



**Government Response to the House of Commons
Health Select Committee Sixth Report of Session 2010-11:
Complaints and Litigation**



**Government Response to the House of Commons
Health Select Committee Sixth Report of Session 2010-11:
Complaints and Litigation**

Presented to Parliament
By the Secretary of State for Health
By Command of Her Majesty

September 2011

© Crown copyright 2011

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit <http://www.nationalarchives.gov.uk/doc/open-government-licence/> or e-mail: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available for download at www.official-documents.gov.uk

This document is also available from our website at www.dh.gov.uk/publications

ISBN: 9780101818025

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID: 2452842 09/11 14907 19585

Printed on paper containing 75% recycled fibre content minimum.

Introduction

1. On 22 June 2011, the House of Commons Health Committee published the Sixth Report of session 2010 – 2011 in respect of NHS Complaints and Litigation.
2. The report followed an inquiry by the Health Committee into the NHS complaints and litigation systems. The Committee took evidence from the Minister of Health, Simon Burns, along with Department of Health officials, the Parliamentary and Health Service Ombudsman, members of the legal profession, healthcare professionals and NHS staff, charities and third sector organisations, and people with personal experience of using the NHS complaints arrangements.
3. This paper sets out the Coalition Government's response to the Health Committee's Sixth Report of the Session 2010-12.

Overview

Complaints

4. Most people who use health and social care services are happy with the care and treatment they receive. However, sometimes things go wrong and, when they do, people need to be able to tell someone what happened.
5. Complaints are important and need to be taken seriously. When something has gone wrong it needs to be put right quickly, and organisations need to work closely with people to find the most appropriate resolution to a complaint. Organisations also need to make sure they learn from every aspect of a complaint so that the same thing does not happen again.
6. The more successful organisations take the views of their customers, including views expressed in complaints, seriously. Senior professionals lead the way in customer care by reviewing what problems have happened, how the problems have been sorted out, and what lessons have been learned from them. Most importantly, these organisations use this information to improve things overall for future customers, ensuring their future viability.
7. The starting point for this Committee's inquiry has been that sometimes patient experience of the NHS falls below the high standards expected, and when this happens, patients should have access to a responsive and effective complaints system.
8. On 12 July 2010, the Government published the White Paper *Equity and Excellence: Liberating the NHS*, setting out our long-term vision for the NHS. The White Paper describes a programme designed to help

deliver our objective of a health service that achieves outcomes amongst the best in the world.

9. The proposals consist of three mutually reinforcing parts:
 - transforming the relationship between citizen and service through the principle of 'no decision about me without me';
 - focussing on improving outcomes: orientating the NHS towards focussing on what matters most to patients – high quality care, not narrow processes;
 - empowering local organisations and professionals, and making NHS services more directly accountable to patients and communities.
10. The Government, in *Liberating the NHS*, set out its aim to put patients, carers and local communities at the heart of the NHS, shifting decision-making as close as possible to individual patients and carers by devolving power to professionals and providers, and liberating them from top-down control.
11. The revised plans we set out in response to the independent NHS Future Forum, will put patients firmly at the heart of our health service; patients will have a stronger voice and the NHS will be more accountable for the quality and experience of care it provides for patients.
12. Under these plans, we propose to create a new committee within the Care Quality Commission, to be called HealthWatch England. This will operate as the national champion for patients and members of the public by presenting their collective consumer voice and using their powers to influence the Secretary of State and relevant bodies to improve the quality and safety of health and social care services.
13. HealthWatch England will address a real need by raising the profile of the public and patient voice. It will collect and analyse views and experiences of patients and members of the public to seek to influence changes made by the Secretary of State, the NHS Commissioning Board, Monitor and the Care Quality Commission.
14. It will also provide national support to Local HealthWatch organisations. Local HealthWatch will be the local consumer voice of health and social care services, to champion the views and experiences of patients, helping to drive improvements in the quality of health and social care services. Amongst its core functions will be in:
 - obtaining the views of people about their needs for, and experiences of, local care services; and

- making those views known through reports and recommendations about how those services can or should be improved to various persons including service providers and commissioners.
15. So, where a Local HealthWatch becomes aware of poor complaints handling within an organisation, such as a provider or commissioner of local care services, it would be able to submit views, reports and recommendations. There will be a statutory duty on that organisation to have regard to such views, reports or recommendations. This duty means that Local HealthWatch organisations would be in a unique and powerful position to champion the views and needs of local people.
 16. The Government believes these plans will significantly strengthen the consumer voice with regard to service users' experiences of local care services.

Litigation

17. Whilst the vast majority of NHS service users receive safe, high quality care, a small minority of complaints about care relate to negligent harm. It is right that in such cases the service user is able to obtain correct and full compensation in a timely manner.
18. However, in recent years there have been widespread concerns that disproportionate costs in some areas of litigation impede access to justice. In particular, the Government is concerned that public funds are increasingly spent on legal costs instead of improving services.
19. Lord Justice Jackson conducted an extensive review of Civil Litigation Costs in 2009, and he published his final report in January 2010. Consequently, the Ministry of Justice (MOJ) is now taking forward reform of civil litigation funding and costs, following full consultation. Those reforms, which require primary legislation, are being implemented through the *Legal Aid, Sentencing and Punishment of Offenders Bill*. The measures include:
 - abolishing the general recoverability of success fees and 'after the event' insurance in 'no win no fee' conditional fee agreements;
 - allowing damages-based agreements (also known as contingency fees) in litigation before the courts;
 - introducing a 10 per cent increase in general damages; and
 - introducing a mechanism to protect the vast majority of personal injury claimants from paying a winning defendant's costs.

20. In addition, the recent Government consultation, *Solving Disputes in the Country Courts*¹, sought views on introducing a simplified claims procedure on a fixed-costs basis for more types of personal injury claim. This includes exploring whether the framework of such a scheme could be extended to cover low monetary-value clinical negligence claims. Final proposals will be published in due course.

21. The Government's civil justice reforms should develop a system that is proportionate, encourages personal responsibility in resolving disputes, and with streamlined procedures to provide timely access to justice. This will improve outcomes for patients seeking compensation, and allow limited NHS resources to be diverted away from legal expenses and back to patient care.

¹ Ministry of Justice; March 2011

Government response to the Committee's conclusions and recommendations

These responses correspond to the conclusions and recommendations of the Committee's report.

