service was good for many patients, the service was found to be inconsistent and some patients were not aware that it existed. As part of the changes brought about by the Health and Social Care Act 2012, ICAS ceased to exist on 31 March 2013. From 1 April 2013, commissioning of NHS complaints advocacy services transferred to individual Local Authorities.

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33 Health Committee, [Complaints and Litigation](#), paras 51 to 53

34 [CRC 69](#) para 22.

65. While the Committee supported proposals for local commissioning of advocacy services in its 2011 report, it appears from the evidence that this commissioning has not had the desired effect. NHS Advocacy services are now commissioned locally, and there is a patchwork of different types of provision. Some services are provided by local Healthwatch, others by third party services, and these can be difficult to identify and locate. Healthwatch England told us that:

We have heard that many of the NHS Complaints Advocacy Services are asked to work under tight budget constraints, and that they sometimes have to limit the number of people they meet with to provide assistance. In some areas, the same organisation that runs Local Healthwatch also runs the complaints advocacy service, which helps to join-up different complaints advocacy and support. However, there is inconsistent access to complaints advocacy across areas based on the appetite of councils and availability of resource.<sup>35</sup>

**66. We recommend that there should be clear commissioning and consistent branding of PALS and NHS Advocacy services to make them as visible and effective as possible to any patient seeking assistance through the complaints process. Current arrangements are variable and too often unsatisfactory.**

**67. In its written evidence the Department of Health said that it would begin a review of PALS services in 2014 and would also review the commissioning arrangements for independent advocacy services. In responding to this report, we ask the Department to set out what progress has been made in reviewing the commissioning arrangements for advocacy services.**

68. HAPIA<sup>36</sup> raise concerns about the role of local Healthwatch following changes legislated for in the Health and Social Care Act 2012. It argues that they are not public facing, and they have no role in complaints advocacy unless commissioned to provide a specific service.

69. HAPIA also allege that local Healthwatch have little information on the performance of providers on complaints issues, since they are not routinely provided with qualitative data from complaints (either by providers or commissioners).

70. There is general concern over the effectiveness of operation of local Healthwatch. While we were quoted examples in evidence of local Healthwatch organisations (e.g. Peterborough)<sup>37</sup> making a difference to local complaint handling, the picture which emerges is of a patchwork of local accountability with worrying potential for gaps.

71. Since funding provided to local authorities for Healthwatch has not been ring fenced, there are suggestions that it has not all been spent on Healthwatch activities and that as a consequence some local Healthwatch organisations are under-resourced. Lisa O'Dwyer, of Action against Medical Accidents, told us:

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35 [CRC 69](#), para 23

36 [CRC 109](#)

37 Q 47

I think there are difficulties with local Healthwatch. Certainly from what we have seen, the service is not consistent. I don't know if that is because of funding. There seem to be differences in funding. There are problems with that. I don't know how accurate the reports are, but apparently the funding that was allocated is £10 million short, and I think there are further complications because the funding has not been ring-fenced specifically for complaints. It goes to the local authority, and it is for the local authority to decide how best the complaints need to be served, so I think there are real difficulties. If you are going to look at strong complaints, you need uniformity and consistency. That is not going to happen unless it is properly funded.<sup>38</sup>

**72. We recommend that the Government provide a progress report on the functioning, funding and budgets of local Healthwatch organisations, in order that the information be available to our successor Committee.**

### 3 The second stage: the Health Service Ombudsman

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73. The Health Service Ombudsman acts as the second stage in the complaints process, reviewing complaints which have not been resolved by complaint to the provider or commissioner.

74. When we looked at the role of the Ombudsman in 2011, we reported on three areas of concern:

- That very few complaints were formally investigated at this second stage (although a considerably larger number were ‘informally’ examined);
- That a significant number of cases were not further examined because there was essentially no prospect of the Ombudsman being able to come to a conclusion, these often being described as cases on which there was likely to be “no worthwhile outcome”, an unfortunate phrase that caused considerable distress and anger
- That many people approached the Ombudsman’s office thinking it provided a general appeal mechanism but the legal framework under which it operated gave it a narrower focus which those looking for redress found frustrating.<sup>39</sup>

75. Some of these Committee concerns about the Ombudsman have been addressed:

- The phrase ‘no worthwhile outcome’ is no longer used
- There has been a change in the threshold used for acceptance of complaints<sup>40</sup>
- The Ombudsman is now accepting more complaints for investigation than hitherto, with a fourfold increase in investigations in the current year.<sup>41</sup>

76. These developments were commented on by both Anna Bradley of Healthwatch England and Robert Francis. Anna Bradley said that

One of the very good news stories from the consumer and user perspective is that the Ombudsman is very clearly committed to investigating a much larger number of complaints that come their way, and that is very helpful.<sup>42</sup>

Robert Francis said that “my impression is that there is less effort put into finding reasons not to investigate the complaint when it comes to the Ombudsman”.<sup>43</sup>

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39 Health Committee, [Complaints and Litigation](#), paras 48 to 50

40 [CRC 91](#), para 4.3

41 CRC 91, para 4.2

42 Q33

43 *ibid*

77. Ombudsman services are under review by Robert Gordon CB, commissioned by Cabinet Office. Pending the outcome of that review, the Ombudsman has put forward her own requests for the reform of legislation. These include:

- Removal of the requirement for complainants to make requests ‘in writing’
- Removal of the bar on accepting cases when alternative legal remedy available
- Introduction of own-initiative investigation power
- The creation of a single public services ombudsman, combining the role of PHSO and LGO<sup>44</sup>

78. On that final point, the Ombudsman, together with the Local Government Ombudsman and Healthwatch England, has published a service-user led vision for complaints, *My expectations for raising concerns and complaints*. This delivers on a commitment made after the publication of the Francis report for these three organisations to develop “a user-led ‘vision’ of the complaints system.”<sup>45</sup> Other organisations have also committed to using the framework that has been developed, including CQC in its inspection regime, and NHS England, which will link it to its outcomes framework.

