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.[35]

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[36] 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)[37] 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.[38]

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.**

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38 Q 218

3 The second stage: the Health Service Ombudsman

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.[39]

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[40]
- The Ombudsman is now accepting more complaints for investigation than hitherto, with a fourfold increase in investigations in the current year.[41]

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.[42]

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".[43]

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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[44]

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."[45] 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.[46]

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.[47]

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. [48]

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, effectives, 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.[49]

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

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47 Q 14

48 Parliamentary and Health Service OmbudsmanThe '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.[50]

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

50 Q 256

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part way through a system change and taking on substantially more cases.[51] 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.[52]

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

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.[53]

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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

53 QQ 340-41

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.[54]

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…[55]

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.[56]

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".[57] 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,

56 Q 374

57 Q 381

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> 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.[58]

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.[59]

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".[60]

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."[61]

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

58 Q 382

59 Q 389

60 ibid

61 Q 383

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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.**

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5 Treatment of staff raising concerns

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.[62]

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.[63] 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

62 Q 128

63 Health Committee, Third Report of Session 2012–13, *After Francis*, HC 657, para 69

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

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.[65] As the Minister made clear, it will be difficult for any measures to be given an explicit retrospective and restorative effect.[66]

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

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)

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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)

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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)

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Formal Minutes

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.

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Witnesses

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

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Published written evidence

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 Kenneth Lownds (CRC0051)
35 Local Government Association (CRC0047)
36 Local Government Ombudsman (CRC0066)
37 London Complaints Consortium (CRC0015)
38 Mark Stephenson (CRC0113)
39 Medical Justice (CRC0025)

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

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List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/healthcom.
The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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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)

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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)

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