[Paragraph numbers after the conclusion or recommendation (bold, in italics) refer to the Health Committee's report.]

The NHS Complaints System

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

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

22. The Government is pleased the Committee has identified an improving level of satisfaction with the local resolution stage of the complaints arrangements. The current arrangements were developed to make the process of complaining quicker and simpler, and to put the focus on meeting the needs of the complainant. Nonetheless, we accept that, whilst some NHS organisations respond quickly and effectively to complaints, others are not so effective.
23. As we made clear in *Liberating the NHS*, we remain committed to empowering individual patients, and agree it is important that NHS organisations view and manage complaints in a positive manner, and use the information obtained to improve service delivery.
24. The Government believes that much has already been done centrally - the 2009 regulations and the Ombudsman's *Principles for Good Complaints Handling* provide an effective framework within which to operate - but we agree the NHS can do more to improve complaints handling. Good practice does exist, and the Department of Health will work with the NHS and other stakeholders to facilitate its wider sharing.
25. Our proposals for reform of the NHS provide an opportunity to drive improvement. The document *Developing the NHS Commissioning Board* commits that engagement with patients and the public will be one of the Board's core processes. The Board will involve the public, and will engage with patients, carers and the public to ensure it focuses, first and foremost, on what matters to patients. It will bring the patient voice directly into the Board's work from an early stage.

26. This approach would be reflected in the Board's leadership, governance, operating model and culture, and will be central to the Board's policy on handling and learning from patient complaints and feedback. A patient's experience of the complaints system will be improved in that there will be a clear indication of how their complaint has been acted upon, and they should be able to see how their feedback has been used to improve services for others.
27. From October 2011, an NHS Commissioning Board Special Health Authority will be formed (subject to the passing of the Health and Social Care Bill), which will focus on business preparation (in readiness for the establishment of the Executive Non-Departmental Public Body in October 2012), and the design of the new commissioning architecture. During this time, the Special Health Authority will work with national and local stakeholders, including the Parliamentary and Health Service Ombudsman, policy officials, NHS professionals, patients and the public. This will ensure that the Commissioning Board is ready to handle patient complaints effectively, and to learn lessons from patient feedback, so that the Board and Clinical Commissioning Groups are able to commission safer, more effective health services. This design work will include identifying how lessons learned from the local investigation of complaints might best be fed into determining how services are commissioned for patients; for example, by influencing the development of commissioning guidance.
28. Clearly, consideration will also need to be given on further lessons to be learned following the conclusion of the Mid Staffordshire Inquiry.

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

29. The Government has sympathy with the view expressed by the Committee. Effective complaints arrangements in any organisation are an important driver for service improvement, and it is right they are reviewed at an appropriate time. However, we believe, as recognised by the Committee, the two-stage model for complaints handling has the potential to deliver improved outcomes. It is, therefore, important for any review to focus on the operation of the arrangements that have been in place since 2009.
30. At the time the new complaints arrangements were introduced in April 2009, the Department of Health expressed an intention to review those arrangements after 3 years of operation. As the Committee notes in its Introduction, its report was prepared before the Secretary of State for Health has received the recommendations of the Mid Staffordshire NHS Foundation Trust public inquiry. We consider it would be important that any evaluation of the 2009 complaints arrangements is

able to take into account the Inquiry's report, and the Department of Health's response to its recommendations.

31. The Government considers that an evaluation should take into account also the reforms envisaged in the Health and Social Care Bill; in particular, the creation (subject to Parliamentary approval) of the NHS Commissioning Board in April 2013. It seems an inappropriate use of resources to evaluate only the operation of complaints arrangements in a system that could shortly change. We will consider undertaking initial work in 2012, followed by a more thorough evaluation in 2014.

The NHS complaints statistics show an increase of 13.4% in complaints between 2008–09 and 2009–10. This is comparison of data between two distinct complaints systems is unreliable. Furthermore, the growing number of people treated by the NHS, the stricter reporting arrangements, more information about how to complain and a general improvement in consumer rights awareness may have added to the volume of complaints that the NHS receives. (Paragraph 24)

32. The Government welcomes the Committee's acceptance that an increase in the number of complaints received by the NHS is not necessarily a reflection of the quality of services provided. The 2009 changes were designed to simplify the complaints arrangements and to make them more accessible. There was also significant publicity around the reforms that will have led to increased awareness of the system.
33. There is also a risk of seeking to read too much into basic quantitative data. An organisation that has good publicity, that welcomes complaints as an opportunity to learn and to improve services, and that has a non-defensive approach in responding to complaints may be expected to receive a higher number of complaints than an organisation with poor publicity and a defensive approach in responding - yet one might also expect its services to be of a higher quality. It is important that organisations are open about the number of complaints received, but these should not be read in isolation – the annual reports that organisations have to produce places a duty on them to provide further information that provides a more rounded view of complaints handling.

In particular, we are concerned about the number of individual cases where complainants did not feel the NHS was sufficiently responsive to their concerns. It is in this variable individual experience, rather than in movements in the headline totals, that the Committee feels that there is a real issue, which the NHS needs to address. (Paragraph 25)

34. Whilst the Government considers the 2009 reforms are better able to provide a quicker and simpler means through which to resolve a complaint, we agree there remains an issue over the handling of individual complaints in some organisations at the local resolution

stage. The number of cases referred to the Health Service Ombudsman may also be seen as indicating that the NHS, as a whole, has some way to go in terms of meeting consistently good standards of complaints handling, and we agree there is a need for greater consistency across the NHS. As we indicated in paragraph 24 above, the Department of Health will work with the NHS and other stakeholders to facilitate the wider sharing of the good practice that already exists.

35. Under our plans for reform, patients will have a stronger voice and the NHS will be more accountable for the quality of care it provides for patients. Local HealthWatch will champion the views and experiences of patients, helping to drive improvements in the quality of health and social care services.
36. Whilst not being directly involved in the handling of individual complaints, Local HealthWatch will provide support, either by explaining where the complainant is able to access those advocacy services, or through the provision of advocacy services to help the complainant pursue the complaint if the LA has contracted with the LHW to do so.
37. Local HealthWatch could also obtain the views of service users about their experiences of complaints handling and, where appropriate, will make recommendations about how procedures, and therefore local care services, could be improved; a patient's experience of an organisation's handling of their complaint will fall within this remit. There will be a duty on organisations to have regard to recommendations of local HealthWatch. This will put pressure on providers and commissioners to improve.