**79. We welcome the work that has been done to produce what is essentially a best practice guide to first-tier complaints handling. There can be no excuse now for any health or care organisation not to have an appropriate mechanism in place to deal with concerns and complaints. It represents an important first step towards an over-arching, single access-point complaints system.**

80. Despite the progress that we have noted here, however, significant concerns remain about the Ombudsman’s own performance in assisting complainants to achieve redress. For example, the PHSO Pressure Group told the Committee that it was unhappy with the standard of investigation:

Whist we commend the Ombudsman for investigating more cases and agree that complainants feel more satisfied if their concerns have received a full investigation; we are concerned about the quality of investigations and the delivery of factually accurate reports. If key issues are overlooked then no action is taken to prevent future harm to patients. In our experience PHSO too often find in favour on minor issues and fail to uphold significant breaches due to a failure to properly collect or evaluate the evidence. Quality must not be sacrificed in order to achieve high case turnover as this will lead to continued public dissatisfaction and failure to properly hold NHS Trusts to account.<sup>46</sup>

81. Ann Clwyd was also critical of the historic situation of few cases being formally investigated, as well as expressing concerns about perceptions of independence:

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44 [CRC 91](#), para 4.7

45 [My expectations](#), page 4

46 [CRC 92](#), section 8

I felt that a large number of complaints go to the Ombudsman but very few are investigated. I think people felt quite angry about that. To take it as far as the Ombudsman requires a lot of effort, and if people find the Ombudsman is only dealing with a small number, they feel angry and frustrated. The feeling was that the Ombudsman was too far away from the action and that it would be good to have a local-type Ombudsman in a region—not only an Ombudsman based in London, but somebody that people could feel they could relate to more easily...

Independence from the NHS is something people felt very strongly about, and they did not feel, even though they know the Ombudsman is independent from the NHS, that the system was independent enough. It is quite a big organisation, and it was felt that it should be looking at a larger number of complaints, but also, basically, that it should be closer to the people making the complaints.<sup>47</sup>

82. Perhaps most significantly, in November 2014 the Patients' Association announced that it would no longer be able to recommend that complainants seek redress through the Ombudsman, because of the poor quality of investigations and the consequent distress to patients and their families.<sup>48</sup>

83. Katherine Murphy of the Patients Association said that

We receive cases every week where people are distressed and even traumatised by the way their case has been mishandled by the PHSO.

The Health Ombudsman should be a court of last resort where uncorrected mistakes by the NHS can finally be put right, but the process is not fit for purpose and often ends up compounding the grief of families. The quality, accuracy, objectivity, effectiveness, openness and honesty of its reports is shameful.

The PHSO cost to the public purse is around £40 million a year, but we have no idea how it really does its job. The total cost to society and families far exceeds the £40 million funding the Ombudsman receives. The emotional cost for families far outweighs the huge financial cost...

We cannot expect Trusts in the NHS to handle complaints appropriately if they are confident that the PHSO will not find failings against them. Radical reform in complaints handling is of paramount importance across the NHS and the PHSO.<sup>49</sup>

84. The PHSO issued a statement in response which said that

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47 Q 14

48 [Parliamentary and Health Service Ombudsman The 'Peoples' Ombudsman – How it Failed us](#), Patients Association, 18 November 2014

49 [Patients Association press release](#), 18 November 2014

Every time someone has a poor experience of our service it really matters to us and we work hard to put things right.

As announced last month, we've embarked on the second part of our modernisation drive. We are engaging with complainants, including some of the people mentioned in this report which features seven cases, to help draw up a service charter - a set of promises to users about what they can expect when they use our service. We are pleased the Patients Association has agreed to be part of this work.

We are committed to acting on feedback from users of our service. The first part of our modernisation drive was to investigate more cases. In 2013-14 we investigated six times more complaints than in previous years (384 to 2199). We have maintained satisfaction levels and halved the average time taken to complete a case. We are modernising our service to provide an even better service to the 27,000 complainants whose cases we deal with every year.

85. The Parliamentary and Health Service Ombudsman, Dame Julie Mellor, gave evidence to us before the Patients Association published its report, but she did discuss with the Committee the criticisms that were made about the PHSO not investigating adequately on the basis of the evidence that complainants had provided.

