House of Commons
Health Committee

Complaints and Litigation

Sixth Report of Session 2010–12

Volume III

Additional written evidence

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The Health Committee

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

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The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

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The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom.

The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

Committee staff

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

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

Ms Manuela Manuel
Jeffrey Williams
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David de Grothier
David Eaton
Martin James Wildman

Anonymous
Miss Donna McCallum
Mr Johnstone
Mr Leslie Smith

Written evidence

Written evidence from Patient Opinion (CAL 03)

1.0 SUMMARY

Patient Opinion is an independent, not-for-profit website where patients, carers, service users and staff can share their stories of care at any major NHS provider in the UK and NI. These stories give Patient Opinion a unique insight into how patients view the NHS, the complaints procedure and litigation process.

In general people using Patient Opinion report that they are dissatisfied with most aspects of both complaints and litigation (eg http://bit.ly/9uRzJB). This supports the wider evidence about complaints and litigation but contrasts strongly with how people view their clinical care on Patient Opinion (around 50% of stories are people saying Thank You).

We believe that web 2.0 tools (as represented by Patient Opinion and other platforms) have huge potential for improving both complaints and litigation.

2.0 ABOUT PATIENT OPINION

We have been using web 2.0 tools to give patients and service users a public, independent voice for the last six years. We aim to direct these stories to "just the right people" in the health community so generating structured, public on-line conversations about those aspects of care that concern patients. We have also learnt a great deal about how to ensure that such feedback is ass useful as possible to busy staff. To date there are around 30,000 stories on Patient Opinion covering all aspects of health care across the UK. Based on this experience and the independent evaluation of Patient Opinion carried out by the University of Birmingham (in press) we believe that:

- Web-based platforms have the potential to generate feedback that improves services from a wide range of people at a lower cost than traditional methods.
- The public and independent nature of web-based feedback shifts power to the patient and away from providers and professionals. Structured in the right way this is potentially very powerful.
- The power of the patient voice is further strengthened by routinely alerting a wide range of stakeholders to relevant stories. On Patient Opinion this includes relevant front line staff, PCTs and PBC commissioners, patient organisations, and Healthwatch/LINks.
- The structured, public conversations that result are useful to both patients and staff and up to 10% of stories result in a service improvement—for example see http://bit.ly/d10AX1.
- Because web-based platforms are scalable they are potentially much cheaper than traditional forms of feedback.

3.0 COMPLAINTS

3.1 *The role of local authorities and Healthwatch in complaints*

Patient Opinion already works with >40 LINks. Based on this experience we believe that web-based feedback could:

- Engage many more citizens in giving feedback (good as well as bad) at much lower cost.
- Engage many more front line staff in dialogues that improve services as a result of patient feedback.
- Enable many more local organisations to monitor and respond to on-going health issues as they emerge locally
- Provide a very low cost way to resolve at least some potential complaints via on-line, public dialogue with relevant front-line staff. (At one substance misuse clinic the number of complaints fell sharply in the months after stories from users were actively sought, responded to, and published in the waiting room).

Given the financial position of both the NHS and local authorities we believe that there are strong arguments for using existing web platforms such as NHS Choices and Patient Opinion to augment or replace some of the current infrastructure for complaints, PALS and advocacy.

Patient Opinion would be interested in exploring how best it can help the emerging Healthwatches role in using its platform to re-engineer the complaints for the new world.

3.2 *Feeding data from complaints into the planned new commissioning arrangements*

Patient Opinion has worked with >20 PBC Consortia. Based on this experience we believe that web-based platforms could help commissioning in the following ways:

- PBC Consortia can add comments to stories originating from their health community. This makes it more likely that a response occurs and if appropriate, a service improvement is made. It also helps generate the Consortium's own reputation with its patients.
- Such service improvements are logged on Patient Opinion so that both the provider's and the commissioner's role in listening to feedback and making improvements can be displayed and acknowledged. In 2011 Patient Opinion will begin showing how all providers in the UK compare with respect to:
    - How often they respond.
    - How often they make service improvements as a result of patient stories.

These mechanisms and metrics drive up quality at the micro level. They could also be used to make complaints more effective in the commissioning process. For example we are currently exploring how we could work with two to three trusts to use Patient Opinion's public web-based platform routinely within their complaints procedures. If this works the resulting public conversations would be routinely available to commissioners who could then add their own comments. Moving complaints outputs online in this way would make the learning from each complaint more widely available whilst increasing accountability.

4.0 LITIGATION

Patient Opinion has been working for the last 18 months to adapt the ideas of restorative justice to the NHS. The aim would be to create a system of "restorative redress" that promotes compassion, mutual understanding and learning between patients, families, clinicians and provider organisations. Restorative redress would not suit everyone but if successful for even a minority of cases could provide much better outcomes and greatly reduced costs compared with current litigation processes.

Restorative redress would use a mixture of on-line and face-to-face interactions to promote mutual understanding. Agreements reached between patient, clinician and Trust would be published on Patient Opinion thus increasing transparency and shifting power towards patients and families.

Restorative redress has gathered interest from a wide range of bodies including the NHS Litigation Authority, defence organisations and lawyers acting both for and against the NHS in medical negligence cases.

Restorative redress is as yet simply a proposal and we are currently in discussion to fund it via a social impact bond. If successful it could have a major impact on developing an open reporting and learning culture in the NHS as well as on extending the scope and effectiveness of mediation.

We would be happy to provide the Committee with more details if this would be helpful.

November 2010

Written evidence from Miguel Cubells (CAL 04)

- The reasons for the recent sharp rise in NHS complaints. Simply because no one can get a solicitor to sue the NHS (Legal aid issues) and/or because more people are dying/harmed due to a festering cover up culture within the NHS. The NHS needs to be opened up, mistakes need to be admitted and robust fixes need to be put in place to stop future harm. The current cover up culture encourages a festering, unhealthy, underlying environment for patients.
- The effectiveness of the new complaints system introduced on 1 April 2009 All smoke and mirrors, there is still no sacking of managers who obstruct Justice, and they can still brand genuine, determined, focused complainants "VCs" (vexatious complainants), only now they are barred for six months, and then are called something else!
- The effectiveness of the constituent parts of the complaints system: local resolution (supported by the Independent Complaints Advocacy Services); and referral to the Ombudsman. Has not made any difference at all, just means the ombudsman is overworked and turns valid cases down at a rate of 98% (2009–10).
- The role of Patient Advice and Liaison Services as a "gateway" to the complaints system. Waste of time in most cases, they are non independent and in the main have the trusts interest at heart.
- The failure of some Foundation Trusts to report numbers of complaints. They are still under no obligation to do so, it just depends on how they classify complaints.
- The Government's plans for future complaints-handling arrangements (the White Paper says, on p. 19, "Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support ... supporting individuals who want to make a complaint"). Just PALS with a different name—they will have no powers at all either.

- How data from complaints will feed into the planned new commissioning arrangements (the White Paper says, at Para. 2.26, "Building on existing complaints handling structures, we will strengthen arrangements for information sharing"). What's the point of sharing lies and forged stats?

LITIGATION

- The cost of litigation against the NHS. If these people did not have a case, it would not cost anything..MIND YOU, DID YOU KNOW THAT THE BULK OF PAYOUTS ARE TO STAFF WHO HAVE SLIP TRIPS AND FALLS? NOT WIDELY PUBLICISED?
- Reasons for the inflation of litigation costs in recent years. Possibly because solicitors are on nice little earner?
- The impact of conditional fee ("no win, no fee") arrangements on litigation against the NHS. This has meant low quantum death patients, ie the most vulnerable groups in society, are ignored due to financial gain by Solicitors. Thousands of people robbed of justice by virtue of a solicitors income from cases, rather than conduct or merit. This has created a very dangerous environment were low quantum patients can be neglected without fear of redress in the Courts. The value of our elderly, low quantum patients needs to be increased for Moral and Just reasons.
- The effect of litigation on the development of an open reporting and learning culture in the NHS. Has had no effect, just increased the incidence of forgery and failure to leave any paper trail of incidents on AIRS systems. So in affect has just increased lies—it's cheaper to tear up a bit of paper than defend it in a courtroom UNLESS ITS A NURSE, WHO GETS A COLLEAGUE TO REPORT A SLIP/TRIP/FALL ON THE AIRS SYSTEM?
- The Government's intentions regarding the implementation of the NHS Redress Act 2006. Not worth the paper it's written on. Besides which, if we're still waiting for a 2006 act to be implemented in 2010—how long is it going to take the present Government to implement any conclusions they draw over nhs complaints?
- The possible benefits of a statutory right to compensation for "treatment injury" from an independent fund, without the need to prove negligence, as required under tort law. Will be a system that runs inappropriately, just like the criminal injuries board did....where you will have a tariff system—true individual losses are not covered by these processes, eg a pianist who loses a finger, loses more than a couch potato who loses a limb.
- Encouraging the use of mediation before litigation is initiated NO WAY! POOR MAN'S JUSTICE—WE ALREADY HAVE MEDIATION, ITS CALLED "COMPLAINING"—IT IS JUST A WAY OF OBSTRUCTING PEOPLES RIGHTS TO SUE—THE POSSIBILITY WERE COMPLAINANTS WILL HAVE TO GO THROUGH "MEDIATION" BEFORE THEY CAN START LITIGATION IS NOT THE WAY FORWARD. TO SIT IN THE SAME ROOM FOR MEDIATION PURPOSES, WITH A DOCTOR WHO HAS NEGLIGENTLY KILLED A FAMILY MEMBER IS UNACCEPTABLE.
- AND STILL THE AREAS NOT BEING COVERED ARE, AS ALWAYS, THE INTERFACES BETWEEN STATE SYSTEMS—EG CORONER/POLICE/GMC/CQC—THE COMPLAINTS ARE ONLY MADE AFTER SOMETHING BAD HAS HAPPENED—THERE IS NO PUNISHMENT OR SANCTION OF MANAGERS WHERE DEATHS AND INJURIES ARE CAUSED BY FAULTY EQUIPMENT (WHICH IS NOT A DR OR NURSE'S FAULT), FAULTY PREMISES, POOR ROTA ARRANGEMENTS, POOR TRAINING OF STAFF, AND A LACK OF MANAGERIAL ACCOUNTABILITY

November 2010

Written Evidence from S Ramskill (CAL 05)

COMPLAINTS

- The reasons for the recent sharp rise in NHS complaints.
  My opinion. Because the hospitals do not address ANY complaints, so the public get annoyed and feel they are being fobbed off, which they are. Some people would accept a reason for the errors together with an apology, BUT the NHS immediately put a wall up ignoring the complainant and treating them as though, it's them that are in the wrong.
- The effectiveness of the new complaints system introduced on 1 April 2009.
  Because my complaint is the first Official complaint with this body of people, BUT I do not rate their competence to address complaints, they fob you off with so many excuses, why they are unable to address your case, OR in my case 99% of my case, and are only investigating 1%. A sham.
  If they only accept 98% of cases, from the PHSO Then only address 1% (as in my case) of the complaint, what work are they doing? They are a waste of public money.

— The effectiveness of the constituent parts of the complaints system: local resolution (supported by the Independent Complaints Advocacy Services) and referral to the Ombudsman.
ICAS did not have any authority to ask the NHS questions, but felt they obtained all my information and gave it the nhs leaving me little to play with BUT the NHS having all the info, almost. they didn't come back with any answers for me, only to go to the next Stage of the complaint system, the phso, what a farce.

— The role of Patient Advice and Liaison Services as a "gateway" to the complaints system. IF? the complaint system had addressed my initial complaint in 2006 maybe? I wouldn't have had to endure the past four years of a sham? They work for the NHS NOT for the public.

— The failure of some Foundation Trusts to report numbers of complaints. I don't believe they publish OR address half the complaints, they fob the public off, or I believe there would be more complaints going to PHSO BUT it doesn't show the hospital trust in its true light. They lie about how many errors they really have had, and reasons for people's deaths.

— The Government's plans for future complaints-handling arrangements (the White Paper say son p. 19 "Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support ... Supporting individuals who want to make a complaint").Unless you change the format and have the complaints systems working for the government ONLY and not the NHS. Then they will cover for the NHS even if they know they are in the wrong? Same as they have for many years. Nothing will change.

— How data from complaints will feed into the planned new commissioning arrangements (the White Paper say sat Para. 2.26 "Building on existing complaints handling structures we will strengthen arrangements for information sharing"). Litigation unless the complaints system and/or icas etc address the public's complaint fairly and without prejudice towards the complainant, there will always be some? Litigation.

— The cost of litigation against the NHS.
Do you believe that people only complain for litigation? Because there would be a very small amount that would, the majority want answers and peace of mind.
Not many solicitors will accept legal aid against the NHS. As one said to me? That would mean I was stating they did it with malice, They did BUT he would not accept my case. The NHS have their fronts and backs covered, no one helps the complainant until their hands are tied.
It's all a farce.

— Reasons for the inflation of litigation costs in recent years.

— When the public have had to fight for years for justice then yes it will cost more in litigation. IF? They were resolved quickly there would be very little paid out? If any?

— The impact of conditional fee ("no win no fee") arrangements on litigation against the NHS. mainly a sham anyway, most people can't get a solicitor to fight for them, depending on the severity of the error the NHS have caused the no win no fee fee system, is subject to maybe? Past events (errors) not those living people who need justice for themselves eg myself.

— The effect of litigation on the development of an open reporting and learning culture in the NHS. If the public have suffered a loss of their family through human error, negligence etc they are entitled to some compensation? The idea is to get competent staff that don't work agency's OR work private in between their shifts. This causes errors.
IF? They named and shamed those making the errors, instead of covering for them, maybe they would take more care in the future and be afraid to make more errors for fear of being named.