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

38. It is right that all complaints should be investigated in a manner appropriate to resolving them speedily and efficiently. A fundamental objective of the changes in 2009 was to facilitate effective handling of complaints at the local level. The regulations provide that a complaint made orally and resolved to the complainant's satisfaction no later than the next working day as one that is not required to be dealt with in accordance with the regulations. The aim is to encourage speedy resolution of oral complaints, often made to front-line staff, thereby reducing unnecessary bureaucracy.

39. However, the flexibility in the complaints arrangements plays an important role in better ensuring that issues underlying an oral complaint, which may be potentially serious, can be identified quickly and addressed within the organisation.
40. The Government considers effective complaints arrangements should place the focus on the complainant, and on considering their needs in the handling of their individual complaint. We consider it inappropriate to assume a verbal apology should be considered to be sufficient in all 'customer service cases'.

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

41. The current NHS complaints arrangements provide an overall framework within which to handle the full range of individual complaints; this framework provides the flexibility to adapt the handling to the needs of the individual case. It is important that proportionate, robust investigation takes place in each case. For example, in sensitive or complex complaints, it may be seen as appropriate for someone completely independent of the organisation concerned, perhaps independent of the NHS, to look into the case. The Government considers the current arrangements have the flexibility to allow organisations to deal appropriately with the full range of complaints.
42. Introducing two systems runs the risk of making the complaints arrangements more difficult to understand by service users, adding complexity, and creating confusion amongst complaints handling staff. It is also possible that what might initially be seen as 'customer service' complaints have more serious, perhaps systemic, underlying implications, which may be missed in a two-tier system, or may take longer to resolve.
43. Regulation 3 of the 2009 regulations provides that the arrangements for dealing with complaints must be such to ensure that complaints are dealt with efficiently, they are properly investigated, complainants receive a timely and appropriate response, and action is taken if necessary in the light of the outcome of a complaint. The Department of Health considers that this legislative framework with the Parliamentary and Health Service Ombudsman's *Principles for Good Complaints Handling* provide the appropriate standards to be followed by organisations in responding to all NHS complaints.

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

44. The Government agrees that it is unacceptable for complainants, or their nominated representatives, not to be informed when a mistake, error or unprofessional behaviour has caused serious harm. We expect the NHS to be open about mistakes, to apologise to those affected, and to ensure that lessons are learned to prevent them from being repeated.
45. We announced in our response to the NHS Future Forum² its intention to strengthen the transparency of organisations and increase patient confidence by introducing a "duty of candour": a new contractual requirement on all NHS providers to be open and transparent in admitting mistakes.
46. In addition, we have already made clear in our policies on how serious untoward incidents are dealt with and in its policy on being open with patients when things go wrong, that patients and their relatives/carers must be involved in the investigation process.

Investigation by the Ombudsman

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

The terminology "no worthwhile outcome" which arises from the Health Service Commissioners Act is being used in communication with complainants. Several have told us that their complaints were rejected because "no worthwhile outcome" could be achieved. The Committee recommends that the Ombudsman urgently reviews the use of this terminology in correspondence, as it appears significantly to undermine public confidence in the complaints handling process. (Paragraph 49)

47. These issues fall to the Parliamentary and Health Service Ombudsman. The Ombudsman is independent of Government, and it would be inappropriate for us to comment on these recommendations. The Government has noted to Ombudsman's response to the Committee on these issues.

Many people see the role of the Ombudsman as a general appeals process for the complaints system, but the remit under the Health Service Commissioners Act is much narrower than that. The Committee

² Paras 4.47 and 4.48 - Government Response to the Future forum Report; CM8113; June 2011

is of the view that a complainant whose complaint is rejected by the service provider should be able to seek independent review. The legal and operational framework of the Ombudsman's office should be reviewed to make it effective for this wider purpose. (Paragraph 50)

48. The Government acknowledges the Health Service Ombudsman's previously stated line that she already has the authority to review any complaint which is referred to her by a complainant, following rejection by a service provider of NHS services. We understand the Ombudsman has informed the Committee of this.

Advice and Advocacy Services

Patient advice and liaison services are crucial, as the first line of contact for many complainants and as teams that can resolve complaints, sometimes on the spot. The Government needs to explore how PALS can have a highly visible presence in hospital receptions and GP surgeries and be well signposted throughout larger NHS buildings. (Paragraph 54)

49. The Government agrees it is important that patients' questions are answered, and their concerns and problems quickly resolved by the NHS. Patient Advice and Liaison Services staff will routinely undertake these activities, with part of the role being to provide information about the NHS complaints arrangements and, if users wish to make a complaint, how to get independent help through, for example, the Independent Complaints and Advocacy Services. We envisage that Local HealthWatch will also have a future role in providing information about access to local care services.
50. We agree it is important that PALS have a visible profile. However, local organisations are best placed to deliver this, having regard to the needs of both their service users and the organisations themselves.

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

51. The Government welcomes this conclusion. PALS act as a conduit between service users and trust staff. They provide on the spot help, listening to and seeking to resolve service user concerns, diffusing potentially problematic situations, and facilitating cooperation and understanding between service users and staff. An effective PALS has an important role in providing information to Board level on the areas of service user concern, and offering suggestions as to how such

concerns may be resolved. This is better achieved by being 'inside' an organisation.

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

52. The Government believes it is right that PALS staff, as with all NHS staff, are appropriately supported and trained. However, the organisation, staffing, and training of PALS staff are best determined at local level, taking into account the views and needs of the local population, the PALS staff employed in an organisation, the designated role of PALS, and the needs of the organisation itself.

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

53. The complaints regulations require NHS organisations to nominate a complaints manager to manage the complaints handling procedures and they are required to designate a 'responsible person' to ensure compliance with the regulations and to ensure that any action is taken, if necessary, as a result of the outcome of an investigation.
54. The complaints manager is the focal point for complaints handling in all NHS organisations, being responsible for managing the procedures for handling and considering complaints in accordance with the regulations. The Department of Health recognises that some organisations have merged their complaints and PALS teams to deliver effective customer services outcomes, but it considers this type of decision in best taken locally, enabling individual organisations to have regard to the views and needs of their local populations and the needs of the organisations themselves.
55. The Government agrees with the Committee on the role of LINKs and, in future, of the proposed Local HealthWatch. They are well placed to consider the collective views of people about their experiences of local care services and to make recommendations on local care services.