Nearly all those cases were historical cases where the organisation had declined to investigate the cases. They never had an investigation report where they could look at the draft and comment. What they got was a reason for the decision not to investigate, which would include some reference to information they had received from the service provider. I can quite understand that it would feel as if that was biased information, and it is part of why we changed. It is part of why we are making sure that what they get is a formal investigation report that lays out the evidence from the service provider and from the complainant, gives our findings based on those facts and then gives an adjudication. Again, I think it is a historical problem that is related to how people felt about the letters they got saying we were declining to investigate. It is different when we are investigating.<sup>50</sup>

86. The experiences of the families quoted in the Patients Association report make for sobering reading. For a major patient advocacy charity to no longer support the second stage of the complaints system is a worrying development, and must result in a thorough examination of the criticisms it has made. The progress that is being made in increasing the numbers of investigations and in modelling a better complaints system will count for nothing if the public perception of the PHSO is that its investigations take too long, require too much of those who are complaining and do not provide appropriate redress at the end of the process.

87. The Ombudsman, appearing before the Public Administration Select Committee (PASC) on 10 November 2014, acknowledged that there are difficulties arising from being



part way through a system change and taking on substantially more cases.<sup>51</sup> PASC has challenged Ombudsman on use of internal and external review of cases and judgment. The Ombudsman accepted the need to focus on the quality of their work. She said that they would in future ask complainants to give feedback on quality of investigation at the draft report stage.<sup>52</sup>

88. The accountability of the Ombudsman is important, especially since decisions cannot be challenged save through judicial review. The Ombudsman is accountable to the House through PASC, which is given the task of examining reports of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England: that Committee has undertaken to follow up issues raised in Ombudsman reports, including on issues relating to the health service.

89. It is clear that the Health Service Ombudsman is going through a process of substantial change, with a welcome increase in acceptance of complaints for investigation. We also welcome the way in which the Ombudsman has addressed our previous concerns about the functioning of her office.

90. Complainants expect investigations to be carried out in a thorough, timely and accurate fashion, with all relevant evidence properly assessed and fully taken into account and institutions tackled robustly. While it is welcome that the Ombudsman has undertaken to share draft findings with complainants and has allowed them the opportunity to comment, we are concerned by reports about the time taken to complete Ombudsman investigations, the quality of initial investigations undertaken and the availability of medical expertise to assess evidence.

**91. The serious criticisms of the Ombudsman from the Patients Association are of grave concern. We recommend that an external audit mechanism be established to benchmark and assure the quality of Ombudsman investigations. In her response to this report we ask the Ombudsman to set out how her organisation is seeking to address problems with its processes, and a timetable for improvements.**

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51 See for example, PASC, [10 November 2014](#), Q 61

52 Ibid, Q 24

## 4 Professional regulators and complaints

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92. The GMC and the NMC both gave evidence on their handling of complaints made against their registrants. This builds on work we have previously undertaken in accountability hearings.

93. Both have undertaken to give greater assistance to the public in supporting complaints made against medical professionals, for instance in support to witnesses appearing in disciplinary cases. Niall Dickson, Chief Executive of the GMC told us:

...one of the key areas that we highlighted in the pledge to the Clwyd/Hart review was about how we support complainants through our process. Traditionally, it has to be said that the GMC...historically have dealt with complainants by writing them letters, often fairly legalistic letters, which are sometimes difficult for complainants to understand, and then the only time that they would see the complainant would be when they turned up for a hearing, if there was a hearing in that particular case. So we have started a process...whereby we actually meet complainants...at the start of the process...

This gives us an opportunity first of all to set expectations, because sometimes complainants have unrealistic expectations of what our processes can do, but also to listen to them, what is really concerning them and what they wish addressed. There is that initial meeting and then there is somebody there to whom they can go during the process. We are also meeting them at the end of the process, when the process is concluded, to explain what has happened during the process and why the decisions, whatever the decisions are, have been made in that. That process of face to face meetings is, as I say, obviously at a very early stage...but the early signs are that patients and relatives really welcome this. Inevitably, you will get more positive at the beginning than at the end because, in our business, inevitably, some people are disappointed at the end of the process, whether they are the doctor or indeed the patient who is complaining.<sup>53</sup>

94. For the NMC, Sarah Page, Director of Fitness to Practise, told us that

...during last year we spoke to a number of witnesses who had been involved in our hearings and asked them about their experience, from making the referral or the complaint to us in the first place through the process up to the point of attending one of our hearing centres. Using that information, we identified some of the things that we needed to improve. One of them was around having, for example, a single point of contact for a witness through the proceedings. Another was about just making sure we kept people

informed at the various stages as things progressed. Witnesses also told us that the actual environment where they had to attend to give evidence was very important to them, and we have made a number of improvements based on that—to make the hearing centre a place that is more comfortable to wait in so that witnesses feel more relaxed when they are called upon to give evidence and various other changes of that type, including providing better training to our staff and our panel members so that they are all aware of how difficult it is to carry through a complaint to the end. What we are intending to do later on this year is to go back and do the evaluation of that by asking another group of witnesses whether or not the changes we have made have brought about improvements.