— The Government's intentions regarding the implementation of the NHS Redress Act 2006.has this law been implemented? Or is it just words? On a paper?

— The possible benefits of a statutory right to compensation for "treatment injury" from an independent fund without the need to prove negligence's required under tort law. If a patient loses their life because of incompetence then surely a bit of compensation is not a lot to ask? too many organs removed and it been wrong? OR operations on wrong people? Wrong diagnosing. The public need to gain trust back into their lives about the competence of NHS. Some are afraid to go into hospital for fear of not going home alive. Myself included.

— Encouraging the use of mediation before litigation is initiated I for one tried mediating with my Dr who informed me he didn't have to justify his actions to me? What chance have we of mediation when the patient cannot get honest answers from their own doctors? Another cover up.

Will the person or persons responsible for my being taking me off a lung transplant list after five years of a sham be sacked? No he/she will remain to destroy another's life, literally.

The complaints system within hospitals is a waste of public money.

When the manager was off sick at my ex hospital, No one there could take over, they said it was a complex case.

When I spoke to the manager (complaints) asking if she mentioned that I had approached her in 2006 with my issue, she replied, I put it in my letter didn't I. It was not in the reply, another cover up within the NHS.

I am a member of the NHS reform group and to read some of the stories are heart rendering, does no one care anymore about the public complaints?

I for one cannot get justice.

Why are they classed as vexatious if they want answers? This is their get out of jail free card and then any future questions will be deleted. They are monsters, not doctors nurses or caring staff.

November 2010

Written evidence from the Royal College of Radiologists (CAL 06)

1. The Royal College of Radiologists (RCR) has approximately 8,500 members and Fellows worldwide representing the disciplines of clinical oncology and clinical radiology. All members and Fellows of the College are registered medical or dental practitioners. The role of the College is to advance the science and practice of clinical oncology and clinical radiology through a range of activities, including setting and maintaining the standards for entry to, and practise in, the specialties of clinical radiology and clinical oncology, and arrangements for continuing professional development (CPD) in both specialties.

2. Complaints and litigation are unfortunately part of normal contemporary practice within the UK now for a wide variety of reasons and this inquiry is therefore most welcome. This response details the RCR's views on the Health Select Committee's questions and outlines the role of the Imaging Services Accreditation Scheme (ISAS) in benchmarking quality improvement in this area.

COMPLAINTS

The reasons for the recent sharp rise in NHS complaints

3. The rises are likely to be due to an increased awareness of litigation possibilities amongst the public and a more proactive legal industry as a result of the NHS Redress Act 2006. Public expectations have been raised inappropriately. There is now an expectation of a definitive accurate diagnosis and management plan every time and less understanding that there are shades of grey or of the concept of reasonable complications or indeed that complications are always possible.

The effectiveness of the new complaints system introduced on 1 April 2009

4. There does not appear to have been much change. Hospital complaints systems can still appear too defensive. In medico legal work there are often long delays in receiving the relevant notes, images etc from Trusts.

The role of Patient Advice and Liaison Services as a "gateway" to the complaints system

5. This appears to have been successful as patients should know where to go to "start" the process.

The Government's plans for future complaints-handling arrangements (the White Paper says, on p. 19, "Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support ... supporting individuals who want to make a complaint")

6. If carried out properly, this may provide an independent source to explain events to patients—provided there is medical input—which could reduce inappropriate litigation. However, this relies on patient involvement before anything goes awry.

How data from complaints will feed into the planned new commissioning arrangements (the White Paper says, at Para. 2.26, "Building on existing complaints handling structures, we will strengthen arrangements for information sharing")

7. This has the potential for disaster. Information needs not only to be shared but understood.

LITIGATION

The cost of litigation against the NHS

8. There is a lack of public awareness of where compensation money comes from.

Reasons for the inflation of litigation costs in recent years

9. See point 4 above. Perhaps there should also be a review of how doctors trained overseas are accepted into NHS posts in the UK.

The impact of conditional fee ("no win, no fee") arrangements on litigation against the NHS

10. It would be useful if a study could be carried out into the percentage of successful actions versus the overall total to assess whether there are too many mistakes or too many claims.

The effect of litigation on the development of an open reporting and learning culture in the NHS

11. Open reporting and protection of whistleblowers is a real problem in the NHS. Doctors are very isolated when trying to correct serious health service deficiencies. Our economy does not support best practice in this area.

The possible benefits of a statutory right to compensation for "treatment injury" from an independent fund, without the need to prove negligence, as required under tort law

12. This may result in doctors refusing to treat difficult cases or anyone who the balance of probabilities suggest will not do well.

Encouraging the use of mediation before litigation is initiated

13. Mediation could have a positive place, provided the clinical case was handled correctly eg possible complications spelt out to patients and relatives. Patients should understand that not everything is controllable and has a programmed outcome. Doctors need to take the time to involve patients and they must be seen in the eyes of the law to have taken their decisions in the full knowledge of the facts. If this is carried out properly and documented, mediation could have an important role.

Imaging Services Accreditation Scheme

14. The Imaging Services Accreditation Scheme (ISAS) is an accreditation process to support radiology services in the UK in delivering higher quality patient-focused services. The RCR jointly established the scheme with the Society and College of Radiographers and it is being run for the two colleges by the United Kingdom Accreditation Service (UKAS).

Achieving ISAS accreditation will mean that Radiology departments have established particular standards of service delivery and expected performance although each department will run their own individual processes for complaints and litigation within the remit of their own Trust processes and structures.

We believe taking part in the accreditation process and ultimately achieving ISAS status will mean that Radiology departments have a better chance of reducing complaints and litigation with respect to their practice and therefore we consider that ISAS accreditation is an example of benchmarking potential quality improvement in this area.

December 2010

Written evidence from the Centre for Effective Dispute Resolution (CAL 07)

Executive Summary of CEDR's Views

- The latest reform of NHS complaints has made few apparent improvements for patients.
- Serious NHS complaints need an independently managed process for effective resolution so as to improve outcomes and minimise the risk of escalation into litigation.
- Systematic requirement of mediation before issue of clinical negligence proceedings will provide a speedier, better and more user-friendly process and outcomes for the benefit of patients and healthcare providers, with immense savings in legal costs.

CEDR's Background

1. The Centre for Effective Dispute Resolution (CEDR) has built up considerable expertise in conflict management and resolution since being founded 20 years ago with support from the CBI and a number of leading law firms and businesses and is registered as a charity with the objectives of developing alternative forms of dispute resolution for the benefit of society. It has developed into the largest provider of mediation services in the UK and Europe and is internationally known for the calibre of its mediator training. It runs conflict management and advanced negotiation courses and has done work for the United Nations, NATO, the World Bank and its business arm of the World Bank, the International Finance Corporation.

2. CEDR has always been actively involved is healthcare disputes. Its work has notably included design and delivery of the retained organs mediations, leading to settlement first of the Alder Hey and then the National Organ Group Litigation. It provided mediators for a number of the cases in the NHS Mediation Pilot in 1996–97 and did training work for the Healthcare Commission.

3. CEDR is also a member of the Clinical Disputes Forum, a multi-disciplinary body set up to design the Clinical Negligence Pre-Action Protocol. One of CEDR's Directors is Treasurer of the CDF and recently

chaired a multilateral working group to produce the latest revision of the Clinical Negligence Pre-Action Protocol. CEDR also submitted a paper on aspects of inquiry procedure and the use of mediation principles to the Mid Staffordshire NHS Trust Inquiry. CEDR' s Chief Executive, Dr Karl Mackie CBE (an honour recently awarded to him for services to mediation) was a member of the Chief Medical Officer's advisory group on the NHS Redress Scheme.

4. During 2005 and 2006, CEDR piloted a scheme for mediating cases where the Healthcare Commission found that a case referred to them looked suitable for further local resolution. These cases involved a carefully managed meeting between the complainant and the clinician involved, which made possible the exchange of frank views, and the expression of such remedies as apology, explanation as to what happened and reassurance of changed practice. On occasions modest compensation was agreed and paid rather than reconvening in some other form. The mediator sent a brief report to the Commission confirming that the mediation had taken place and whether or not the complaint was closed. Most did achieve this, relieving the Commission of any further need to intervene. Several cases were of a nature that could easily have moved into litigation (fatalities, for instance).

Nhs Complaints

The current position and the PHSO's First Report on NHS complaints

5. The first PHSO Report on NHS complaints notes a 100% rise in complaints over the previous year: suggesting:

- a massive worsening in NHS service, giving rise to a gross increase in complaints; or
- a massive deterioration in the effectiveness of the new form of local resolution, inducing far more referrals fro review by dissatisfied service users; or
- no increase in gross complaints, but better routeing into review by the PHSO.

Only a tiny proportion of the more than 15,500 referrals made to the PHSO were investigated fully by her office, so a huge number are still not beyond first stage and might well be festering there. Cases actually reported to the PHSO are a tiny proportion of the whole number of complaints received by the NHS. There must be great concern that the (yet again) revised complaints system is still generating dissatisfaction at local levels and that there is much to complain about in both substantive terms (things actually to complain about) and also in procedural terms (the way complaints are handled). Bearing in mind that this is the third major reform since the Wilson report in 1996, it is lamentable that the situation is still so bad.

6. The report's title "Listening and Learning" indicates the area which remains seriously under-provided for, and that is response to individual claimants. Complaints belong not to the NHS, as a source of information and learning (though every organisation should learn well from its mistakes): it is essentially about the individual complainant who summoned up the nerve (not at all easy for many) to complain about a huge organisation or a professional perceived to have failed somehow. Such people deserve proper responses conducted through a transparent and independently run process through which people to have their say, however uncomfortable, and believe that their concerns have been heard through respectful and appropriate responses.

The need for an Independent Element in Improved Local Resolution of Complaints

7. CEDR's experience suggests that there is enormous value to all who participate in complaints processes in their being run by a **neutral process manager**, chairing joint meetings but also seeing parties privately, and crucially perceived as independent of the NHS. Difficult meetings conducted by NHS employees and managers, often on NHS territory, will not be seen as independent. Bilateral meetings involving only patient and clinical staff will risk both perceived imbalance of power (which even the best advocacy from ICAS will not eliminate) and also defensiveness on the part of clinicians and healthcare bodies, making true resolution less likely.

The Committee's Concerns

8. We have answered only those questions within our expertise.

8.1 *The reasons for rising NHS complaints.*

8.2 *The effectiveness of the new complaints system.*

We fear that we think this signifies yet another failed solution. We argued that, while the new system sought to generate learning for the NHS, the proposals were weak on process provision for satisfying complainants who want someone of suitable status to listen and respond to their particular concerns at a human level. Chief Executive letters are of very dubious usefulness: we have seen these aggravate and not alleviate complaints. Listening and learning are not enough: there is a need for responsive communication too.

8.3 *The effectiveness of the constituent parts of the complaints system.*

8.4 *The role of Patient Advice and Liaison Services.*

8.5 *The failure of some Foundation Trusts to report numbers of complaints.*

8.6 *The Government's plans for future complaints-handling arrangements.*

8.7 *Complaints data and the planned new commissioning arrangements.*

Good advocacy and support are obviously vital in circumstances where legal representation is either disproportionate or too expensive or not sufficiently or properly focused. ICAS has impressed us, and it would be a shame if its good work was lost. But advocacy is not enough. Heavier complaints which might become litigious if not dealt with well, should have independent chairing.

CEDR's Overall Views on NHS Complaints

9. Any system for complaints handling must be affordable. But the parallel rises in complaints and claims suggested by the PHSO and NHSLA reports over the last two years suggest a correlation between these. A badly handled serious complaint risks turning into a claim, with a whole new level of cost to the NHS. So we cannot afford not to have a sound complaints handling system.

10. In less cash-strapped times, we would strongly suggest setting up some kind of independently funded Healthcare Mediation and Arbitration Service to deliver a degree of independence to NHS complaints handling in the NHS, even perhaps also covering the myriad internal disputes which bedevil the NHS, making it possible to build up unified skills and experience and enable national learning, with relatively local (perhaps regional) delivery of consistent and neutral interventions. Such a service could even deliver NHS Redress, if implemented.

11. Instead we suggest that:

- A survey of complaints processes is undertaken nationwide and a database established. What works well locally should be universally available.
- Information gleaned should be presented to a symposium of those interested and fixed with developing the next generation of complaint handling systems. A national policy devised nationally and devolved and delivered regionally will be preferable.
- DH in consultation with an experienced dispute resolution organisation identified by tender and the PHSO should draw up guidelines for procedures, recruitment and training for such neutrals, and the classification of complaints into categories best handled by internal staff and by external neutrals.

Health Litigation

12. CEDR has long argued the need to improve clinical negligence claims processes for the benefit of claimants and healthcare providers. We have strongly advocated mediation as the very best process available. Mediation of such claims achieves settlement rates of over 90%, and with very high satisfaction levels among participants. People often also say "I never really wanted to sue the NHS"; "if only my original complaint had been handled properly I would never gone this far"; "if only they had apologised and explained what went wrong, I would have been satisfied" and the like. This underlines the necessity for properly handled complaints to minimise their conversion into hugely expensive health litigation.

13. A good source of empirical comment and research is still to be found in the report written by Professor Linda Mulcahy about the NHS Mediation Pilot in the late 1990s. This captures the enthusiasm felt by participants in the few cases which were handled within that pilot (12 in all, against a background of seriously adverse circumstances for its operation, as the report makes clear), all of which all settled satisfactorily. Its preparatory research also revealed that over 70% of claimants were very or seriously dissatisfied with the claims process they had undergone, even when they obtained compensation. Its research also confirmed the importance of non-monetary remedies to claimants, such as apology, explanation and reassurance of changed practice, none of which can be ordered by a court. NHSLA guidance has certainly made apology more possible without any assumption of liability, but even the PHSO's Report makes clear that defensiveness by the NHS in responding to complaints is still a problem.