It is a significant anomaly that complaints to a professional regulator cannot be supported by ICAS, even when this forms part of a complaint that is being made to the NHS. The Committee recommends that

Government remove this restriction as part of its review of the complaints system. (Paragraph 67)

56. When the regulator takes action against a professional as a result of a complaint, the regulator, in effect, becomes the complainant, and the original complainant may be seen as a witness. In these circumstances, the type of support required may be different from that provided by ICAS.
57. In its recent performance review³ the Council for Healthcare Regulatory Excellence (CHRE) acknowledged that some regulators have developed initiatives that represent significant improvements to the arrangements that have previously been in place to support witnesses. The Government welcomes CHRE's emphasis on developing better support for witnesses. It will continue to work with CHRE to consider how regulators can further improve the support to those who raise concerns about professionals with them.
58. In relation to complaints about the professional regulators themselves, the recent Command Paper, *Enabling Excellence*, announced plans to create a new route for people to raise their concerns. Where complaints are made about maladministration by a regulator, or where there are concerns that a regulator may be failing properly to fulfil its statutory duties, the Government intends to give CHRE the power to investigate such complaints. The creation of a new route for people to raise concerns about the professional regulators will strengthen the accountability of those regulators to those who use the services of their registrants, and to the wider public

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

The Committee is concerned that some complainants who would benefit from support from ICAS are simply not aware of its existence. (Paragraph 72)

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

³ Para 2.36 CHRE Performance Review Report 2010/11, June 2011
[http://www.chre.org.uk/_img/pics/library/110623_Final_-_CHRE_Performance_Review_report_2010-11_\(Colour_for_web_-_PDF_version\).pdf](http://www.chre.org.uk/_img/pics/library/110623_Final_-_CHRE_Performance_Review_report_2010-11_(Colour_for_web_-_PDF_version).pdf)

59. ICAS is a demand-led service, available to all who wish to make a complaint about the NHS. ICAS will support a complainant in a manner appropriate to the needs of the complainant and the nature of the complaint.
60. There will continue to be cases where individual complainants, who have not sought the support of ICAS, will prematurely refer their cases to the Ombudsman. The Government considers it appropriate for individual complainants to decide whether to seek ICAS support.
61. Nonetheless, we do accept that the profile of ICAS needs to be raised. The 2009 regulations place a duty on NHS bodies to provide, as far as reasonably practical, assistance to complainants to enable them to understand the procedure in relation to complaints, or to advise them of where they may obtain such assistance. We consider this includes the provision of details of ICAS. We agree it is important that this information is made available, and the Department of Health will issue to all NHS Chief Executives a reminder of this requirement. We envisage that Local HealthWatch will also have an important future role in providing information about access to independent NHS advocacy services.
62. The Government believes it is for individual service users to decide whether they wish to use ICAS. PALS should not be referring any type of complaints case to ICAS without the express wishes of the complainant, although PALS can help complainants to understand the role of ICAS, the type of support they are able to provide and, where appropriate, to assist the complainant in contacting ICAS .

The Role of Commissioners

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

63. *Developing the NHS Commissioning Board* sets out that (subject to the passage of the Health and Social Care Bill) clear accountability arrangements will be a core value and culture within the NHS Commissioning Board (NHSCB), and the NHSCB's accountability to the public and patients will be a key element of this.
64. Proposals about how the NHSCB could go about fulfilling this function are still under development, ahead of consideration by the Special Health Authority and decided upon by the NHSCB itself, once established. Ensuring that complaints data are properly analysed and

understood to bring about improved outcomes is a key component of this design work.

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

65. The Government has already committed to implement a contractual duty of candour requiring hospitals to be open with patients when things go wrong, and work is now required to deliver the detail on implementing this contractual requirement (see paragraph 45).
66. The NHSCB, once established, will wish to take a view on this recommendation when considering its wider leadership responsibilities.

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

67. Consideration is being given to how such a duty would most effectively be incorporated into NHS standard contracts.
68. The Department of Health will explore in the forthcoming consultation on the contractual requirement for openness introducing an explicit contractual requirement on providers to report where things have gone wrong to their commissioners, and to inform patients or their representatives.
69. The Government believes that making a duty of candour from providers to patients a part of the terms of authorisation from Monitor would be inconsistent with the duties and functions proposed for Monitor in the Health and Social Care Bill. Terms of authorisation, which currently apply only to foundation trusts, would, in future, be superseded by Monitor's licensing regime, under which Monitor would have responsibility for regulating other providers of NHS services, not just foundation trusts.
70. The Committee has also stated it does not think that placing further statutory duties on the NHS will produce the shift in culture that is required to ensure that patients get full disclosure of information when things go wrong. Making a Duty of Candour to patients' part of the terms of authorisation for providers would represent a further statutory duty. For this reason, the Government does not currently intend to

introduce a statutory duty of candour into the CQC registration requirements.

71. The CQC registration requirements already place a duty on providers to report patient safety incidents, to involve service users in making decisions about their care, to have an effective complaints procedure, and to reflect appropriate guidance such as that around being open with patients when things go wrong. These registration requirements go a long way towards requiring registered providers to be open with service users about failures in patient care. More important is the issue of actually detecting non-disclosure; the CQC has said it is not able routinely to monitor and enforce such a duty, and this does not fit with their role as a risk-based regulator.
72. However, the consultation on introducing the contractual requirement will explore what we should expect commissioners to report publicly in terms of their enforcement of the requirement. If appropriate, there may be an opportunity, in future, to include such information in the CQC's Quality and Risk Profiles.

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

73. The Department of Health will explore in the forthcoming consultation on the contractual requirement for openness what expectations should be placed on commissioners in terms of publicly reporting how often they are made aware of instances of non-disclosure and what action they have taken as a result.