...One of the things that is important for us to address right at the beginning is managing the expectation of the person who is complaining to us in terms of what we can do—what changes we can effect...we are a regulator that regulates individuals. We can take action to protect the public. We can't necessarily resolve all the issues that the witness may have brought to the table, so part of what we do at the beginning is making sure that the witness understands the part they are playing in the process and what the possible outcomes may be. Also, in terms of demystifying the process, we offer an opportunity to witnesses to come and have a look at a hearing centre, sit in the place where they are going to give evidence and also understand some of the jargon and some of the questions they may be asked, to try and help people through that process.<sup>54</sup>

95. The GMC also made clear that its purpose is to hold to account the practice of its registrants only: it does not seek to involve itself in examining the clinical governance arrangements in Trusts. Niall Dickson told us:

Our focus is on individuals, not on the hospitals themselves. That does not mean, of course, that we are not concerned with or do not seek to influence the culture within organisations, nor does it mean we do not have to rely on—which we do—the recommendations, for example, for revalidation, which are based on clinical governance arrangements within these institutions. But we have neither the statutory powers, nor the resources, frankly, to start second guessing and inspecting the clinical governance arrangements, including the culture of safety...<sup>55</sup>

96. The GMC has a helpline for staff to raise concerns about medical practice, including about the practice of its own registrants. The GMC told us in August 2014 that since its establishment in December 2012 the helpline had received over 1200 calls: these had covered a wide range of issues, and were not always about the fitness to practice of a doctor. 191 of the calls received had been about matters specific to the fitness to practise of one or more doctors, and 81 investigations had been opened as a consequence. 87 of these 191 calls had been made by people who wished to remain anonymous. The GMC told us

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54 Qs 355-56

55 Q359

that “we believe that the helpline will continue to be a useful tool in helping doctors to navigate their way through the complaints/raising concerns system. We also believe it gives doctors the confidence to act when they have concerns. We will continue to support this helpline and to increase awareness of its operation among doctors and professional bodies.”

97. Of the 191 people who have contacted the GMC’s confidential helpline to raise concerns about the fitness to practise of a GMC registrant between its inception in December 2012 and August 2014, just under half have not been prepared to identify themselves. This appears odd, given the confidential nature of the helpline: it may reflect an initial lack of confidence in any protocols surrounding the helpline’s operation in its early days.

**98. While we agree with the GMC that people wishing to give information about poor practice should be able to do so anonymously, we consider that medical professionals raising concerns about poor practice via a confidential helpline are under a professional duty to provide as much information as possible to enable the matter to be investigated and to put patients first.**

99. We raised with the GMC witnesses the handling by the GMC of fitness to practise cases against registrants which had been initiated by other registrants, sometimes as counter-complaints, and by Trusts. There could often be strong conflicting claims of malpractice which were difficult to resolve, including instances where registrants were reported to the GMC for not themselves having reported instances of poor practice to the GMC earlier. Niall Dickson set out the GMC’s general approach to dealing with such contested cases:

[T]he basic principle is—and I do not think we should depart from this—that we should treat everybody the same in the sense of looking at the circumstances of their case, taking into account the context within which they have been working and then assessing the evidence to the best of our ability. The fact that somebody has complained about somebody else and then gets referred themselves—either way round—means we need to look at the circumstances of each case and examine its strengths and merits.<sup>56</sup>

100. Mr Dickson freely acknowledged that there were instances where a Trust could seek to use a referral as retaliation against a registrant raising legitimate concerns about practices in the Trust, and told us that “there is history around this of individuals who are classic whistleblowers”.<sup>57</sup> In such cases, he observed that trying to differentiate instances where a registrant was raising genuine concerns from instances where a registrant’s practice was giving genuine cause for concern and investigation was difficult. In such cases the GMC’s approach had to be evidence-led:

[...] trying to sort this out, as it were, is part of what our investigations have to do. We have to try and establish where the truth lies. We should not automatically accept, because it is a trust’s management, as you put it,

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56 Q 374

57 Q 381

putting in the complaint, that they are right and that the individual is wrong. You have to take it on the basis of the evidence that we are presented with.<sup>58</sup>

101. Niall Dickson was clear in evidence that the GMC wanted to support a more open culture in response to complaints, but that the way to achieve this was not to be heavy-handed in disciplinary matters:

The idea that people will become more transparent and open because there is more threat on them I don't think works. I think we have to use another set of levers, more difficult and more complicated levers.<sup>59</sup>

He said that his concern was “the responsible officer level, the medical directors, who are, I think, beginning to take on the role of revalidation. We will absolutely hold them to account for what they do, but we also absolutely want to support them in doing what I think is a really difficult job”.<sup>60</sup>

102. In response to concerns raised by the Committee about past disciplinary treatment of medical professionals who have raised concerns, the GMC has established a review chaired by Sir Anthony Hooper to examine how it deals with doctors who raise concerns in the public interest. Niall Dickson told that “One of the things we are prepared to do is to review how we handle the whistleblowing area and how we manage to deal with people who are saying they are whistleblowers. We want to get this right.”<sup>61</sup>

103. The GMC acknowledges the complexity of many the cases it has to deal with, particularly where registrants and Trusts are involved in referrals and counter-referrals, and where there are strong conflicting claims of malpractice. The GMC has to take such cases on a case by case basis, and has defended to us its approach, which is to examine the evidence on all sides and see where it leads. It is inevitable that in such cases fine judgments will have to be made between competing claims in the GMC's adversarial and evidence-based processes which determine fitness to practise. The GMC has committed itself to a review of its practices, which we discuss further below. **We welcome the willingness of the GMC to review its practices and investigations to ensure that they adequately support registrants who genuinely raise patient safety concerns in the public interest, and protect them from retaliatory action. Such a review must have as its primary purpose the establishment of an open reporting culture.**

104. **The Committee welcomes the GMC initiative in establishing the Hooper Review to examine how it deals with doctors who raise concerns, and looks forward to examining its conclusions.**