What does mediation bring to resolution of clinical complaints?

14. Mediation brings:

- A good quality **settlement event** managed by a skilled neutral, with a degree of inclusiveness, confidentiality and a mix of formality and informality;
- The **personal presence** of the claimant and (where desired) the healthcare professional (HCP) involved;
- Hence a **direct encounter for all key decision-makers** in an evidentially secure and confidential environment, skilfully managed by a neutral chair. who is committed to assisting all present to participate as fully as they feel able, enabling open communication, catharsis, risk analysis review and assisted negotiation, with the claimant restored to the heart of their claim and able to negotiate non-monetary remedies such as apology, explanation and reassurance of reformed practice.

How are clinical claims currently resolved?

15. Mediation seems to be used very rarely in clinical claims in England and Wales. Over 90% settle without trial (see the NHSLA's statistics), by either conventional negotiation, acceptance of a formal Part 36 offer or

at a bilateral round table meeting (RTM), where both legal teams meet to discuss settlement, usually (but not always) with the claimant present but not the clinician or trust representative. Lawyers tends to dominate RTMs and there are still reports of rapid deadlock and walkout from RTMs, with cases proceeding to trial. So far as CEDR knows, no empirical research has been done on the effectiveness of the RTM process, and certainly not in comparative terms as against mediation. There are a number of ways in which the mediation process is clearly superior in the way benefits are conferred on the parties to a clinical dispute which can be enlarged upon orally, if required

Achieving Earlier and Better Settlements

16. The Clinical Negligence Pre-Action Protocol has recently been revised by a multi-lateral group of interested stakeholders in clinical disputes chaired by a CEDR Director and mediator. It awaits ratification by the Rule Committee. Its purpose is to effect sufficient exchange of positions and information to make it possible to consider settlement without the need for issue of proceedings. It requires parties to consider ADR (including mediation) before issue as a way of achieving resolution. Its provisions are simply not being observed and enforced. Mediations are not taking place much at all, let alone after the protocol has been observed and before proceedings are issued, the point where they might most usefully be deployed to explore satisfactory early, economic and effective settlement. Claimants have three years before they must issue a claim, giving plenty of time to comply with the protocol's requirements to exchange positions and sufficient evidence to assess liability and causation in most cases.

17. A pre-issue settlement event to explore the desirability of settlement gives an opportunity for parties to capture the **goodwill dividend** said to underlie claimants reluctant to sue the NHS, knowing that damages simply reduce clinical budgets. Early proposals for non-monetary may enable a modest fairly risk-discounted settlement to be negotiated before the huge expense of court fees, drafting proceedings and indeed full involvement of legal teams on both sides are incurred. It will also minimise further entrenchment of attitude that litigation almost inevitably involves. The costs of pre-issue mediations can be minimised by the NHSLA or MDO involved having in-house representation. Claimants, mostly represented by very experienced accredited law firms, will only instruct counsel in the heaviest cases.

18. Mediation makes risk-discounted settlement possible. Clinical claims are rarely certain of success, with probably the lowest overall success rate for claimants of any area of negligence law. There is no injustice in settling a claim worth £100,000 for £70,000 if an honest appraisal of risk suggests that the claimant will win seven times out of 10 and lose three times. Claimants are often much more risk averse than their professional advisers, and to be given the opportunity to consider, with expert advice from their legal adviser, accepting a risk discounted settlement now rather than the risk of going on.

19. The Committee's specific concerns

19.1 *The cost of NHS litigation and reasons for costs inflation.*

The current cost seems extraordinary and unsustainable. Before CFAs were introduced, clinical negligence lawyers were content to accept Legal Aid base rates and reduced rates for cases that were not won. Now they carefully monitor the cases they take on to minimise the risks of losing and seek 100% uplift on costs as soon as they properly can. The problem is over paying claimant lawyers for properly undertaken work on cases which do not proceed successfully. There tends to be a high drop-out rate in clinical claims because they are harder to substantiate, so more work is required for success.

19.2 *Conditional fee arrangements.*

The impact of CFAs, success fees, ATE premiums and the activities of claims farmers in this area, plus the limited financial scope of LSC funding has been immense, as vividly illustrated by Sir Rupert Jackson's Costs Review. The NHSLA submission to the Jackson Review of Civil Costs and its Annual Reports over much of its lifetime since 1995 make a number of telling points to substantiate this fact.

19.3 *The effect of litigation on developing a learning culture.*

The NHSLA surely feeds back what it learns from claims handling.

19.4 *Implementing the NHS Redress Act 2006.*

Having contributed to the process of designing the NHS Redress Act, we are glad that this recognised the value of mediation in resolving cases thereunder. The Welsh Assembly is implementing it, unifying serious complaints handling with clinical claims up to £40,000 in value in one process. Whether England (or indeed Wales) can afford it needs consideration. We hope that NHS Redress will conclude lower value disputes swiftly and effectively, with modest compensation available through the complaints process, and with mediation integral to the system. Lower value cases are not free either from complexity or high emotion. They will encompass "dead baby" cases and deaths of a non-dependent close relative for whom only bereavement damages are payable, as well as contentious but low damages claims by the living. Mediation as a good process for handling the high emotions usually dominant in such cases needs to be embedded from the outset.

19.5 *Compensation for "treatment injury" without proving negligence?*

We agree with the CMO's conclusions in *Making Amends* that no-fault compensation was undeliverable in the UK. Its limits are very low in New Zealand, and it will be hugely expensive and here it will not necessarily either achieve the social benefits argued for it or the costs savings, and eliminating blame and a sense of personal or corporate responsibility from compensating those who have suffered avoidable damage from healthcare may well not lead to improved standards.

19.6 *Encouraging the use of mediation before litigation is initiated.*

Steps should be taken to require **as a norm** mediation of clinical claims before proceedings are issued, though always subject to exceptions approved retrospectively by the court. Procedural machinery is in place in the protocols, and the Civil Procedure Rules do not need amendment for the judiciary to ensure (as they are not doing currently) that this happens. Research by the NHSLA should confirm that many cases are settled not long after issue. Such cases should be targeted as capable of settlement before proceedings, thus alleviating pressure on the courts and giving earlier outcomes to claimants and relieving professional defendants from the strain of litigation.

December 2010

Written evidence from the National Children's Bureau (CAL 08)

SUMMARY

- This submission focuses on the extent to which existing structures for supporting the public to make complaints about health services are effective in working with children and young people, and the implications for government's plans for NHS reform.
- If government implements its plan to require local HealthWatch to support patients to make complaints, it is of central importance that all HealthWatch bodies effectively engage and support children and young people from inception, and draw on lessons learned and existing good practice within Patient Advice and Liaison Services and Local Involvement Networks.
- We urge the Committee to recommend that government:
  - involve children and young people, including those with complex needs, in the further development and implementation of HealthWatch England and local HealthWatch;
  - use the Health and Social Care Bill to make *explicit* that local HealthWatch bodies have a responsibility to provide their services to children and young people;
  - put in place mechanisms to support HealthWatch and continuing PALS to effectively work with and support children and young people and engage them in the development of their service, including by:
  - put in place mechanisms via which local HealthWatch and PALS can share and build upon each others' good practice in working with children and young people, including the most vulnerable, perhaps through HealthWatch England;
  - provide incentives to ensure that local HealthWatch bodies engage in effective outreach work with marginalised groups of children and young people and those with complex needs; and
  - consider the use of a standardised local HealthWatch brand to help members of the public, including children and young people, navigate the local complaints system and identify sources of support.

1.0 ABOUT NCB

1.1 NCB's mission is to advance the well-being of all children and young people across every aspect of their lives. As the leading national charity which supports children, young people and families, and those who work with them, we focus on identifying and communicating high impact, community- and family-centred solutions.

1.2 NCB has a long history of promoting health improvement among children and young people, and enabling children and young people to influence the quality and choice of the health services they receive. Our work focuses on improving health outcomes for disadvantaged children, including disabled children and young people, children in the care, black and minority ethnic groups and young people involved in the youth justice system and in supported housing. As one of the Department for Health's strategic partners, we also provide practical support to charities, voluntary organisations and social enterprises delivering health services in England. Our submission draws, in particular, on two NCB projects supporting Patient Advice and Liaison Services and Local Involvement Networks to better engage and support children and young people.

2.0 THE EXPERIENCE OF PATIENT ADVICE AND LIAISON SERVICES AND LOCAL INVOLVEMENT NETWORKS

Patient Advice and Liaison Services (PALS)

2.1 PALS were established to support users of healthcare services to access information and express concerns or make complaints about their treatment. They were expected to work with *all* patients, including children and young people, with the implementation guidance stating explicitly that:

> *"All public sector bodies now have a responsibility to ensure children are heard and that services meet their needs...Hence, not only do PALS need to meet this requirement but they can and should play an active role in ensuring their respective organisations achieve this aim".*[1]

The subsequently published national standards and evaluation framework were, however, far weaker on work with children and young people.[2]

2.2 Research suggests that PALS have tended to be ineffective in engaging with and supporting children and young people. In a survey and focus groups conducted by NCB:[3,4]

- most children and young people were unaware of PALS services;
- 75% of PALS reported that their service did not actively involve children and young. The main reason for this was a lack of the necessary resources, skills and support from managers;
- 60% of PALS reported not following any guidelines regarding the participation of children and young people; and
- only one out of 114 respondents reported attending training on how to involve children and young people.

2.3 Similarly, studies carried out by the University of York[5] found that:

- children and young people are low users of PALS;
- PALS services have been developed as a generic service, with policies, service specifications and targeted activity unlikely to focus on children and young people; and
- PALS staff tended not to receive training on working with children and young people, focusing instead on other vulnerable or disadvantaged groups, such as those with communication problems, ethnic minorities and older people.

2.4 Despite these findings, parents who *have* used PALS demonstrate high levels of satisfaction about the service.[5] Furthermore, those children, young people and parents who were not aware of PALS when consulted, thought that the service could be really useful once it was explained to them.[4,5]

2.5 Despite this low level of engagement, there *are* examples of good practice in PALS, particularly where they have sought to involve children and young people in their work to help attract, and meet the needs of, younger age groups. Examples of good practice identified by NCB included:

- engaging young people (and young adults) as PALS volunteers;
- involving children and young people in the development of promotional materials;
- appointing children and young people impact champions to review services, carry out "mystery shopping" etc;
- appointing or identifying a specific member of staff to lead on the engagement of children and young people;
- forming strong working relationships with wider children's services—eg schools and colleges—to raise awareness of the service and better understand children and young people's needs; and
- engaging in specific and targeted activity with vulnerable young people, such as those in custody.

2.6 Through our PALS project, NCB has provided training to 174 of the approximately 500 PALS in the country, many of whom have since reported increased involvement of children and young people.[6]

Local Involvement Networks (LINks)

2.7 With government planning to replace LINks with local HealthWatch bodies and give them greater responsibility for supporting patients to make complaints,[7] it is important to draw upon the experience of LINks in working with and involving children and young people. LINks were established in law to promote and support the involvement of people in the commissioning, provision and scrutiny of local health and adult social care services.

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[1] Department of Health (2002) *Supporting the Implementation of Patient Advice and Liaison Services: A resource pack* http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4015493

[2] Department of Health (2003) *PALS core national standards and evaluation framework: Assessing performance against national core standards for PALS* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4119314

[3] Pobi S (2007) PALS: *Getting it right for children and young people—A report on the results from NCB's PALS survey in July 2007* http://www.ncb.org.uk/default.aspx?page=605

[4] Pobi S (2007) PALS: *Getting it right for children and young people—Consultations with children and young people* http://www.ncb.org.uk/default.aspx?page=605

[5] Heaton J and Sloper P (2003) *Access to and use of Patient Advice and Liaison Services (PALS) by children, young people and parents—a national survey;* and Heaton J et al (2008) "Access to and use of NHS Patient Advice and Liaison Services (PALS): the views of children, young people, parents and PALS staff" in *Child: care, health and development*, Vol. 34.2, p.145–151

[6] The PALS resources are available at: http://www.ncb.org.uk/resources/free_resources/pals_project.aspx

[7] Department of Health (2010) *Equity and excellence: liberating the NHS*

2.8 A survey of the level of engagement of children and young people (and voluntary organisations that work with them) provides a somewhat improved, if mixed, picture, when compared to the PALS studies.[8] 81% of LINks that responded said that they had involved children and young people in their work via the voluntary sector, and 64% had involved children and young people in other ways. On the other hand, 12% of respondents said their LINk had not involved children and young people at all. Challenges to doing so included:

— a perception that this was not part of the LINks remit;

— lack of capacity; and

— limited resources.

The percentage of LINks members that were children and youth organisations varied from one to 90%, with an average of 31%.

2.9 These results are somewhat positive, although it should be borne in mind that the sample was self-selecting, reflecting the position of the third of LINks that chose to respond to the survey. There has been no systematic analysis of the implementation of LINks in relation to children and young people, a piece of work which would be helpful in informing the future implementation of local HealthWatch.

2.10 Respondents had a number of suggestions for what could help them to better engage children and young people:

— clarity around LINks' remit regarding children and young people;

— training on working with children and young people, and with children's voluntary organisations;

— advice on providing training for children and young people to advocate for improved services themselves;

— education of the children's and health sectors so they understand how LINks work and how they can be used; and

— networking opportunities.