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

74. The Government believes there is a need for meaningful, comparable complaints information, which can be used to help drive improvement in healthcare and to strengthen the quality of services for patients and the public. The regulators and the NHS are signatories to the joint agreement on complaints information (with the Department of Health, the Health Services Ombudsman, and others) that will strengthen the use of complaints data, better enabling benchmarking across organisations, making it easier to identify poor performers.
75. Additionally, data on complaints handling are important sources of information about patient experiences, and we would expect local HealthWatch to obtain the views of service users about these

experiences and, where appropriate, to make recommendations about how such services could locally be improved.

76. Providers of 'regulated activities' (for example, providers of personal or nursing care, surgical procedures and treatment of disease, disorder or injury) are required to register with the Care Quality Commission (CQC), and to comply with sixteen safety and quality requirements. These include a requirement on complaints, which requires registered providers to have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf.

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

77. As we have stated in paragraph 74 above, the Government believes meaningful, comparable complaints information can be used to help drive improvement in healthcare, and to strengthen the quality of services for patients and the public. Effective information of this type will also assist in 'benchmarking' across organisations, and better enable poorly performing organisations to be identified at an early stage.
78. However, we do not believe this responsibility should rest with a single organisation. For example, in the first instance, service providers are directly accountable to the bodies that commission those services. All organisations within the overall health system have an important role to play in better ensuring effective complaints handling, whether as providers, commissioners, regulators, or the Ombudsman.
79. HealthWatch England will have a clear role in providing advice to the Secretary of State, the NHS Commissioning Board, Monitor and the CQC on the views of local HealthWatch on the standards of provision of health and social care services, and how those services could or should be improved. However, although a committee of the CQC, HealthWatch England is not, itself, a regulator of NHS services, and we do not believe it appropriate for HealthWatch England to set or monitor standards of care.

The Committee thinks that commissioners need to have a much greater focus on complaints handling and on complaints data. We would like to establish the principle that providers must account to their commissioner on complaints handling, and that the commissioner in

turn must account to the public and local Healthwatch for the performance of their providers. (Paragraph 90)

80. Ensuring that complaints data are properly analysed and understood to bring about improved outcomes will be a key component of work around making the NHS Commissioning Board accountable to the public and patients (as described in paragraphs 25-27).
81. Local HealthWatch will strengthen the collective voice of patients, better enabling their views to be heard by commissioners and providers of local care services. To retain their independence, Local HealthWatch will sit outside the NHS, and it would be inappropriate for commissioners of NHS services to be directly accountable to them.
82. Where, in obtaining the views of service users about their experiences of complaints handling, a local HealthWatch considers that this handling needs to be improved, it would consider it appropriate to make recommendations to the body that commissioned the service about how to bring about improvement; the commissioner would then have to have regard to these recommendations.

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

83. The existing NHS Standard Contract already requires providers to report complaints information to commissioners. This is then discussed as part of the clinical review meeting process between providers and the commissioner, which take place monthly. There is also a requirement for providers to implement learning from complaints and other incidents.
84. The Department of Health will look again at the complaints reporting elements of the contract reflecting the reporting of complaints information to commissioners to see whether improvements may be made.

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

85. As mentioned in paragraph 83 above, the existing NHS Standard Contract requires providers to report complaints information to commissioners.

86. The Government believes that complaints data are valuable sources of information that are able to contribute to improving service delivery. But the data available need to be improved to enable providers to compare themselves with others, and for commissioners to be able to hold their providers to account. We believe the work undertaken with the Ombudsman and other stakeholders, as described in paragraph 74, will help to achieve these aims.

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

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

87. The Government supports the general view that providers need to be made more accountable to the commissioner and service users for implementing action plans, but believes this recommendation, as drafted would be over-burdensome. We suggest a similar outcome may be achieved through other mechanisms.
88. Under the 2009 regulations, all providers and commissioners of NHS-funded services are under a duty to prepare an annual complaints report. The report must, amongst other things, summarise any matters where action has been or is to be taken to improve services as a consequence of complaints received. The Department of Health will review this current duty with a view to placing greater emphasis on a summary of action plans produced during the year, and a summary of progress on those action plans.
89. The regulations also place a duty on providers and commissioners of NHS-funded services to include in the response to a complaint any matters for which they consider that remedial action is needed, and confirmation that as to whether they are satisfied that any action needed has been taken or is to be taken. The Department will also consider whether it would be possible to make it a requirement for organisations to respond to individual complainants who follow up a complaint by enquiring about progress in taking forward an action plan related to that complaint. We will also, subject to consultation, seek to place a duty on all providers and commissioners to publish the annual reports.
90. The NHS Standard Contracts have had a requirement to report complaints to the commissioner since 2008/09, and it has remained a reporting requirement since then. The current contracts also have a requirement for complaints to be discussed as part of the clinical

review meeting between the provider and the commissioner. There is a further requirement on providers to implement learning from complaints and other incidents.

91. The qualitative element of a report is more challenging to incorporate into a legally binding contract, but the Department of Health will consider this in more detail.
92. Overall, the Government considers these approaches would be more effective, and less burdensome, than placing a duty on commissioners to share all complaints action plans and progress updates with their Local HealthWatches.

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

93. The Government considers that individual Local HealthWatch organisations will be best placed to determine what to share with HealthWatch England, and when it is appropriate to do so, and the proposed duties in the Bill will enable this.
94. Initially, we would expect Local HealthWatch organisations to seek to deal with poor performance locally; where appropriate, making recommendations about how local care services could or ought to be improved. In more serious circumstances, Local HealthWatch organisations could make their views immediately known to HealthWatch England or to the Care Quality Commission. However, we again envisage these decisions being taken locally on the basis of individual circumstances, and in discussion with HealthWatch England.

The proposed health reforms

The Committee welcomes the provisions in the Health and Social Care Bill that support information sharing between organisations but would like to see the proposals strengthened in a number of areas relating to the complaints system. (Paragraph 104)

95. The Government acknowledges that the current systems for capturing complaints information require significant improvement, and will continue to work with the Health Service Ombudsman, the Care Quality Commission, Monitor and other stakeholders to deliver more meaningful, comparable complaints information.
96. Clause 204 of the Health and Social Care Bill removes the current restrictions on those to whom the Health Service Commissioner (generally known as the Health Service Ombudsman) can send investigation reports and statements of reasons (these are her reasons for declining to investigate a complaint). It allows the Ombudsman to share them with whomever she thinks appropriate.