105. Professional regulation is not formally part of the complaints system, but holding clinical professionals to account for failings which may have had significant effects on patients is an important part of protecting patients. Both the GMC and NMC are grappling with the issue of how to support those who raise concerns about clinical staff and advise

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58 Q 382

59 Q 389

60 *ibid*

61 Q 383

them on what is and is not likely to be the outcome. Given the seriousness of the sanctions that can be applied by the professional regulators, the processes are necessarily very formal and, as with other issues we discuss in this report, change is an incremental process. **Linking together professional regulation, system regulation and the complaints system is essential. Progress towards this goal is another issue that our successor Committee will need to monitor in the next Parliament.**

## 5 Treatment of staff raising concerns

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106. The treatment by NHS organisations of staff who raise concerns in the public interest about their organisation has long been a matter of controversy. Several NHS employees who have raised concerns about poor clinical or management practice in Trusts, and who can consider themselves vindicated by the findings of subsequent inquiries, nevertheless consider that they have suffered detriment as a result of their whistleblowing, through management or professional disciplinary action, victimisation, severance or dismissal.

107. The Government argues that whistleblowers are protected from detriment by the Public Interest Disclosure Act (PIDA). But evidence from Public Concern at Work and others argues that PIDA is a deterrent rather than a remedy, and that if an employee has to have recourse to PIDA's provisions then his or her prospects are already substantially impaired. Cathy James, Chief Executive of Public Concern at work, told us:

[PIDA] is a vehicle for protection that is not really about protection but about looking back at the damage that has been done. We have always said when working with organisations, and in the model policy that we talk about, in all sectors, but particularly in health, that the Public Interest Disclosure Act is not mentioned until probably the last line of the policy: "If you are worried about your rights, you can look it up." It is the way somebody is going to sue an organisation, not the way an organisation encourages its staff to speak up. What they should be doing is giving very clear assurances on the position of the individual, clear assurances on confidentiality and clear assurances around not tolerating victimisation, and acting on it where people have meted out reprisal.<sup>62</sup>

108. The Committee has said previously that employment tribunals and related fora are no place for honestly-held concerns about patient safety and similar issues to be debated.<sup>63</sup> A means must be found for health and care service workers to be able to speak up safely about professional concerns.

109. The Committee's position has long been that there is an unambiguous professional duty on professional registrants to speak up, but that equally there is a similar duty on employers to establish an open culture which encourages concerns to be raised and acts to address and resolve them, rather than punish the person raising them. There are welcome signs that this is being addressed but only in some areas, for example through the role established for Helene Donnelly at Staffordshire & Stoke on Trent Partnership NHS Trust. This kind of initiative is sadly far from common, and her evidence indicated that there is a long way to go to achieve the necessary cultural change across the system.

110. In a development which the Committee welcomes, in June 2014 the Secretary of State appointed Sir Robert Francis to lead an independent review into creating an open and honest reporting culture in the NHS. The Freedom to Speak Up review sought evidence from staff across the NHS on their experiences of raising concerns and comments on how

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62 Q 128

63 Health Committee, Third Report of Session 2012–13, [After Francis](#), HC 657, para 69

the process might be improved. The Review received more than 600 written responses and 17,500 online responses and will report early in 2015.<sup>64</sup>

111. It is to be hoped that the findings of the Freedom to Speak Up review will set out a template for dealing with these issues. The Francis review is explicitly not a forum for the airing and redress of historic cases. While those who claim to have suffered detriment unfairly for having raised concerns have been encouraged to engage with the Francis process, it will not provide them with individual redress.<sup>65</sup> As the Minister made clear, it will be difficult for any measures to be given an explicit retrospective and restorative effect.<sup>66</sup>

112. It is clearly unacceptable if any employee in public service suffers detriment for having raised a concern in good faith. While PIDA provides protection against detriment, its effect is meant to be deterrent rather than restorative, and the complexity of the legislation is such that success in a case brought under PIDA cannot be guaranteed.

113. The Francis review is welcome, as the treatment of whistleblowers is a stain on the reputation of the NHS and has led to unwarranted, inexcusable pain for the courageous individuals affected. The aim for an NHS complaints and raising concerns system must be to establish a reporting culture in the health and care sector which parallels the open reporting culture on other safety-critical sectors such as aviation and nuclear energy: one in which the concept of the whistleblower is quite simply redundant.

**114. The failure to deal appropriately with the consequences of cases where staff have sought protection as whistleblowers has caused people to suffer detriment, such as losing their job and in some cases being unable to find similar employment. This has undermined trust in the system's ability to treat whistleblowers with fairness. This lack of confidence about the consequences of raising concerns has implications for patient safety.**

**115. We expect the NHS to respond in a timely, honest and open manner to patients, and we must expect the same for staff. We recommend that there should be a programme to identify whistleblowers who have suffered serious harm and whose actions are proven to have been vindicated, and provide them with an apology and practical redress.**

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64 Health Service Journal, [Francis whistleblowing review delayed](#), 27 November 2014,

65 As Sir Robert says on the [Review website](#), "*This Review is not about deciding on past judgements and I realise that I am asking something quite difficult of people; that they tell me about their personal experiences of making disclosures in the public interest without me being able to do anything to resolve their individual cases. Nonetheless I hope that people will come forward to the Review and share their views and experiences in order to help inform better practice in the future.*"