2.11 The voluntary organisations we consulted on the NHS White Paper were concerned about the effectiveness of LINks (and therefore future local HealthWatch organisations) at working with a range of members of the public, saying that some often only give a voice to the "usual suspects".

3.0 The Future Role of HealthWatch

3.1 In its NHS White Paper, the government has proposed that every local area establish a local HealthWatch organisation. Replacing Local Involvement Networks (LINks), these bodies will be responsible for ensuring patient and public feedback is taken into account in local commissioning. However, government has also suggested that they take on functions currently carried out by PALS, providing complaints advocacy and supporting individuals to exercise choice.

3.2 NCB sees the potential in bringing together the work of LINks, and aspects of the remit of PALS, in the role of local HealthWatch. It makes sense to bring together, in a single local body, support for patients and the public to inform local health service planning, make complaints and exercise choice.

3.3 While the NHS White Paper suggested that government intends for local HealthWatch to take on aspects of PALS' functions, there was little information on government's intentions for PALS services themselves. For example, government may expect PALS currently based within Primary Care Trusts (PCTs) to be replaced by HealthWatch; or they may expect GP consortia to establish their own PALS services. Furthermore, while PALS working within PCTs are likely to be abolished with their host body, there are likely to continue to be PALS operating within NHS trusts (hospital trusts, mental health trusts etc).

3.4 With a range of organisations potentially operating within a given area providing information and complaints support to patients, it is important that members of the public, including children and young people, are able to navigate the system and be clear about where they can go with their complaint or concern. Young people we consulted on PALS suggested the services use a standardised logo, and leaflets and posters, so the public are better able to recognise the service. This suggests that a standardised brand for local HealthWatch would help members of the public (including children and young people) to know where they can go for support when making a complaint.

HealthWatch effectively engaging children and young people

3.5 If local HealthWatch does take on a role in supporting patients to make complaints, it is vital that all local HealthWatch bodies are supported from the earliest stage to effectively work with children and young people. This should include drawing on lessons learned and existing good practice within PALS and LINks. HealthWatch staff will need knowledge, capacity and skills to engage children and young people, and a strong understanding of the value of working with both children and young people and their parents and carers. Additional effort will be needed to ensure that those with the most complex needs or who are vulnerable are engaged and understand how the service can help them.

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[8] NCB (2010) LINks: getting it right for children and young people

3.6 Good partnership arrangements with other local services working with children and young people will also be central to better engaging with, and promoting the HealthWatch service to, children and young people and their parents. This would include work with schools, colleges and early years, youth and social services. Work with local voluntary and community organisations will also be key, as they are often able to reach the most excluded and vulnerable members of society who may be reluctant to engage with complaints mechanisms, or to express their concerns about health services.

3.7 Children and young people should be engaged in the development of HealthWatch, both nationally and locally, to ensure it reflects their needs. This can be achieved by building on existing participation mechanisms and resources, such as: working with national children's charities; the PALS and LINks projects referred to above; Participation Works;[9] school councils and youth councils; children in care councils; and Parent Partnership Networks.

4.0 Conclusion

4.1 In conclusion, we urge the Committee to recommend that government:

- nvolve children and young people, including those with complex needs, in the further development and implementation of HealthWatch England and local HealthWatch;
- use the Health and Social Care Bill to make *explicit* that local HealthWatch bodies have a responsibility to provide their services to children and young people;
- put in place mechanisms to support HealthWatch and continuing PALS to effectively work with and support children and young people and engage them in the development of their service, including by:
  - drawing on existing good practice and lessons learned within PALS and LINks and utilising existing participation mechanisms;
  - establishing effective working relationships with wider children's services;
  - working alongside local voluntary and community sector organisations providing services and support to vulnerable and marginalised groups of children and young people;
  - ensuring local authorities (as commissioners of local HealthWatch), when awarding contracts, assess the extent to which potential providers will be able to work with children and young people;
- put in place mechanisms via which local HealthWatch and PALS can share and build upon each others' good practice in working with children and young people, including the most vulnerable, perhaps through HealthWatch England;
- provide incentives to ensure that local HealthWatch bodies engage in effective outreach work with marginalised groups of children and young people and those with complex needs; and
- consider the use of a standardised local HealthWatch brand to help members of the public, including children and young people, navigate the local complaints system and identify sources of support.

December 2010

Written evidence from HealthCare Resolutions (CAL 09)

THE ADVANTAGES OF A CO-ORDINATED APPROACH TO MEDIATION IN HEALTH AND SOCIAL CARE COMPLAINTS AND LITIGATION

Summary

1. Health Mediation (which was called "Conciliation") is an effective way of resolving NHS complaints and has been an important component of local resolution since the NHS Directions for Complaints, July 1998.

2. Health Mediation uniquely offers an independent and impartial service to both complainants and practitioners.

3. It is commonly used for health complaint resolution in many countries eg Australia, Canada, New Zealand, and the USA.

4. In the UK Health Mediation has received very limited support in comparison to other forms of local resolution.

5. Health Mediation has been used successfully as a primary tool for local NHS complaint resolution in Kent since 1998. The text below details this experience and proposes a model for delivery in other areas of the UK.

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[9] www.participationworks.org.uk

GENERAL

6. There has been a health mediation service in Kent since 1998, which now covers all NHS Health Providers and Local Authority linked cases in Kent and Medway.

7. The service is effectively run using a part-time manager and part-time administrator. The mediators are self-employed and used on an ad hoc basis.

8. The service prevents cases at a local resolution level escalating to the Ombudsman and probably has prevented litigation.

9. Mediation is under used across England in the early stages of complaints and prior to litigation and could better help resolve issues and assist the parties to communicate with each other.

THE DETAIL

10. The mediation service was originally set up in 1998 by West Kent Health Authority to assist with Primary Care Complaints and largely, at that time dealt with GP and Dentists. Three years later it was commissioned by East Kent Health Authority to cover the rest of Kent.

11. Since then the service has widened to include PCT and hospital based complaints and where these relate to Local Authority (LA) services these can be included. There has been some work done with LA children services as well.

12. The service is now funded by the three PCTs in Kent and Medway and is hosted by the local mental health Trust (KMPT) although it would be better placed alongside other local mediation services.

13. Each referral is sent to the service manager who allocates it to a mediator. There are 17 mediators who are geographically dispersed. They are "self-employed" and only used on a case by case basis. Supervision and support of the mediators is provided by the manager. The manager is employed three days a week and has administrative support for two days. The over head costs are thus low and could be further reduced if the service operated alongside local mediation schemes (reducing NHS overheads).

14. A case will typically take about six to nine hours of a mediators time and is normally started by the mediator visiting the complainant to hear their story and to ascertain what is trying to be achieved through the complaint. The responding party is then visited and an attempt is made to open up communication at this point. Ideally a joint meeting is held and cases are best resolved in this way but the mediator can also "shuttle" between the parties.

THE ADVANTAGES OF A CO-ORDINATED APPROACH

15. There are a number of advantages to a service which co-ordinates mediators for the various agencies that could use mediators.

16. It is difficult for individual NHS and LA service providers especially small organisations like GPs to know about the availability of mediators with the skill and knowledge to do complaints mediation. A service approach has suitable mediators "on tap" who can be used at a few days notice.

17. There are no national standards for mediators. A service will set and maintain standards.

18. A service can offer a one-stop-shop which can cover the variety of complaints that are generated across the NHS and Las and learn from them to be benefit of all.

19. Access is easy and quick. Most referrals to this service are allocated in a day.

20. There is a set rate for paying mediators and contracting with them. For individual service providers this might be timely and costly.

21. With a clear service level agreement costs can be set out in advance.

22. Patients/complaints can access mediators without going through the PCT.

23. There is a common evaluation scheme run across the whole area.

A MODEL FOR OTHER AREAS

24. There are probably very few other co-ordinated schemes in England and indeed it is very likely that the use of mediators by NHS and LAs is low compared to their potential benefit for all parties.

25. Mediation offers an early opportunity to bring parities together when communication has begun to break down or there is a danger of the process moving to the Ombudsman or into litigation. We have found over the last 12 years that giving people an independent person to talk to allows people to get to the route of their complaint and articulate what they want to achieve.

26. Allowing parties to meet in a confidential space is valuable to allow open conversations and people to see the humanness in each other. The legal protection that mediation allows parties to be frank a bout matters

that might not be explored elsewhere and allows an apology and offer to put things right which might not otherwise be available. It avoids litigation and can prevent escalation of disputes.

27. There is probably a role for mediation to be offered in secondary Trust disputes before they go to the Litigation Authority where expensive lawyer/mediators are used.

28. There is an argument for health mediation to be integrated into local mediation schemes. In England most urban areas have a local mediation scheme which could easily be encouraged to take on health/LA work.

December 2010

Written evidence from Independent Healthcare Advisory Services (CAL 10)

Executive Summary

Effective handling and resolution of complaints is a cornerstone of good healthcare delivery. It helps ensure that patient satisfaction with the overall service is not adversely impacted and, if intelligent corrective action is taken, allows for service learning and improvement.

The Independent Sector Complaints Adjudication Service (ISCAS) has for over ten years operated by reference to a well-established Code of Practice for Handling Complaints (http://www.independenthealthcare.org.uk/index.php?/component/option,com_phocadownload/Itemid,131/download,295/id,14/view,category/) across the independent sector, the management of which is undertaken by Independent Healthcare Advisory Services (IHAS). This includes the provision of a small dedicated secretariat.

Key learning over those 10 years is as follows:

1. A Code of Practice, owned by IHAS members, summarises the importance of effective complaints management, and sets out consistent standards to be achieved by members.
2. A three-stage complaints process has been running for over ten years. The stages are: Stage 1, *Local* Resolution; Stage 2, *Organisational* Resolution; Stage 3, Independent External *Adjudication* (these are sometimes referred to as *In, Up and Out*). ISCAS manages Stage 3.
3. A three-stage complaints process maximises the ability of healthcare service providers to take ownership of complaints (in Stages 1 and 2), and resolve them within the provider. It thus minimises the number of complaints coming through to Stage 3 (adjudication).
4. External adjudication has a high success rate in resolving the more difficult or intractable complaints.
5. Adjudication is not focused on a "win" or "lose" approach and, ideally, does not seek to blame or to discredit any of the parties but rather to explain what has happened.
6. The main aim of adjudication is to leave all the parties with a better understanding and insight into the issues that have been raised, which leads to a greater focus on the lessons learnt.
7. The outcomes can include an apology being offered or compensation or recommendations being made, or it can include all three remedies. Financial compensation (with a maximum set at a sensible level) awardable by the Adjudicator can help reduce litigation, and in fact becomes a viable alternative—especially for service complaints.
8. Medical Defence Organisations acknowledge the benefits that this system has brought forward.
9. Private Patients treated within the NHS have no ability to complain to any external body about their treatment. The NHS Complaints Ombudsman has no jurisdiction, and NHS PPUs are not members of ISCAS. With the removal of the cap on private income, this will be a developing problem.

Introduction

1.1 ISCAS membership comprises members and specialists across the health care industry in all four countries, to share a unique level of knowledge, experience and understanding on the effective management of complaints about any aspect of service provided within the healthcare units of its members.

1.2 Almost all members of ISCAS also subscribe to services from IHAS, which provides advisory and support services in the areas of regulatory compliance and policy setting.

1.3 IHAS core objectives are to:

- facilitate effective communication between subscribers, the government and external organisations
- strive to develop and drive policy advancement through shared subscriber input and consultation
- deliver focused, practical information and guidance in all areas of regulation and policy, sharing and distributing knowledge

1.4 IHAS's primary focus is in the area of operational policy and the regulation of the sector. As such it seeks to:

- Facilitate the development of operational policy, through consultation with its member organisations

- Provide its members with accurate and timely information regarding regulatory and policy matters
- Administer an independent complaints and adjudication process and promote best practice
- Develop a range of quality initiatives to raise awareness of good practice within independent providers
- Represent independent health care providers to government, external organisations, and the public, providing a channel for effective communication and dialogue

1.5 The terms of this inquiry refer to NHS complaints. However it is important to consider complaints across the entirety of the sectors involved in the provision of healthcare (NHS and independent) as the patient pathway will cross both sectors. In addition the experience and achievements of managing complaints in the independent sector can provide a comparator for the NHS. This response sets out some of the key successes and achievements of the IHAS Code of Practice. IHAS would however welcome an opportunity to give evidence in person should this be helpful to the Committee.

1. 10 Years Experience

2.1 For over 10 years, patients using the services of the independent sector have had the benefit of an effective complaints resolution procedure from organisations signed up to the Code of Practice and the independent adjudication service. The Code of Practice was commenced following the work of the Health Select Committee in 1999 in which the private sector was criticized for not having a complaints system that could be recognised by patients. That situation is dramatically different today. A recent chair of the Care Quality Commission described the IHAS complaints process, and the ISCAS process as "*……better than any system operating in the NHS*".

2. What is the IHAS Code of Practice?

3.1 The Code of Practice was agreed by the sector over 10 years ago and is now "hosted" by IHAS. ISCAS has been set up as a member-owned co-operative, operated by its members who are independent healthcare providers. ISCAS operates the third stage of the complaints resolution procedures of the IHAS Code of Practice:

- Stage 1—local resolution (hospital/clinic level).
- Stage 2—Internal review (CEO/Board of Trustees).
- Stage 3—Independent External Adjudication.

3.2 The three stages are essential in managing complaints and achieving resolution for the vast majority without accessing the final adjudication stage. The second stage allows an organisation to review a complaint outcome at senior level and is one step removed to make sure all options have been exhausted to resolve the complaint.