97. The Ombudsman is the final, independent arbiter of NHS complaints but as it currently stands, there are limitations on what valuable information the Ombudsman can provide to other stakeholders. This clause allows the Ombudsman to share more widely her complaints investigation reports and her statements of reasons with regulators, advice and advocacy organisations, and other stakeholders.
98. As the proposals in the Bill are taken forward, the Department of Health will continue to work with all stakeholders to ensure complaints information is appropriately recorded and shared, to support improved patient choice and public accountability.

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

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

99. The Government welcomes the Committee's support for our proposal for NHS complaints advocacy to be commissioned by local authorities. We believe this move away from central commissioning will better enable complaints advocacy services to meet the needs of the local population.

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

100. The Government is clear that, subject to the passage of the Health and Social Care Bill, the NHS Commissioning Board will directly commission primary care services. The precise operating model through which the Board will discharge this function is still emerging. However, the resolution of complaints about primary care has been identified as a key area for development in the design proposals being undertaken in preparation for the establishment of the Board.

101. In the design work, we are identifying those functions that would be best undertaken locally, as well as identifying what unwarranted variation can be reduced by following a single process - though discharged at local level where appropriate - across the system. There will also need to be a strong working relationship with clinical commissioning groups and other primary care clinicians, and a clear route for patients and the public to communicate with the system at all levels.

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

102. The Government agrees that patient and service user generated information - which includes complaints, as well as information collected from patients and staff through surveys, real-time feedback, ratings of services and Patient Reported Outcome Measures (PROMS) - forms a vital strand of our proposals to improve services and help patients to make informed choices about their care.
103. Patient and service user-generated information provides a rich source of intelligence that can be used to improve services. The experience of other sectors clearly shows that strong user feedback can have a positive impact on the design of products and services.
104. This is why our consultation document *Liberating the NHS: An Information Revolution* included four specific consultation questions on using all forms of user feedback - including complaints - to improve services within a section entitled *Patient and service user generated information*. Responses to these specific questions are being used to inform the Government's forthcoming Information Strategy.

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

105. The Government agrees with the Committee that complaints data along with other information about quality of services should support informed decision-making by patients. This is why the package of data transparency commitments, announced by the Prime Minister on 7 July 2011, included a commitment to publish complaints data held by NHS hospitals (which will include foundation trusts), so that patients can see which issues have affected other patients and take better decisions about which hospital suits them. The annual reports on complaints handling, which all providers of NHS-funded care are required to provide, are also an important source of complaints data.

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

106. The Government is pleased the Committee welcomes the joint agreement on complaints information between the Department of Health, the Ombudsman and others. As the Committee requests, we will keep it apprised of progress as plans are developed for its implementation.

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

107. The Government agrees that it is important for service users to have all relevant information to enable them to make informed choices about their healthcare. Despite some limitations on the conclusions to be drawn from the central NHS complaints data returns (as laid out in paragraph 33), these data do contain information on the number of complaints received by an NHS trust, and the Information Centre will, in future, break down a trust's complaints into 25 subject categories.

108. Although the majority of foundation trusts do provide central data returns on a voluntary basis, we agree central data returns should be provided by all NHS trusts. The Department of Health will be discussing with Monitor how this situation may best be rectified.

109. From 2011 onwards, the NHS Information Centre, in line with the Government's Transparency Agenda, will list all Foundation Trusts in the annual NHS complaints data publication, whether or not these Trusts voluntarily provide data on complaints. This will enable Trusts who do not supply complaints data to be readily identified.

110. The standard contract can require the providers to submit data to the IC, but only on the basis that there is an Information Standard Notice and Review of Central Returns (ROCR) licence in place. This is not expected to be an obstacle but officials consider the issue would be that the IC does not routinely collect information from organisations other than NHS trusts and FTs on a voluntary basis. Officials will begin discussions with the IC to test its feasibility.

The withholding of NHS complaints reports from the public until they are specifically requested runs counter to the principles of the Information

Revolution. The Government must take action on this and ensure that complaints reports and serious untoward incident reports are automatically returned to commissioners who can then publish a rounded view on NHS-funded providers. These reports must also be automatically published by local Healthwatch organisations. (Paragraph 127)

111. The Government wishes to make clear that this is not an issue of 'withholding'. The regulations place a duty on all providers of NHS-funded services, amongst others, to make annual reports on complaints handling available to anyone who requests it. When reviewing the regulations, in relation to the content of the Health and Social Care Bill and recommendations from the Mid Staffordshire Public Inquiry, we will consider how best to ensure the availability of an organisation's annual report on complaints handling is better publicised.
112. The 2009 regulations place a duty on all providers of NHS-funded care to send a copy of their annual reports on complaints handling to the Primary Care Trust that arranged for the provision of its services. We will consider, when amending the 2009 complaints regulations a provision to extend this to place a duty on all providers to send a copy of their annual report also to the Local HealthWatch.

Complaints Cultures

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

113. The Government agrees with this assessment. The 2009 regulations specifically allow for a complaint to be made to either the provider or the commissioner, acknowledging a fear amongst some service users about complaining directly to the organisation that has, and may continue, to deliver their healthcare.
114. The 2009 complaints arrangements seek to place a greater focus on service users, making the arrangements accessible and delivering effective outcomes for those making the complaints.

The Committee strongly supports the use of tools that allow patients to give feedback anonymously and that can demonstrate that changes have been made to service provision based on feedback received. (Paragraph 135)

115. The Government agrees. We believe this may be achieved through a number of mechanisms including the use of 'real-time' feedback. Real-time patient feedback is a general term for the use of a variety of

approaches to capturing feedback from patients and service users at, or close to, the point of care – this can include hand-held devices,” texting”, kiosks, comment cards, and internet-based feedback.

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

116. The Government considers this is something that Trusts could explore. Local organisations should use whichever methods are most suitable and appropriate for their patients and populations⁴. The benefits of ‘real time’ data are that the data can be adapted to address local issues and questions; it is fast and is relevant to clinicians ‘on the ground’. As such, it is a very important source of local improvement. However, because different organisations collect different data in different ways, any national aggregation would be meaningless. The Department does not collect real-time feedback data centrally.
117. It is important for the experience and knowledge of these various ‘real-time’ initiatives to be shared across the NHS, which is why the Department of Health initiated a patient experience network, run by the NHS Institute for Innovation and Improvement.