66 Q 498-501



# Conclusions and recommendations

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## Developments since the Committee's 2011 report

1. There is no doubt that the landscape has changed significantly since our earlier inquiry. Patient safety and the treatment of complaints and concerns have become high profile issues. There is equally no doubt that we are only at the beginning of a process of change with significant scope for further improvement. (Paragraph 10)
2. We recommend that the Government publish a detailed evaluation of the progress achieved, and work remaining to be undertaken, by the Complaints Programme, in order for the public and our successor Committee in the next Parliament to be able to monitor progress. The Department should also include an evaluation of the operation of the complaints system across the health sector in the light of the post-Francis changes. A review was promised for 2014 but has not been undertaken. (Paragraph 14)
3. While there have been some improvements there are still too many individual cases which are mishandled, from instances of poor communication to those which end in a complete breakdown in trust between patients, their families and NHS institutions. (Paragraph 16)
4. We recommend that our successors on the Health Committee in the next Parliament continue this work of monitoring improvement in the complaints process. (Paragraph 18)

## What should good complaint handling look like?

5. We recommend that Trusts be required to publish at least quarterly, in anonymised summary form, details of complaints made against the Trust, how the complaints have been handled and what the Trust has learnt from them. (Paragraph 27)

## Complaint handling by providers

6. We agree that the onus should be on the system to help a complainant. People should not be forced to search out the most appropriate way to raise concerns. We recommend that the complaints system be simplified and streamlined by establishing a single 'branded' complaints gateway across all NHS providers. This should be available online, but not exclusively so. There should be adequate resourcing to enable complaints to be examined, identified, and directed speedily to the appropriate channel. (Paragraph 31)
7. The relationship between the provider and the commissioner is, in our view, key to determining the day-to-day quality of services provided under NHS contracts. It is the commissioner which is best placed to work constructively with the provider on delivering improvements. We do, however, expect the CQC to examine the culture of complaints handling by providers. (Paragraph 42)

### Role of commissioners in complaints, and handling of complaints by commissioners

8. We recommend that the system for service users to make complaints to commissioners about NHS services should be integrated into a single complaints system. Commissioners need to take a far greater role in holding providers to account for delivering a well-functioning complaints system. (Paragraph 47)

### Complaints handling in primary care

9. The Committee is concerned about the effects of centralising complaint handling in primary care by NHS England. We do not believe that primary care complaints should be investigated in a different region. This has led to fragmentation and disconnection from local knowledge and impaired the ability to deliver a timely response and learn from complaints. We recommend NHS England reports on progress on providing a primary care complaints system that is responsive to patients in a timely manner and which results in local learning and improvement. (Paragraph 52)

### Complaint handling in social care

10. On the evidence we have heard there is a strong case for working towards the integration of social care complaints into a single complaints system. As a first step we consider there should be a single health and social care ombudsman. (Paragraph 55)

### Complaint advocacy services

11. We recommend that there should be clear commissioning and consistent branding of PALS and NHS Advocacy services to make them as visible and effective as possible to any patient seeking assistance through the complaints process. Current arrangements are variable and too often unsatisfactory. (Paragraph 66)
12. In its written evidence the Department of Health said that it would begin a review of PALS services in 2014 and would also review the commissioning arrangements for independent advocacy services. In responding to this report, we ask the Department to set out what progress has been made in reviewing the commissioning arrangements for advocacy services. (Paragraph 67)
13. We recommend that the Government provide a progress report on the functioning, funding and budgets of local Healthwatch organisations, in order that the information be available to our successor Committee. (Paragraph 72)

### The second stage: the Health Service Ombudsman

14. We welcome the work that has been done to produce what is essentially a best practice guide to first-tier complaints handling. There can be no excuse now for any health or care organisation not to have an appropriate mechanism in place to deal with concerns and complaints. It represents an important first step towards an over-arching, single access-point complaints system. (Paragraph 79)

15. The serious criticisms of the Ombudsman from the Patients Association are of grave concern. We recommend that an external audit mechanism be established to benchmark and assure the quality of Ombudsman investigations. In her response to this report we ask the Ombudsman to set out how her organisation is seeking to address problems with its processes, and a timetable for improvements. (Paragraph 91)

### Professional regulators and complaints

16. While we agree with the GMC that people wishing to give information about poor practice should be able to do so anonymously, we consider that medical professionals raising concerns about poor practice via a confidential helpline are under a professional duty to provide as much information as possible to enable the matter to be investigated and to put patients first. (Paragraph 98)
17. We welcome the willingness of the GMC to review its practices and investigations to ensure that they adequately support registrants who genuinely raise patient safety concerns in the public interest, and protect them from retaliatory action. Such a review must have as its primary purpose the establishment of an open reporting culture. (Paragraph 103)
18. The Committee welcomes the GMC initiative in establishing the Hooper Review to examine how it deals with doctors who raise concerns, and looks forward to examining its conclusions. (Paragraph 104)
19. Linking together professional regulation, system regulation and the complaints system is essential. Progress towards this goal is another issue that our successor Committee will need to monitor in the next Parliament. (Paragraph 105)

### Treatment of staff raising concerns

20. The failure to deal appropriately with the consequences of cases where staff have sought protection as whistleblowers has caused people to suffer detriment, such as losing their job and in some cases being unable to find similar employment. This has undermined trust in the system's ability to treat whistleblowers with fairness. This lack of confidence about the consequences of raising concerns has implications for patient safety. (Paragraph 114)
21. We expect the NHS to respond in a timely, honest and open manner to patients, and we must expect the same for staff. We recommend that there should be a programme to identify whistleblowers who have suffered serious harm and whose actions are proven to have been vindicated, and provide them with an apology and practical redress. (Paragraph 115)

# Formal Minutes

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**Tuesday 13 January 2015**

Members present:

Dr Sarah Wollaston, in the Chair

Charlotte Leslie  
Grahame M. Morris

David Tredinnick

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

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

Paragraphs 1 to 115 read and agreed to.