3.3 What sets the IHAS Code apart from its NHS equivalent is the comprehensive and progressive three-stage process of complaints management, as opposed to the two-tier approach seen in the public sector. The Code of Practice emphasises a preference for Stage 1 (local) resolution but incorporates a "safety-net" Stage 2 (internal review), which is still conducted under the local complaints procedure. Only once the internal processes of the first two stages have been exhausted does an independent external adjudication, overseen by the ISCAS whose secretariat is supplied by IHAS, become activated.

3.4 The purpose and outcome of adjudication is principally to offer answers and then, if possible, to put things right in the most appropriate way. The complainant benefits by not only being offered a deeper insight into the issues raised but may also receive a financial award in recognition of any failings. Importantly, for complainants, there is no cost to them through participation and, therefore, no risk involved. Additionally, the decision to engage in the adjudication process does not preclude the complainant from pursuing litigation at a later stage if that is what they wish to do although it is important to remember that the outcome of the adjudication process is likely to be taken into account by any subsequent judgment.

3.5 The Adjudicator can review the case by reference to the correspondence and clinical records, or convene a full panel hearing for the case. This would include attendance by the complainant. The panel is made up of the Adjudicator and 2 expert witnesses and may include a lay person where necessary, all facilitated by the secretariat. However many cases are completed through a case file review and may or may not require expert advice. The Adjudicator produces a comprehensive report for the complainant and the healthcare provider.

3.6 The Code provides clear expectations and principles in managing a complaint (http://www.independenthealthcare.org.uk/index.php?/component/option,com_phocadownload/Itemid,131/download,295/id,14/view,category/) and has retained timescales to meet the expectations of complainants. In addition complaint managers have best practice guidance based on shared learning from organisations.

3. Effective Local Resolution

4.1 In 2008 one major provider had 1,573[10] stage 1 complaints and, of these, 38 needed to be escalated to stage 2 internal review. From these 38 cases only three cases could not be resolved and therefore moved to independent adjudication with ISCAS.

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[10] A rate of 1 complaint per 115 admissions.

4.2 The independent sector healthcare providers have a culture that actively captures patient's complaints and uses the information to improve services and patient satisfaction. A good complaints system is seen as a sign of a quality service.

4. Funding the Adjudication Process

5.1 The subscribers to ISCAS pay an annual fee for the secretariat services and support from IHAS. This base cost is shared across all members on a sliding scale according to size. Compliance with the IHAS Code and the Independent External Adjudication scheme is the basis of membership of the ISCAS.

5.2 Each case accessing adjudication incurs a cost, which is paid for by the individual organisation. The allocation of the costs of complaints to an organisation can help to facilitate an effective local resolution in the majority of cases and learning lessons from previous experiences. In addition the Code of Practice allows the Adjudicator to award an ex gratia payment to a complaint in recognition of any inadequacies identified by the complaint which is paid by the individual organisation. The complainant does not contribute to the financial costs of adjudication.

5. ISCAS Annual Report Highlights

6.1 ISCAS publishes an annual report highlighting complaints activity for the year and setting out key learning and other messages from the Adjudicator and the secretariat (http://www.independenthealthcare.org.uk/index.php?/component/option,com_phocadownload/Itemid,131/download,265/id,14/view,category/). The secretariat saw a 33% increase in complainant contact for 2009 and looks set to see a continued increase for 2010. However, this does not equate to a 33% increase in complaints to each member, as the membership continues to grow.

6.2 The majority of these contacts are at stage 1 of the procedure with the provider and generally involve the complainant seeking independent clarification of the way forward, or signposting to the provider organisation. Of 184 contacts in 2009 with the ISCAS secretariat, only seven of those continued to adjudication as the provider was able resolve the majority of complaints locally.

6.3 The secretariat continues to receive enquiries from complainants who have been treated within the NHS and experience real difficulty in accessing clear information about how to complain about the service provided by the NHS hospital. In particular, IHAS has raised the issue of NHS Private Patient Units (PPUs) whose complainants have no access to any form of independent review. This is because a complaint about private medical care and treatment cannot be referred to the health service ombudsman and NHS PPU's are not subscribers to ISCAS which leaves a significant gap in a complaints process for these complainants.

6.4 There has been a steady rise in the number of adjudication cases, with 22 cases held to date in 2010. This may indicate a growing recognition by the sector of the benefits of the adjudication process. Since 2006, there has been a significant rise in the number of Heads[11] of Complaint across the industry, and this figure has increased again in 2009. In part, this reflects an increase in the number of complaints received but it is also indicative of greater detail in the identification of the individual issues that make up a complaint.

6.5 The benefits of the increase in the analysis of complaints, which provides a more specific identification in the Heads of Complaint, is that the response is more complete, and better targeted to the complainant and to the member organisation complained against.

6.6 As well as providing a resolution process for complainants, one benefit of the adjudication service is to resolve the complex burden placed on providers by particularly difficult or intractable cases.

6.7 Complex cases often demand a disproportionate amount of management time to resolve but the timely use of adjudication offers a solution both to complainants and to providers. One of the key benefits of the service is that the Adjudicator is able to offer a more distanced perspective of the issues which focuses on the broader picture while, simultaneously, scrutinising the case in detail. The service has a high success rate in resolving the more difficult complaints.

6. Monitoring ISCAS

7.1 The secretariat meets on a regular basis with the Adjudicator and with specific representatives from the sector, to review the adjudication process and how it is working. This results in development opportunities and keeping up to date with the issues facing provider organisations as well as complainants. It also serves to assist in the smooth running of the service to make sure it delivers to both the complainant and the provider. Recently ISCAS started a more streamlined report for less complex cases which provides a more concise focussed report for the complainant and reduced costs to the organisation. New organisations wishing to join ISCAS must also make a declaration of compliance with the Code of Practice which can then be monitored by the secretariat.

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[11] "Heads of Complaint" are the number of issues raised within a complaint identified by the complainant or the adjudicator

7. Sharing Experiences and Practice

8.1 ISCAS shares learning and best practice with organisations through the IHAS monthly update briefing paper issued widely to all subscribers. This contains relevant references to current complaint news and a monthly message from the Adjudicator. (http://www.independenthealthcare.org.uk/index.php?/ihas-update-december-2010.html)

8.2 The annual report also contains a summary of recommendations based on thematic outcomes of the adjudication cases for the year. These provide practical learning points for organisations to improve their practice in managing complaints and use learning points from individual organisations (although these do not identify the organisation).

8.3 The success of ISCAS is becoming increasingly known amongst a wider group of independent healthcare providers, with new organisations wishing to subscribe and adopt a well established Code of Practice. This includes stand-alone smaller organisations that need to offer an independent review process to complainants. For example, recently a small private GP practice has recently joined ISCAS to ensure it meets required standards for providing its patients with an effective complaints procedure.

8. Recognition of the Code of Practice

9.1 The Code of Practice was refreshed and launched in 2009, building on nearly ten years experience, following a review by the IHAS working group made up of leaders with experience and knowledge of successful complaints handling. The then Care Quality Commission (CQC) Chair, Baroness Barbara Young, afforded the revised edition a ringing endorsement, telling delegates: "*I would encourage the independent sector, both providers and doctors, to embrace this Code as it is currently better than any system operating in the NHS.*" It was the second stage of the procedures that Baroness Young singled out for praise, as a robust buffer between the ultimate Stage 3 procedure and a first line of management which is not always as dispassionate as it could be, at the Stage 1 phase. ISCAS also welcomed the positive support of the revised Code of Practice from the Medical Defence Organisations who attended the launch; the MDU, MPS and MDDUS.

9.2 CQC continue to recognise ISCAS by signing up to an Operating Protocol with IHAS which means complainants are better signposted to the right procedures and which facilitates sharing of information with the secretariat. This year Health Inspectorate Wales (HIW) has also signed a similar Operating Protocol recognising the value of the Code. HIW have strongly recommended new applicants for registration as independent providers in Wales to join ISCAS to demonstrate compliance with the regulations governing complaints management.

9.3 The self regulation scheme Treatments You Can Trust for Botulinum Toxin and Dermal Fillers has incorporated the complaints management system run by IHAS for registrants of the scheme. Patients having Cosmetic Injectable treatments have previously not had access to a Complaints system (www.treatmentsyoucantrust.co.uk).

9. Providing Information for Patients and the Public

10.1 The ISCAS Guide for Patients, supported by the Patient's Association, about making a complaint continues to be very much appreciated by patients from feedback to the secretariat. With the contributions of the working group, the guide has been reviewed to ensure it is up to date and continues to be an easy read and source of essential information for patients and the public resulting in a new publication being planned for early 2011. The web page for members of the public is dedicated to complaints information and often receives comments of support and appreciation from patients for its clarity.

10. Adjudication versus Litigation in the Handling of Complaints

11.1 Before making a decision about whether to pursue litigation or adjudication, complainants should be encouraged to consider which is the most appropriate route—based on the nature of the case and on their desired outcome. The different options deliver different benefits.

11.2 Time spent at this early stage in identifying the core objectives of the complainant and the most suitable resolution process can save time; reduce cost and deliver more meaningful benefits for all parties involved. The secretariat will always encourage a complainant to undertake this assessment.

11.3 Litigation is the preferred route where there are issues of negligence and where there is a potential claim of loss and damage because, normally, the principal aim of the complainant is to achieve compensation. It is essential, however, before proceeding with litigation that a detailed risk/benefit analysis is carried out as part of the process of evaluating whether there is merit in the case. This is because the costs of proceeding may not be outweighed by the compensation which is sought. In addition, the experience of litigation—which may run over many months or even years—can be a gruelling and challenging one for the complainant and should be considered carefully. These issues need to be factored into the evaluation of the options as there may be greater value in seeking alternative possibly more rapid solutions that could bring equally satisfying benefits to the complainant.

11.4 The fundamental difference between litigation and adjudication is that litigation is an adversarial process where the parties engage in argument with each other in order to "win" the case. The process is driven by, and focused upon, this central goal which aims to persuade those in judgement of the validity of the case being argued. The way in which information is disclosed is managed strategically in order to gain advantage, rather than to achieve openness and transparency and this impacts on the outcome of litigation which, essentially, is focused on financial compensation rather than on lessons learnt.

11.5 Litigation is a lengthy and costly process but it does not always deliver what the complainant most wants which might include an explanation, an apology; a financial remedy or more frequently with health complaints, positive action to ensure that the same mistake is not repeated. The over-emphasis on achieving compensation can eclipse the focus on these wider objectives.

11.6 Adjudication as an alternative method of complaint resolution offers a number of benefits which reflect the fact that it is a non-adversarial process designed to conduct a detailed investigation of the facts and sound evaluation of the evidence in an unbiased manner. All the facts are set out in a transparent way and the judgement should be linked closely to the evidence base, and be well reasoned and fair to all parties. Adjudication is not focused on a "win" or "lose" approach and, ideally, does not seek to blame or to discredit any of the parties but rather to explain what has happened. The outcomes can include an apology being offered or compensation or recommendations being made, or it can include all three remedies. The main aim of adjudication is to leave all the parties with a better understanding and insight into the issues that have been raised, which leads to a greater focus on the lessons learnt. The emphasis on lessons learnt is a significant benefit of the adjudication process for those complained against because previously hidden systemic weaknesses may be identified which can lead to meaningful solutions being offered and implemented to introduce improvements.

11.7 As indicated earlier, the purpose and outcome of adjudication is principally to offer answers and then, if possible, to put things right in the most appropriate way. The complainant benefits by not only being offered a deeper insight into the issues raised but may also receive a financial award in recognition of any failings. Importantly, for complainants, there is no cost to them through participation and, therefore, no risk involved.

11.8 The decision to engage in the adjudication process does not preclude the complainant from pursuing litigation at a later stage if that is what they wish to do although complainants are encouraged to treat the adjudication as final. It is important to remember that the outcome of the adjudication process, particularly an award of compensation, is likely to be taken into account by any subsequent judgment.

11.9 The clear distinction, therefore, between litigation and adjudication is that adjudication is focused on answers and explanations; on learning from the mistakes; on making recommendations to improve future service delivery as well as on compensating the complainant where appropriate.

11.10 Above all, adjudication is able to offer all these benefits at a significantly lower cost than litigation.

December 2010

Written evidence from Jan Middleton (CAL 13)

INTRODUCTION

1. This submission is from Jan Middleton, acting in both a personal capacity and as Lead Member of the London branch of Cure the NHS.

2. I would like to appear before the Committee to give evidence, as on my observations too often those appearing are actually in receipt of funding from NHS Trusts or commercial providers of services to the NHS, despite claiming to be commenting in an independent capacity.

3. A précis of some of my experiences at one NHS Trust, Imperial College Healthcare Trust, and with Hammersmith & Fulham PCT and London SHA can be found on the following website:

http://www.curethenhs.co.uk

http://www.curethenhs.co.uk/site/content_london_cure_the_nhs.php

4. All of the following comments are based on my own direct experience, as well as comments made by people who have emailed me in my London Cure the NHS capacity, seeking help from LCNHS.

5. Before my health was destroyed by medical incompetence and in my view, medical negligence, I was a lawyer. My work included forensic investigation and also dealing with allegations of employee misconduct.

SUMMARY

6.

- The NHS Complaints System does not work, and merely exhausts, frustrates and infuriates complainants.
- Increase in litigation costs is largely due to incompetence of NHS Trust staff.

— No fault compensation could work well, but must be in the hands of a properly regulated and accountable public body, and not the NHS Trusts.