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

118. The Government agrees that employers must deal with performance issues as, and when, these issues arise.

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

119. The NHS is currently preparing for the introduction of medical revalidation. Revalidation will provide greater assurance to patients and the public, employers and other health care professionals that licensed doctors are up to date and fit to practise. A commitment was made in October 2010 by the UK health departments and the General Medical Council (GMC) that, subject to an assessment of readiness, medical revalidation will start in 2012/13.

⁴ Para 3.10; The Operating Framework for the NHS in England 2011/12; Department of Health; December 2010.

120. The Government's recent response to the *Future Forum* report highlighted the important role of responsible officers in medical revalidation. The introduction of responsible officers in January 2011 has been an important change in clinical governance, ensuring a high quality clinical medical workforce and putting in place the building blocks for medical revalidation.
121. The revalidation decision will be based on a series of annual appraisals with doctors using supporting information to demonstrate they are continuing to meet the principles and values set out in the General Medical Council guidance *Good Medical Practice*. The Responsible Officer will make a recommendation to the GMC about a doctor's fitness to practise, normally every five years.
122. The General Medical Council (GMC) has recently published its expectations of doctors in terms of the six types of supporting information that the doctor would be expected to provide and discuss at appraisal - a review of complaints and feedback from patients are two of them. Doctors are expected to be aware of any complaints received, participate in the investigations and response, action any response required and consider whether any opportunities for professional development have been identified.
123. In addition, the GMC has also appointed Employment Liaison Advisers who will work with Responsible Officers and organisations to ensure that issues are managed at the most appropriate level.

The Committee recommends that NHS organisations offer patient or user satisfaction training that includes basic “customer care”, patient safety and how complaints should be responded to when received by front line staff. Complaints data should be fed back to teams and individual practitioners to support learning, appraisal and changes in practice. (Paragraph 143)

124. The Government agrees it is right that staff are appropriately trained, and we agree this responsibility rests with the individual employer. Complaints data are an important element of feedback that offer a strong opportunity to learn from mistakes and improve services.

The Committee takes the view that NHS staff should fully support complaints investigations and local resolution, even when they have left the organisation concerned. The Committee recommends that the Government explore the potential for placing staff under a duty to supply information and attend local resolution meetings, even if they have left the organisation concerned. (Paragraph 144)

125. The Government believes it would be difficult to include this as a contractual requirement for existing staff. Once the individual has left an organisation, and there is no ongoing contractual relationship, there

would be no practical means by which to enforce the requirement. It would also be challenging to achieve for new staff because any substantive changes to NHS contracts of employment are normally subject to national collective bargaining.

126. Any new terms would have to be capable of collective agreement and inserted following negotiation with the unions, or else agreed by each individual employee. Given the lack of force such terms would carry, we consider it impractical.

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

127. The Government agrees foundation trusts must be accountable, transparent and autonomous in the way they operate.
128. Foundation trusts are locally accountable in contrast to NHS trusts, which are accountable to the Secretary of State. Governors will want to assure themselves that the provisions in the Health and Social Care Bill, which would require open board of director meetings and allow for the discussion of confidential and sensitive matters in private sessions, are used appropriately. The Government's amendment to the Bill mirrors the existing requirement on other public bodies and boards of governors of foundation trusts.
129. The Bill promotes greater transparency and public scrutiny of foundation trusts, and strengthens their internal governance, making them more accountable. Governors - who are responsible for ensuring their organisation is locally accountable - have a key role in scrutinising foundation trusts on behalf of their patients and communities and are in a good position to hold boards to account. The Bill enhances Governors' existing power to appoint and remove non-executive directors by giving the Board of Governors the power to call a special meeting to hold the Directors to account for their performance and to vote on motions of their choosing.

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

130. As we have stated earlier in this response, the Government agrees there is a need for meaningful, comparable complaints information, which can be used to help drive improvement in healthcare and strengthen the quality of services for patients and the public. We agree that all types of user feedback, including patient and staff surveys, concerns and compliments also provide important information.
131. We believe that the mechanisms are already in place, or proposed in the Health and Social Care Bill, provide for organisations providing NHS-funded care to be accountable to their Boards, their commissioning bodies, and their local populations, through local HealthWatch. Decisions on whether to undertake cultural surveys, or to obtain an independent assessment of organisational culture are best taken locally.

Litigation

The Committee believes that the existing clinical negligence framework based on qualifying liability in tort offers patients the best opportunity possible for establishing the facts of their case, apportioning responsibility for errors, and being appropriately compensated. (Paragraph 157)

132. The Government acknowledges the Committee's conclusion.

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

133. The Civil Justice Council (CJC) is responsible for drafting and publishing pre-action protocols covering civil litigation, which includes the protocol relating to clinical negligence disputes. It is currently looking into revising the pre-action protocol for clinical negligence. However, they have deferred suggesting any changes until the impacts of the implementation of the proposals put forward by Lord Justice Jackson are known.

The Committee believes that the Government is in possession of the industry review report of the NHS Litigation Authority. In order to prevent further uncertainty the Committee suggests that it complete the review process and make its conclusions known as soon as possible. (Paragraph 165)

134. The industry review contains recommendations with potentially far-reaching implications for the application of the NHS Indemnity Schemes that are administered by the NHS Litigation Authority. We are currently working through the potential implications of these recommendations before we publish the report in the autumn.

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

135. The Government notes the Committee’s concerns about claims management companies (CMCs) and their relationships with lawyers in relation to the rising costs of litigation to the NHS claims. The Government acknowledges there are concerns about the marketing and referral practices amongst some CMCs operating in the accident and public liability claims areas. The evidence gathered by the Ministry of Justice’s Claims Management Regulation Unit indicates that few CMCs provide services in relation to clinical negligence claims and those that do are likely to specialise in such claims and refer to appropriately qualified clinical negligence lawyers.
136. The conduct rules governing CMCs restrict marketing and other aspects of CMC trading practices. These restrictions already include banning CMCs from advertising in hospitals without the explicit approval of the hospital management concerned. The content of the advertising is typically concerned with injuries sustained in road, workplace or public liability environments and not to claims against the NHS or other medical organisations. Cold calling by telephone is already banned if the claim is to be passed to a solicitor and is otherwise required to be conducted out in accordance with strict industry guidelines.
137. The Ministry of Justice is reviewing the CMC conduct rules and plans to issue a public consultation in the autumn with a view to implementing changes to the rules from April 2012. To the extent that CMCs are dealing with clinical negligence claims, the Government’s proposed reforms to end the recoverability of success fees and after the event, insurance premiums will reduce the costs of civil litigation, in particular for defendants (businesses and insurers) and the number of frivolous and unnecessary claims being pursued. These reforms, which, are being taken forward by the Legal Aid, Sentencing and Punishment of Offenders Bill – currently before parliament are likely to have a significant impact on many CMCs general business practices. The Government is also sympathetic to the idea of a ban on referral fees and is considering this as part of wider reforms.