Summary agreed to.

*Resolved*, That the Report be the Fourth 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.

[Adjourned till tomorrow at 9.00 a.m.]

## Witnesses

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The following witnesses gave evidence. Transcripts can be viewed on the Committee's [inquiry page](#).

### Tuesday 11 February 2014

*Question number*

**Rt Hon Ann Clwyd MP**

[Q1-19](#)

**Anna Bradley**, Chair, Healthwatch, and **Robert Francis QC**, Honorary President, Patients Association

[Q20-67](#)

### Tuesday 18 March 2014

**Dr Kim Holt**, Patients First, **Helene Donnelly OBE**, Ambassador for Cultural Change, Staffordshire and Stoke on Trent Partnership NHS Trust, and **Cathy James**, Chief Executive, Public Concern at Work

[Q68-172](#)

### Tuesday 13 May 2014

**Lisa O'Dwyer**, Director of Medical and Legal Services, Action against Medical Accidents, **Liz Thomas**, Head of Policy and Research, Action against Medical Accidents, and **Sonia Sodha**, Head of Public Services and Consumer Rights Policy, Which?

[Q173-223](#)

**Dame Julie Mellor**, Parliamentary Commissioner for Administration and Health Service Commissioner for England, and **Dr Jane Martin**, Local Government Ombudsman and Chair of the Commission for Local Administration for England

[Q224-262](#)

### Tuesday 17 June 2014

**David Behan CBE**, Chief Executive, Care Quality Commission, **Professor Sir Mike Richards**, Chief Inspector of Hospitals, Care Quality Commission and **James Titcombe**, National Advisor on patient safety, culture and quality, Care Quality Commission

[Q263-338](#)

**Niall Dickson**, Chief Executive, General Medical Council; **Anthony Omo**, Director of Fitness to Practise, General Medical Council; **Jackie Smith**, Chief Executive, Nursing and Midwifery Council and **Sarah Page**, Director of Fitness to Practise, Nursing and Midwifery Council

[Q339-394](#)

### Tuesday 8 July 2014

**Dean Royles**, Chief Executive, NHS Employers, **Rob Webster**, Chief Executive, NHS Confederation, and **Chris Hopson**, Chief Executive, Foundation Trust Network

[Q395-450](#)

**Dr Daniel Poulter MP**, Parliamentary Under-Secretary of State for Health, Department of Health, **Jane Cummings**, Chief Nursing Officer for England, NHS England, and **Neil Churchill**, Director, NHS England, Improving Patient Experience

[Q451-528](#)

## Published written evidence

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The following written evidence was received and can be viewed on the Committee's [inquiry web page](#). CRC numbers are generated by the evidence processing system and so may not be complete.

- 1 Action Against Medical Accidents ([CRC0031](#))
- 2 Action on Hearing Loss ([CRC0057](#))
- 3 Andree Roberts-Keen ([CRC0062](#))
- 4 Anonymous ([CRC0034](#))
- 5 Association of McKenzie Friends ([CRC0044](#))
- 6 Care Quality Commission ([CRC0095](#))
- 7 Charter UK ([CRC0027](#))
- 8 Chartered Society of Physiotherapy ([CRC0043](#))
- 9 Cure The NHS North East ([CRC0022](#))
- 10 David Drew ([CRC0018](#))
- 11 David Rapp ([CRC0001](#))
- 12 Department of Health ([CRC0074](#)) ([CRC0114](#))
- 13 Dr Jane Cooper ([CRC0108](#))
- 14 Dr Mark Tattersall ([CRC0067](#))
- 15 Dr Mike Sheaff ([CRC0039](#))
- 16 Dr Sam Barrell ([CRC0111](#))
- 17 Eifion Edwards ([CRC0099](#))
- 18 Elsie Gayle ([CRC0070](#))
- 19 Foundation Trust Network ([CRC0056](#))
- 20 General Dental Council ([CRC0080](#))
- 21 General Medical Council ([CRC0052](#)) ([CRC0116](#))
- 22 General Pharmaceutical Council ([CRC0083](#))
- 23 Geoff Hill ([CRC0098](#))
- 24 HAPIA ([CRC0109](#))
- 25 Heal the Regulators National Campaign ([CRC0011](#))
- 26 Health and Care Professions Council ([CRC0024](#))
- 27 Healthwatch England ([CRC0069](#))
- 28 Helene Donnelly ([CRC0089](#))
- 29 Help the Hospices ([CRC0049](#))
- 30 Hospedia Ltd ([CRC0036](#))
- 31 Independent Sector Complaints Adjudication Service ([CRC0013](#))
- 32 Jackie Thompson ([CRC0009](#))
- 33 John Driskel ([CRC0059](#))
- 34 Julian Stell ([CRC0119](#))
- 35 Kenneth Lownds ([CRC0051](#))
- 36 Local Government Association ([CRC0047](#))
- 37 Local Government Ombudsman ([CRC0066](#))
- 38 London Complaints Consortium ([CRC0015](#))
- 39 Mark Stephenson ([CRC0113](#))