NHS Complaints System

7. I have been utterly appalled by the incompetence, white wash, and deceit that is inherent in the NHS complaints system. Delay, evasion and prevarication are common traits. Trusts rarely respond within the recommended 25 day timescale, often delaying for many, many months.

8. The NHS complaints system is designed to delay, distract and exhaust the complainant. There is little intention properly to investigate complaints or hold NHS employees to account. Some Trusts even have staff documentation which make it clear that the focus of the "investigation" of a complaint is to protect and support the complained of employee.

9. Trust Board members are complicit in this. For example, the Managing Director of Imperial College Healthcare Trust simply refused to answer my questions on infection issues, even after my MP had intervened.

10. NHS Trust employees, including doctors and nurses, can and do behave in a disgraceful manner with impunity, knowing that there is no accountability and that they most unlikely to be subjected to any proper disciplinary process.

11. In my direct experience as an NHS patient, that behaviour has included abuse, aggressive behaviour, actual assault, and an attempt to steal prescribed drugs from me when I was an in-patient. None of these incidents were properly investigated and no sanctions were taken against any of the administrative staff, doctors or nurses concerned.

12. To give two short illustrative examples:

12(i)(a) On Ward 10 North at Charing Cross Hospital in March 2009, recovering from emergency surgery for a brain infection given to me by the hospital a couple of months earlier, a nurse attempted to steal prescribed drugs from my locker. I asked her what she was doing and she was extremely aggressive and abusive to me.

12(i)(b) I complained about this incident within half-an-hour (I would have done so sooner, but was told that the Sister in charge of the ward at the time would not leave a meeting that she was in). I complained again the next day to the Ward Manager. I complained to the Trust's Managing Director in writing shortly after being discharged from the hospital. No investigation was carried out for several months.

12(i)(c) The Ward Manger was then appointed as investigator by Imperial College Healthcare Trust, despite my raising with them that as the Ward Manager had overall responsibility for the dire state of Ward 10 North, and the nurse's absolute confidence that she could behave in the manner complained of was only one aspect of numerous failings that reflected their poor management. Also, the Ward Manager had herself told me that she hadn't the first idea of how to run an investigation.

12(i)(d) the Ward Manager failed to take statements from staff who had witnessed what happened. They then conspired with the nurse to come up with some ludicrous story, which was not at all reflected in the facts, but which purportedly excused the nurse's behaviour.

12(i)(e) I then spent a lot of time making a formal complaint to the NMC. This included pointing out all of the failures to investigate properly and why the story that the Ward Manager and nurse had contrived was utterly illogical.

12(i)(f) The referral to the NMC was made in July 2009. After several months for me of time consuming correspondence, collating evidence, doing statements etc, the NMC informed me at the end of October 2010 that there was "no case to answer" for the nurse, on the basis that the allegations by me had been "fully investigated by the Trust and no disciplinary action was deemed necessary".

12(ii)(a) I was a helpless and paralysed patient on Chelsea & Westminster Foundation Trust ICU/HDU in September 2009 following twelve hour major surgery.

12(ii)(b) During my 48 hour incarceration on this Unit, I was—amongst other things—yelled at in an aggressive and abusive manner by a doctor for politely asking her to stop yelling an account of her sex life to a colleague at the other end of the Unit; assaulted by another doctor and repeatedly woken up by staff telling me that I should agree to get out of the bed as another patient needed it and I should consider the other patient's needs.

12(ii)(c) Chelsea & Westminster Foundation Trust purports to encourage feedback from patients. After complaining about the abuse in the HDU/ICU, there followed in October 2009 another wholly unacceptable incident. An abusive and aggressive secretary told me—wholly unprovoked—that I was "a known time-wasting troublemaker" and then deliberately attempted to ram her office door into my damaged face.

12(ii)(d) Despite contemporaneous complaints made by me and notified to the Chief Executive Heather Lawrence, Chelsea & Westminster Foundation Trust carried out no proper investigation into any of these serious matters.

12(ii)(e) Moreover, they refused to identify the doctor even though I had informed them that I would be

> making a complaint to the Police. They then deliberately delayed for several months—the upshot of this is that when I decided to complain to the Police despite still not having the doctor's identity, I was told by the Police that too many months had passed and hence they would have to categorise the events as "historic", although they would have investigated had I gone to them earlier.

13. Such systemic failures run through the entire system.

14. NHS Trusts deliberately evade doing effective investigations and deliberately delay and try to exhaust and discourage the complainant, who frequently is also suffering from illness or bereavement.

15. They not only fail to record complaints, but to investigate them.

16. My PCT, Hammersmith & Fulham, appears to be staffed by overpaid people who do not even understand what their investigatory role is, and try to push any complaints back to the Trust.

17. My SHA, London, refused to investigate my concerns about general failures in the medical services provided and insisted that these are a matter for the Health Ombudsman.

18. The Health Ombudsman is notorious amongst NHS Campaign Groups as utterly ineffective. I myself have not yet done an FOIA request so cannot confirm this, but I understand from someone who has that the number of cases that the Health Ombudsman actually agrees to investigate is proportionally extremely low as compared to the number actually received.

19. The GMC refuses to accept complaints about doctors unless they come from the NHS Trust. They refuse to take up patients' concerns even when the complainant can demonstrably show that the Trust investigation was inadequate or a cover up.

20. The NMC follows the same line as the GMC.

21. My local council, LBH&F, has refused to have any discussion about the general poor standards of some of the healthcare provided in the borough.

22. I have yet to meet with my local LINks group, but all the feedback I have had from other NHS Campaign Group members in different parts of the country is that LINks groups are ineffective in holding healthcare providers to account. The Mid Staffs Inquiry is currently exposing weaknesses in the LINks system.[12]

23. My local LINks Group has told me that it does not register complaints about poor healthcare services. Yet in a recent press release, it claimed that it "contribute(s) towards achieving improved health outcomes for the wider community" and "support(s) quality improvement". Further, it states that it is " imperative for every citizen to become involved in how these services are being delivered, as it is they who will be monitoring their local services. As members, they will have a stronger voice, using LINk's powers to hold service providers to account".

24. I have not yet had the opportunity to ask the LINks Steering Group how it can achieve these aims whilst ignoring complaints from service users about the services provided.

25. I have yet to find a Governor on any of the Boards of any of the Trusts that have treated me, who is properly accessible to patients, or who carries out their purported role of robustly questioning the Trust Board. My observations are that many Governors appear to wish to be elected solely as a career enhancement on their CV, and have no interest in patients.

26. Department of Health employees have responded to matters raised with them stating that their role is only in making policy, and they have no regulatory role in the NHS.

LITIGATION

27. As regards litigation, often the disgruntled patient had no intention of issuing any sort of proceedings when s/he first approached the Trust, but is often forced by the obduracy of Trust employees to obtain input from lawyers.

28. The cost of litigation is frequently needlessly run up by NHS Trust employees, who routinely delay and prevaricate. My direct experience is that some Trust Board members do not understand that the purpose of the pre-action protocol is to try to avoid litigation.

29. They also are unwilling to comply with the NHS Litigation Authority's view that investigation of a potential claim does not amount to "launching a claim" or expressing a firm intention to do so.

30. Indeed, NHSLA have made this clear to NHS Trusts a number of times, and I quote:

> *"There are no barriers to giving an honest explanation if indeed you know [what happened]......The Litigation Authority has stated this position in a circular to the health service a number of times....We don't want anyone in the NHS to be using [the threat of litigation] as an excuse for not doing what we think is the right thing,"* says Mr. Walker. (Stephen Walker, Chief Executive, NHS LA in HSJ article).

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[12] www.midstaffspublicinquiry.com

31. They frequently also seem to lack familiarity with the content of the Circular quoted below: *"Patients and their relatives increasingly ask for detailed explanations of what led to adverse outcomes. Moreover, they frequently say that they derive some consolation from knowing that lessons have been learned for the future. In this area, too, the NHSLA is keen to encourage both clinicians and NHS bodies to supply appropriate information whether informally, formally or through mediation."*—NHS LA circular, 2009

32. As the cost of any settlement and legal costs will not be met by Trust employees, they have little encouragement to organise things properly, especially as if they mishandle matters, there will be no sanctions against them.

33. Unlike the complainant, their lives are unaffected—they do not have their homes taken over by folders of papers, they are not put under the same stress, they are paid a high salary despite their incompetent performance, they can switch off at the end of the day.

No Fault Compensation

34. Clinical negligence is actually a very difficult case to bring and it is nonsense to suggest that litigation has risen because of the so-called compensation culture. People rarely litigate for trivial clinical matters.

35. Trusts appear to be unaccountable—for example, in 2009 Imperial College Healthcare Trust was exposed by questions in Parliament to be paying record financial damages to patients for clinical negligence, yet was nonetheless receiving high scores from NHS regulatory bodies.

36. I understand that no-fault compensation works well in New Zealand, but have done no study of it.

37. Local resolution and *ex gratia* payments for clinical negligence should be taken out of the NHS Trusts' hands and administered by an accountable public body. My own experience of attempted resolution meetings is that these can be handled in an inappropriate manner and the patient is subjected to unacceptable and patronising comments such as they should perhaps consider how much worse off other people in the world are.

December 2010

Written evidence from Hill Dickinson LLP (CAL 14)

Introduction

Hill Dickinson LLP is a national firm acting for a wide range of insurance and institutional clients. They also themselves act for Health service clients including the National Health Service Litigation Authority and therefore have particular regard in this submission to the sphere of clinical negligence litigation.

Executive Summary

Complaints

- Multi-fold reason for increased numbers of complaints—changing complaint system captures more complaints, increased public awareness, higher patient expectations, complaints co-existing with litigation and low morale in current economic climate.
- Varied effectiveness of new complaints system—PALS, revised timescales, complainant-led system and face-to-face meetings work well; wide interpretation and requirement to log expressions of dissatisfaction as complaints in certain circumstances does not work well.
- Constituent parts of new complaints system more effective—more complaints resolved at local resolution but ombudsman does not always share how decision was made.
- PALS functions as an effective gateway to the complaints system assisting complainants.
- Some Foundation Trusts do not report the number of complaints but the reasons are not clear; speculatively there may be administrative factors involved. Complaints are however reviewed with the aim of lesson learning.
- Mixed views concerning Government plans for future complaints/handling arrangements. Current process with ICAS functions well and does not need replacing; to do so would lose the experience and knowledge already gained. Health Watch may lack the understanding and experience to deal with complaints.
- Various systems being established to process data from complaints into new commissioning arrangements. Uncertainty as to how a variety of systems will interact. A unified approach may be more appropriate.

Litigation

- Steady rise in cost of litigation against the NHS—amount paid in respect of Claimant's costs increasing substantially.

— Multiple reasons for the rise in litigation costs—delays in the current legal system, funding of claims by way of Conditional Fee Agreements and/or ATE insurance and failure to use Alternative Dispute Resolution being factors.

— Rise in use of Conditional Fee Arrangements corresponding with rise in costs reserves for Claimant's costs. Steady increase over recent years in the use of CFAs for Clinical Negligence cases. Funding proposals to remove Legal Aid for Clinical Negligence cases may mean that yet more cases are funded by way of CFA (and costs increased).

— Complex interaction between litigation and development of an open reporting/learning culture in the NHS. Exact impact unclear. Arguments that it may assist in developing an open reporting/learning culture but also arguments that it may hinder.

— NHS Redress Act considered to be a sensible and pragmatic means of "fast tracking" lower value cases. Possibility of extending the upper monetary limit to, say, £30,000–50,000.

— Creation of a statutory right for "treatment injury" without needing to prove negligence inappropriate and contrary to established legal principles. Would lead to inequality depending on the mechanism by which a person sustained injury and risk of substantial increase in cost to the public purse.

— Use of Alternative Dispute Resolution (rather than mediation as such) to be encouraged prior to litigation with likely reduction in costs. Logistical difficulty in timing ADR prior to proceedings when Claimants take on average almost two years to investigate a Clinical Negligence claim before serving the Letter of Claim.

A. Complaints

1. *The reason for the sharp rise in NHS complaints*

In an effort to provide evidence as to the reasons for the sharp rise in complaints we surveyed some of our clients who are either PALS or Complaints Managers. The main reasons are likely to be as follows:-

1.1 *Recording of complaints.* When the new complaints system was introduced on 1 April 2009 the manner in which complaints need to be recorded has changed. Section 13(1) of the Local Authority Social Services and National Health Service Complaints (England) Regulation 2009 ("The Regs") states "A complaint may be made orally, in writing or electronically". Where a complaint is made orally, the responsible body to which the complaint is made must make a written record of the complaint and provide a copy of the written record to the complainant. Therefore previously whilst oral complaints may have been made, there was no duty for it to be recorded as a complaint.

1.2 *Increased awareness.* Section 16 of the Regs state that "each responsible body must make information available to the public as to its arrangements for dealing with complaints and how further information about those arrangements may be obtained". In the circumstances the general public are likely to be more aware that there exists recourse for any complaint they wish to raise.

1.3 *Increased or higher (often unrealistic) expectation.* Complainants often base their arguments on information that they have derived from the Internet which may not be based on any medical experience/application. Therefore if the outcome is not as they expected then they may complain.

1.4 *Duty on Trusts to investigate complaints and claims in tandem.* Under the 2006 regulations where a complainant advised the investigating body that they intended to bring a claim for compensation there was no obligation on an NHS body to investigate the complaint. This exception does not exist under the 2009 regulations. Therefore if a complainant is contemplating or in the process of instructing solicitors to investigate a clinical negligence claim on their behalf the NHS body must still investigate the complaint internally unless it can be shown that there is a significant prejudice to the NHS body.