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

138. As the Committee notes, the Government is proposing a tightly drawn power to permit the recovery of ‘after the event’ (ATE) insurance premiums to cover the costs of expert’s reports in clinical negligence cases. We are also discussing with the NHS Litigation Authority and other stakeholders how the commissioning of expert reports can be improved in clinical negligence cases so that, for example, joint expert reports can be commissioned wherever possible. The Government believes that, with the change it has made to the original proposals in this area, claimants in clinical negligence will still be able to fund their claims under a no win no fee conditional fee agreement in the new regime.
139. In personal injury cases, including clinical negligence, there will be a cap on the amount of damages that may be taken as a success fee. The cap will be set at 25% of the damages other than those for future care and loss. This will help to protect claimant’s damages generally, and will specifically protect those relating to future care and loss. In cases involving the most seriously injured, special damages for future care and loss can run into many millions of pounds; these will be protected. The Government is also proposing to introduce a system of qualified one-way costs shifting in personal injury claims (including clinical negligence claims). This will mean that losing claimants will generally not have to pay a winning defendant’s costs, which in turn will avoid or significantly reduce the need for expensive ATE insurance products to cover this risk.

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

140. The legal aid scheme is a vital part of the system of justice in this country but one that needed fundamental reform to ensure access to public funding in those cases that most require it, to encourage early resolution of disputes instead of unnecessary conflict, and to improve its affordability.
141. The legal aid reforms are designed to ensure that legal aid is targeted at those who need it most, for the most serious cases in which legal advice or representation is justified. The Government considered from

first principles which issues should attract public funding in the light of the financial constraints. This took into account our domestic, European and international legal obligations, including the European Convention on Human Rights.

142. Prioritising critical areas for legal aid funding means making clear choices about availability of legal aid elsewhere. The response paper on legal aid provides that legal aid would continue to be routinely available in cases where people's life or liberty is at stake, where they are at risk of serious physical harm, or immediate loss of their home, or where their children may be taken into care.
143. Although the issues raised in clinical negligence cases are likely to be very important, we consider that there is a viable source of alternative funding to legal aid in CFAs, which are more readily available in such cases than for other claims. The Government therefore considers that legal aid is not justified in these cases and that our limited funding would be better targeted at other priority areas, such as those concerning physical safety, liberty or homelessness.
144. As noted above, the Government has listened carefully to concerns about the high costs of expert reports in clinical negligence cases. To address these concerns, the Government is making one change to Lord Justice Jackson's key recommendations, by seeking a tightly drawn power to allow recoverability of after the event (ATE) insurance premiums to cover the cost of expert reports only in clinical negligence.
145. The Government recognises that there may be clinical negligence cases, such as obstetrics cases, with high disbursement costs, which are currently funded by legal aid but for which it may be difficult in the future to secure a conditional fee agreement. We have proposed a safety net in the form of an 'exceptional funding' scheme, which would ensure that individual cases of this type continue to receive legal aid where failure to do so would be likely to result in a breach of the individual's rights to legal aid under the Human Rights Act 1998 or EU law. In considering whether exceptional funding should be granted we will take into account the ability of the client to present their own case, the complexity of the matter, the importance of the issues at stake, and all other relevant circumstances.
146. The Government believes that these legal aid changes constitute a substantial set of very bold reforms, the overall effect of which should be to achieve significant savings whilst protecting fundamental rights of access to justice. This is reflected in the retention of certain areas of law (as provided above) within scope, but also in the new exceptional funding scheme for excluded cases. Under its terms, funding will be made available, where the observance of core protections, such as those guaranteed by the Human Rights Act, require it.

The Committee welcomes the development of a rapid resolution process for lower value clinical negligence claims against the NHS, as this will speed up admissions of liability and access to redress for patients, and reduce costs for the NHS. The Committee would like to see evidence of how the complexity of low monetary value claims will be managed whilst costs are reduced. (Paragraph 186)

147. The MoJ is working closely with the NHSLA and the Association of Personal Injury Lawyers (APIL) to agree a scheme that will enable a speedier resolution of clinical negligence cases and aims to reduce costs. Further information about proposals will be published in due course.
148. The proposed scheme will have four stages. They are:
 - a. Stage 1: Early notification, direct to the NHSLA, by secure electronic data exchange.
 - b. Stage 2: Joint instruction of an expert on breach of duty and/or causation.
 - c. Stage 3: Medical evidence on quantum, offers to settle and negotiation.
 - d. Stage 4: Quantum hearing before the courts, or alternatively agreed binding arbitration.
149. Direct and early notification together with agreed timescales will speed up the overall process and reduce costs. It is envisaged that fixed recoverable costs will be introduced to increase transparency and enable clearer decisions to be made on the risks of pursuing and defending a claim.



information & publishing solutions

Published by TSO (The Stationery Office) and available from:

Online

www.tsoshop.co.uk

Mail, Telephone, Fax & E-mail

TSO

PO Box 29, Norwich, NR3 1GN

Telephone orders/General enquiries: 0870 600 5522

Order through the Parliamentary Hotline Lo-Call 0845 7 023474

Fax orders: 0870 600 5533

E-mail: customer.services@tso.co.uk

Textphone: 0870 240 3701

The Parliamentary Bookshop

12 Bridge Street, Parliament Square

London SW1A 2JX

Telephone orders/General enquiries: 020 7219 3890

Fax orders: 020 7219 3866

Email: bookshop@parliament.uk

Internet: <http://www.bookshop.parliament.uk>

TSO@Blackwell and other Accredited Agents

ISBN 978-0-10-181802-5



9 780101 818025