- 40 Medical Justice ([CRC0025](#))
- 41 Mencap ([CRC0072](#))
- 42 Mind ([CRC0033](#))
- 43 Mr Yu Tan ([CRC0002](#))
- 44 Mrs Jacqueline And Mr Phillip Naylor ([CRC0048](#))
- 45 Mrs Jill Mizen ([CRC0097](#))
- 46 Mrs June Short ([CRC0012](#))
- 47 Ms Valerie S. German ([CRC0104](#))
- 48 Narinder Kapur ([CRC0003](#))
- 49 National Institute for Health and Care Excellence (NICE) ([CRC0058](#))
- 50 NHS Confederation ([CRC0061](#))
- 51 NHS Employers ([CRC0081](#))
- 52 NHS England ([CRC0087](#)) ([CRC0118](#)) ([CRC0115](#))
- 53 Nursing And Midwifery Council ([CRC0046](#)) ([CRC0112](#))
- 54 Nursing Times ([CRC0050](#))
- 55 Office of the Children's Commissioner ([CRC0078](#))
- 56 Pamela Linton ([CRC0075](#))
- 57 Parkinson's UK ([CRC0084](#))
- 58 Parliamentary and Health Services Ombudsman ([CRC0091](#)) ([CRC0120](#))
- 59 Patient Opinion ([CRC0026](#))
- 60 Patients First ([CRC0017](#))
- 61 Pearl Baker ([CRC0004](#))
- 62 PHSO Pressure Group ([CRC0092](#))
- 63 Public Concern at Work ([CRC0101](#))
- 64 Rosemary Cantwell ([CRC0088](#))
- 65 Royal College Of Nursing ([CRC0029](#))
- 66 Royal College of Pathologists ([CRC0073](#))
- 67 Royal College of Physicians ([CRC0055](#))
- 68 Royal College of Physicians Of Edinburgh ([CRC0065](#))
- 69 Royal College of Psychiatrists ([CRC0094](#))
- 70 Royal College of Surgeons Patient Liaison Group ([CRC0077](#))
- 71 Sharmila Chowdhury ([CRC0086](#))
- 72 South West Whistleblowers Health Action Group ([CRC0041](#))
- 73 St George St Strategic Consultancy ([CRC0063](#))
- 74 Stephen Bolsin ([CRC0006](#))
- 75 Sue Ryder ([CRC0054](#))
- 76 Susan Jenkins ([CRC0007](#))
- 77 The Relatives & Residents Association ([CRC0105](#))
- 78 Tom McCartan ([CRC0117](#))
- 79 VoiceAbility ([CRC0037](#))
- 80 Wayne Stimson ([CRC0100](#))
- 81 Which? ([CRC0110](#)) ([CRC0085](#))

## List of Reports from the Committee during the current Parliament

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All publications from the Committee are available on the Committee's website at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom).

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

### Session 2014–15

First Report	2014 Accountability hearing with the Health and Care Professionals Council	HC 339 (Cm 8916, HC731)
Second Report	Managing the care of people with long-term conditions	HC 401 (HC 660)
Third Report	Children's and adolescents' mental health and CAMHS	HC 342
First Special Report	2013 accountability hearing with the General Medical Council: General Medical Council's Response to the Committee's Tenth Report of Session 2013–14	HC 510
Second Special Report	2013 accountability hearing with Monitor: Monitor's Response to the Committee's Ninth Report of Session 2013–14	HC 511
Third Special Report	Managing the care of people with long-term conditions: Monitor's Response to the Committee's Second Report of Session 2014-15	HC 660
Fourth Special Report	2014 accountability hearing with the Health and Care Professions Council: Health and Care Professions Council's Response to the Committee's First Report of Session 2014–15	HC 731

### Session 2013–14

First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584 (Cm 8735)
Second Report	Urgent and emergency services	HC 171 (Cm 8708)
Third Report	After Francis: making a difference	HC 657 (Cm 8755)
Fourth Report	Appointment of the Chair of Monitor	HC 744
Fifth Report	2013 accountability hearing with the Nursing and Midwifery Council	HC 699 (HC 1200)
Sixth Report	2013 accountability hearing with the Care Quality Commission	HC 761 (HC 1218)
Seventh Report	Public expenditure on health and social care	HC 793
Eighth Report	Public Health England	HC 840
Ninth Report	2013 accountability hearing with Monitor	HC 841 (HC 511)
Tenth Report	2013 accountability hearing with the General Medical Council	HC 897 (HC 510)
First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality	HC 154



	Commission Responses to the Committee's Seventh Report of Session 2012–13	
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee's Ninth Report of Session 2012–13	HC 581

### Session 2012–13

First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)
Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality Commission	HC 592
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and Midwifery Council	HC 639
Tenth Report	2012 accountability hearing with Monitor	HC 652
Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)

### 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 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)

Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)