1.5 *Current economic climate.* One of our clients suggested that due to the current economic climate leading to rationalisation of staffing levels due to cut backs and changes to staff's contractual agreements regarding sickness and absence pay there is a general low morale amongst staff which may be affecting the treatment being provided, ultimately leading to more complaints.

2. *The effectiveness of a new complaints system introduced on 1 April 2009*

2.1 The data received from clients suggest that on a scale of 1 to 5 the average effectiveness is 3.5. That said the responses ranged from 2 to 5 and therefore there appears to be very little consensus. For those who responded with 5, their view was that it was extremely effective if it was implemented properly.

2.2 The specific aspects which were effective include:

2.2.1 *The role of Patient Advice and Liaison Services* (PALS) as a "gateway" to the complaints system (for further information see below).

2.2.2 **T***he new timescales.* Under the old regulations, a complainant had to register a complaint within six months and a response had to be provided within 25 days. Under the new system complainants have 12 months from the occurrence giving rise to the complaint or from the time that they become aware of the matter. The Complaints Manager retains discretion to investigate complaints later then this if there are good reasons for the delay and it is still possible to carry out the investigations. In terms of investigation and response the responsible body to whom a complaint is made must investigate the complaint in a manner appropriate to resolve it speedily and efficiently and during the investigation keep the complainant informed, as far as reasonable practicable, as to the progress of the investigations (Section 14). There is no specific timescale in which a complaint needs to be investigated and is meant to be proportionate to the complaint that is made.

2.2.3 *The flexibility.* The new complaints procedure seeks to ensure that the process is much more complainant led and flexible so that the NHS body is clear on what it is that the complainant requires as an outcome and is aware of the steps being taken to investigate the complaint. Further the new process seeks to ensure that lessons are learnt from the complaint made with a view to seeking continuous improvement.

2.2.4 *Face to face meeting***s** were very positive and worked well.

2.2.5 *A simplified system* which is designed to make complaints handling open and accountable by creating a system which applies to both health and adult social care. Further if a complaint is made to a service provider about a service the service provider may either investigate the complaint themselves if felt to be appropriate or the service commissioner to investigate the complaint themselves.

2.3 In terms of areas that did not work as well, our clients were of the view that the fact that an expression of dissatisfaction which had not been resolved within 24 hours had to be logged as a complaint was time consuming and unnecessary.

2.4 One client said that the procedure is all but in name the PALS model of practice. Currently its application is open to such a wide level of interpretation it is hard to judge if it is more effective than its predecessor. It does enable NHS organisations to take a critical look at itself but this in itself will not always improve complainant's satisfaction levels.

2.5 Finally one of our clients (and we are of the view that it is likely to be mirrored by other clients) thinks that investigating a complaint alongside a clinical negligence claim is ineffectual and potentially contradictory.

3. *The effectiveness of the constituent parts of the complaints system*

3.1 The purpose of removing the Healthcare Commission and creating a two tiered service rather than a three tiered service was to simplify the procedure. The response to our survey was mixed. One client Trust was of the view that many more complaints are resolved at a local resolution without referral to the Ombudsman. It would therefore appear that this system is much more effective than it was previously.

3.2 One client however said that local resolution has not made any significant changes as the constant is whether the complainant gets the answer and/or action they want as a result.

3.3 In terms of referral to the Ombudsman, some clients felt that it worked very well. One complaint manager said that he and other managers had received mixed interpretations of the complaints procedure from the Ombudsman but the general feeling was that it was a significantly better service than was provided by the Healthcare Commission.

3.4 Further one client said that the Ombudsman does not always share how she comes to her decision and that she has made criticisms when taking a creative/individualised approach to resolve a concern.

4. *The role of PALS as a gateway to the complaints system*

4.1 From our questionnaire the majority of the clients who responded to the survey felt that the role of PALS was very effective and was of assistance to resolving initial *"concerns"* rather than complaints which need to be recorded under the 2009 regulations.

4.2 One trust client however advised that they no longer have a PALS team and the PALS and complaints have merged to form a Customer Services team.

4.3 One client trust felt that PALS was undervalued and under resourced nationwide by NHS organisations.

4.4 It would appear therefore that there may be scope for further use of the PALS system.

5. *The failure of some Foundation Trusts to report numbers of complaints*

5.1 The data we have obtained from our client Trusts are that they do report the complaints. It is difficult to comment on the reasons behind failure of some Foundation Trusts to report the numbers of complaints. The authors would speculate that there may be administrative factors involved. The response from our client Trusts suggests that they review the complaints with a view to lesson learning including review at Trust Board level and senior clinical effectiveness meetings.

6. *The Government's plans for future complaints/handling arrangements*

6.1 Our client Trusts have expressed a mixed reaction to this point. The feedback is that ICAS are very effective in taking on a support and advocacy role for individuals who wish to make a complaint. The concern is that the remit and function of the local Health Watch is felt to be currently too vague to gain assurance in their ability in this function and some concern has been expressed that members of LINks would be able to take on the additional role of advocacy within Health Watch. It is questioned whether they would have the knowledge or expertise to deal with Complainants, NHS staff or the complaints procedure and that LINks nationally does not appear to have had time to embed its own approach of becoming a representative of the community it serves before taking on such a significant additional workload.

6.2 The general thread is that the current process with ICAS provided by The Carers Federation works well and does not need replacing. There is concern that there has been an over-estimation of what Health Watch could achieve. Trusts have built up a relationship with their local ICAS staff who in turn have the experience and knowledge of the NHS and complaints procedure.

6.3 In broad terms, the concern seems to be that the current system with ICAS works well and that reviewing the system would only disrupt its effectiveness and require a substantial learning curve. The knowledge which has been gained would be lost. The overall view of our client Trusts is that establishment via the Local Authority of a local Health Watch/Health Watch England would increase the number of complaints brought with the function of the PALS Team being diminished so as to establish the Health Watch. Further concern is expressed that poor handling of the complaints by Health Watch would impact on the number and there may be a significant time lapse before Health Watch fully appreciates the challenges of complaints management. There is concern that individuals may look to drive the agenda of what Health Watch focuses on but an overriding concern that Health Watch would lack the understanding and experience to deal with the complaints.

7. *How data from complaints will feed into the planned new commissioning arrangements*

7.1 The overall view expressed by our client Trusts is that they have arrangements in place for "information sharing" of complaints. For some Trusts the role is undertaken by the Associate Medical Directors (who are GPs and members of practise-based commissioning consortia) whereas other Trusts as regional providers collate the standard data such as the timeframe in which complaints are resolved and then provide bespoke information depending on what the commissioner seeks. Other Trusts report having a mixture of methodologies.

7.2 There must be some concern that with numerous different arrangements the benefits of information sharing will be weakened or lost. A unified approach may be more appropriate.

B. LITIGATION

1. *The cost of litigation against the NHS*

1.1 It is undisputed that the cost of litigation against the NHS is on the rise.

1.2 In 2009–10 6,652 clinical negligence and 4,074 non-clinical negligence claims against NHS bodies were received by the Authority. This was an increase from 6,088 clinical negligence and 3,743 non-clinical negligence claims in 2008–09.[13]

1.3 £878 million was paid in connection with clinical negligence claims during 2009–10 (which can be broken down as £651 million for CNST cases, £135 million ELS cases and £954,000 ex Regional Health Authority cases). This is an increase from £769 million which was paid in connection with clinical negligence claims in 2008–09.[14]

1.4 This represents a significant rise from payments made in clinical claims in 2004–05 when only £503 million was paid by the Litigation Authority.[15]

1.5 The increase in payment is mirrored by the increase of legal costs paid to Claimant and Defence lawyers. That said the costs claimed by Claimant solicitors continues to be significantly higher that those incurred by Defence solicitors. In 2009–10 the NHSLA paid over £163 million in total legal costs against these claims of which £121 million (74% of the total costs expenditure) was paid to Claimant lawyers.[16]

1.6 This represents a significant increase from 2004–05 when the total legal costs paid to Claimant and Defendant solicitors was £143 million of which approximately £85 million was paid to Claimant solicitors (59%).[17]

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[13] Information taken from NHSLA website

[14] Information taken from the NHSLA's report and accounts 2010, page 15.

[15] Information taken from the NHSLA's report and accounts 2010, page 15.

[16] Information taken from the NHSLA's reports and accounts 2010, page 17. These figures cannot be equated with the figures for total expenditure claims in 2009/10 because they relate only to claims closed during this year

[17] Information taken from the NHSLA's report and accounts 2010, page 17.

2. *Reasons for the inflation of litigation costs in recent years*

2.1 Delay

2.1.1 Delays are a fundamental cause of additional expenses and therefore there is much to be said for robust deadlines and timetables. The authors consider that there has been an ongoing erosion of the obligations upon parties to comply with procedural deadlines under the Civil Procedure Rules and those established in the Court directions.

2.2.2 The perception amongst practitioners appears to be generally that there is little risk of any adverse order as a consequence of *"minor"* delays in filing court documents. There is, for example, no longer any real expectation that a Claimant will be struck out for failing to serve proceedings within 4 months of issue, even where the delay is many months old.

2.2.3 Greater concern, it is suggested, needs to be placed on the prejudice to the judicial system as a whole as a consequence of widespread delays and disregard for procedure deadlines and the result in inflation costs as well as the impact on judicial resources.

2.2 Conditional Fee Agreements/ATE insurance

2.2.1 There is no doubt that conditional fee arrangements have allowed in many cases a gross disproportion between costs and damages to exist. In the clinical negligence field, it is not at all uncommon to find that hourly rates of £300 will be inflated by 100% to leave Claimant firms making enormous profits even allowing for the cross subsidy of failed cases.

2.2.2 The market has wholly failed to regulate the level of success fees in those cases falling outside the fixed success fee regime. For example, in clinical negligence claims the vast majority of practitioners present bills with a 100% success fee uplifts as if they were entitled as a right by the nature of the work, as opposed to the facts of a particular case.

2.2.3 Little wonder we would suggest that there has been so much satellite litigation in this area, as insurers have struggled to undo the damage the new funding system has caused.

2.2.4 Of course the Health Select Committee will be aware that the voices in opposition to this injustice have been growing for some time.

2.2.5 Following Lord Justice Jackson's cost review on 16 November 2010 the government published two consultation papers setting out comprehensive proposals. The one which is of interest to this submission is the reform of civil litigation funding generally. It is readily acknowledged within this paper that there is a need to rebalance the current situation, where presently Claimants in many circumstances are permitted to litigate with no personal risk in relation to costs.

2.2.6 In respect of alternative funding the consultation paper is in all material respects a ringing endorsement of the proposals advanced by Lord Justice Jackson in his seminal review, completed earlier this year.

2.2.7 The principle proposal is to end the recoverability of success fees and ATE premiums. If this proposal is ultimately adopted, then these costs will have to be met by the Claimants from their damages. Success fees will be capped at a percentage of damages (excluding future damages).

2.2.8 Importantly the main requirement for ATE insurance should be removed by the introduction of one way costs shifting. Essentially this will mean that in all but exceptional circumstances even if successful, the Defendants will not be able to recover their costs from Claimants. However, all the available evidence suggests that the net effect would be significantly in the Defendants' favour.

2.2.9 It is also intended that *"contingency fee arrangements"*, by which a Claimant's solicitors will charge their fees as a percentage of the damages recovery should be permitted in all civil litigation.

2.2.10 The consultations run until February 2011 and the Government will then publish its responses and presumably in due course draft legislation. The papers do not set out a timescale for implementation but the inference is that this will be within the current parliamentary term.

2.2.11 Clearly whilst this is welcome news to proponents of Lord Justice Jackson's review the Claimant lobby will oppose the changes vociferously no doubt with reference to principles rather than profit.

2.3 Failure to use alternative dispute resolution

2.3.1 In his final access to Justice Report, Lord Woolf recommended that the unreasonable refusal to participate in alternative dispute resolution *("ADR")* should appropriately be taken into consideration when the issue of costs was for determination. The overriding objective includes an obligation on the Court to encourage the parties towards ADR.

2.3.2 It is now common place for many District Registries to adopt Master Ungley's draft directions on the issue of ADR, or a version of the same, which while stopping short of compelling participation, provides that the Court must be provided with justification by any party who refuses to participate. In Manchester, the clinical negligence District Judges order a joint settlement meeting in all cases with a value in excess of £100,000.

2.3.3 Still, since before the inception of the Civil Procedure Rules, there were calls for mandatory ADR and the others considered that there would be merit in revisiting this, whilst bearing closely in mind that ADR does not include only mediation. Mandatory ADR would not breach article 6 as the parties can ultimately proceed to Trial.

2.3.4 It is the authors' view that by proceeding to ADR this could potentially lead to a significant saving of costs.

2.4 Current economic climate

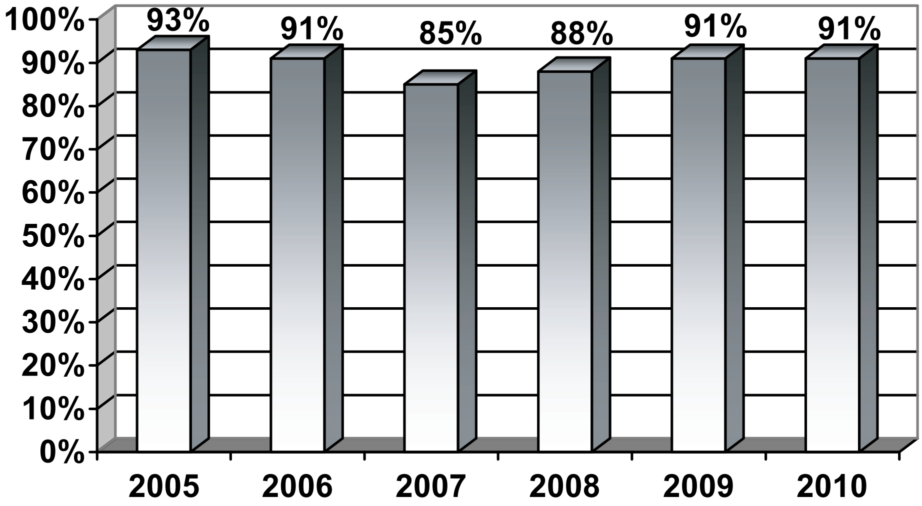
2.4.1 Historical data suggests that in a time of recession the number of claims increase. The authors would refer the readers to number 1 above.

3. *The impact of conditional fee arrangements on litigation against the NHS*

3.1 It is indisputable that litigation has increased as a result of conditional fee agreements. The authors would suggest that one such reason is that for many Claimants there is no personal risk in relation to costs as the costs is borne by the insurance companies rather than the individual.

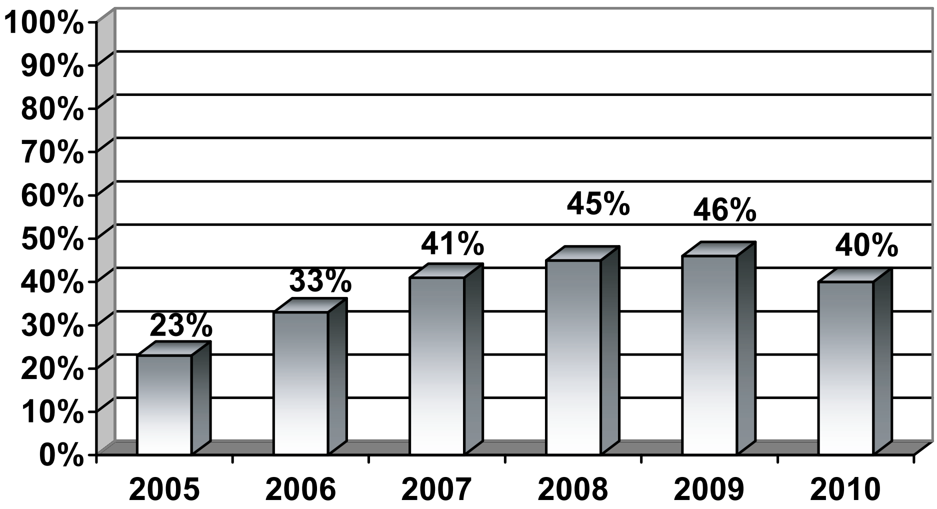
3.2 Hill Dickinson's data indicates that over the six year block 2005–10 the proportion of new cases in Employer's Liability/Public Liability claims funded by way of a Conditional Fee Agreement or else a Conditional Fee Agreement combined with After the Event Insurance have remained broadly level at around 91%.

Percentage of EL/PL cases funded by CFA/ATE



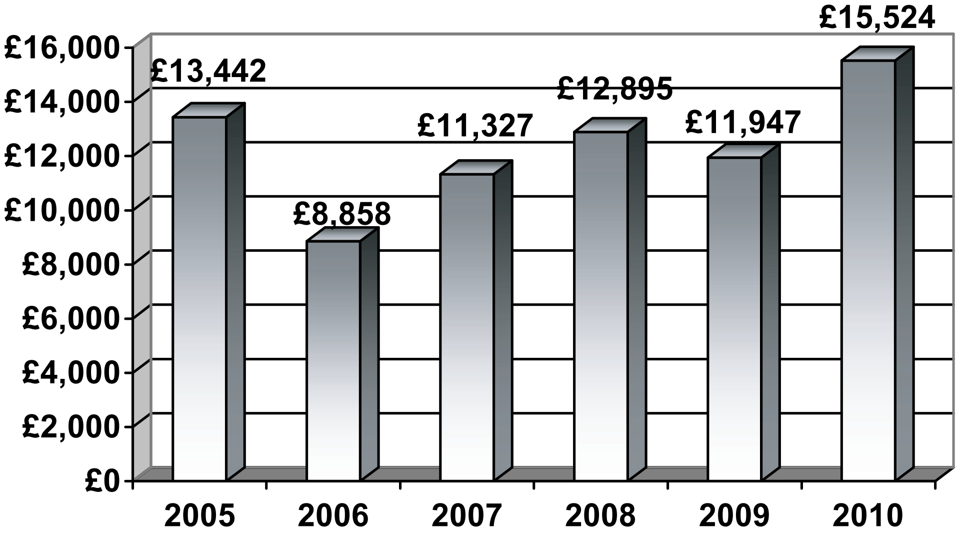
3.3 However, in terms of the clinical negligence cases, the proportion of new cases which are funded by way of a Conditional Fee Agreement or else a Conditional Fee Agreement combined with After the Event Insurance have substantially increased up to the 40–45% mark. Claimants are of course obliged to consider alternative methods of funding and it is submitted that a proportion of Clinical Negligence cases would be funded by way of Legal Services Commission funding (Legal Aid). However, proposals to remove Legal Aid for Clinical Negligence cases would we submit lead to an increase in the proportion of claims funded by way of Conditional Fee Agreements (or Conditional Fee Agreements combined with After the Event Insurance).

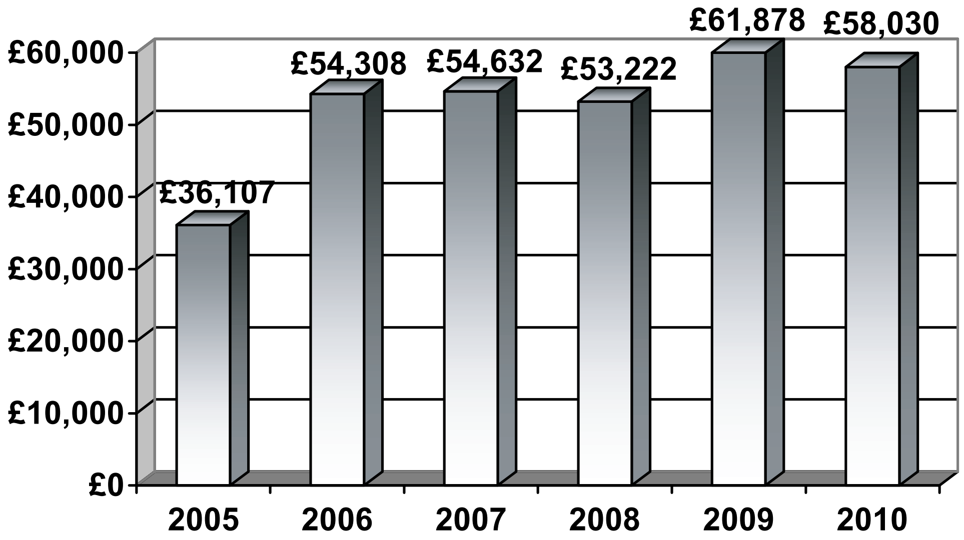
Percentage of Clinical Negligence cases funded by CFA/ATE



3.4 When the average reserves for Claimant's costs are compared across the years the picture is more telling. The reserves for Employer's Liability/Public Liability cases have remained broadly the same, on average £12,000–15,000 per case. However, for the Clinical Negligence cases the average reserve per case has substantially increased from around £36,000 to £60,000.

Average Claimant's Costs Reserve per case – Employer's Liability/Public Liability





3.5 The clear picture is that the legal costs of claims (Claimant's costs) are increasing substantially.

4. *The effects of litigation on the development on an open reporting and learning culture in the NHS*

4.1 The response from our client Trusts on the effects of litigation on the development of an open reporting and learning culture within the NHS was very variable. Some reported no effect. Some reported that litigation hindered an open reporting and learning culture. Others reported that it helped following receipt of a claim with risks being identified and reported to the Risk Manager who would take action to address issues and ensure the incident does not occur again. Such would however appear more a benefit from a risk management perspective rather than development of an open reporting culture in the NHS.

4.2 The impact of litigation on an open reporting and learning culture is clearly complex. The authors can see rational grounds to argue that it is unlikely to lead to an open reporting culture (fear of sanctions, involvement in litigation, impact on career development). Equally there are arguments that it would assist with an open reporting and learning culture (exposure of systemic issues enabling risk management to deal with the same).

5. *The Government's intentions regarding implementation of the NHS Redress Act*

5.1 The NHS Redress Act 2006 affirms Parliament's view that fault-based liability should remain the basis of compensation for Clinical Negligence. We would endorse that general principle. There would appear to be no justification for creating an exclusive class of cases which do not need to fulfil the usual criteria so as to receive compensation. Such would create anomalies with the person injured through no fault of their own in a motor accident being left with the same outcome as the person who suffers the injury as a consequence of Clinical Negligence. More starkly, the patient who suffers a poor outcome at a private hospital would not receive compensation in the absence of negligence whereas one who suffered a poor outcome at an NHS hospital would and would not need to show any negligence on the part of the doctors. Such cannot be right.

5.2 The premise of the Redress Act to provide a consensual "fast track" for lower value claims seems eminently sensible and should, in the authors' views, lead to a reduction in the time of litigation and a consequent reduction in the costs in those cases to which it applies.

5.3 The upper limit for monetary compensation under the Redress Act is currently £20,000. Consideration could be given to the possibility of increasing the threshold to, say, £30,000 or £50,000.

6. *Possible benefits of a statutory right to compensation for "treatment injury" from an independent fund without the need to prove negligence as required under tort law*

6.1 As set out above (5.1), the authors do not see that there is any merit in creating an exclusive class of cases for which the basis of compensation would be different. Currently, negligence must be proved for an individual to receive compensation. The authors can see no logical justification to create a class of people who suffer injury as a consequence of treatment to receive compensation as of right whereas those with identical injuries suffered otherwise than by way of treatment would not receive the compensation. There is also the more stark contrast between the patient who suffered non-negligent "treatment injury" at a private hospital who does not receive compensation and one who suffers the same at an NHS hospital who does receive compensation.

6.2 The authors express concern that to create a statutory right to compensation for "treatment injury" might serve to reduce some legal costs (in not having to establish whether or not negligence occurred) but other costs will remain as issues of causation (what the "treatment injury" has caused and how the patient's outcome is any different than it would have been in any event) as well as quantification issues will still need to be looked at.

6.3 Removing negligence from the test for compensation will help to speed up an individual case but the concern is that all patients with a less than perfect outcome will pursue a claim and the overall cost to the public purse will substantially increase. The increased numbers of cases will most likely lead to a slowing down of dealing with cases overall.

6.4 The authors are conscious that there have already been a number of consultations and changes proposed regarding the funding of legal claims (including the provision of public funding for Clinical Negligence claims) as well as consultations and proposals regarding the costs system. Those proposals are of course relevant and the author's view is that the proposed costs reforms will of themselves hope to reduce costs to the public purse. The presence of a statutory right to compensation for "treatment injury" without having to show negligence could however easily eclipse that.

7. *Encouraging the use of mediation before litigation is initiated*

7.1 Based on our current data, Claimant's solicitors take on average 22 months to investigate a Clinical Negligence claim before serving a Letter of Claim setting out the basis of the case. The Defendant will then have to respond within three to four months. Often proceedings will have to be issued because of approaching expiry of the limitation period (three years).

7.2 The authors' view is that the use of mediation or other forms of Alternative Dispute Resolution ("ADR") before litigation is initiated is pragmatic and appropriate.

7.3 The authors do not think that mediation as such should be enforced but rather Alternative Dispute Resolution so that the parties are not tied to having to follow the mediation route which can be costly. However ADR should be encouraged which could include mediation.

7.4 The timing of such ADR must however be appropriate. ADR would only be appropriate after the Claimant's Letter of Claim has been served so that the Defendant can know the case it has to meet. If ADR is to lead to savings in costs and reduction in Court time then it will need to take place prior to proceedings being issued. There will be benefits to using ADR pre-proceedings in certain cases although the authors can envisage that some cases would not be suitable for ADR at this time. The difficulty with ADR prior to litigation is the timescale required for investigating claims as set out above.

December 2010

Written evidence from Terry Leigh PhD (CAL 16)

The following evidence applies to the Health Committee's enquiry into Complaints and Litigation. It is particularly applicable to the following areas:

- The effectiveness of the constituent parts of the complaints system: local resolution (supported by the Independent Complaints Advocacy Services); and referral to the Ombudsman.
- The Government's plans for future complaints-handling arrangements.
- Encouraging the use of mediation before litigation is initiated.

SUMMARY

- Conciliation (also known as Health Mediation) is a very effective tool in resolving NHS complaints and has been an integral part of local resolution for many years.
- Conciliation is independent and impartial with respect to **both** complainants and NHS practitioners. It is a relatively quick process and effectively reduces the time, energy and costs of complaint management.
- Conciliation plays a significant role in healthcare complaint resolution in many countries eg Australia, New Zealand, USA, Canada and parts of Europe.
- Despite the international recognition of the effectiveness of conciliation, it has received extremely limited funding and promotion in the United Kingdom compared to the other constituent parts of the complaints system.
- The use of active, resolution-seeking and cost-effective conciliation services should significantly reduce the budget requirement and improve both complainant and practitioner experience of local resolution within the NHS Complaints System.

1. *The Role of Conciliation in the Local Resolution of Complaints*

Conciliation is a very effective tool for NHS complaint resolution and has been an integral part of local resolution for many years.

> "Conciliation offers a significant opportunity. It can re-establish stalled dialogue. It can help participants to understand that there are other valid points of view, and narrow the gap between differing expectations. The potential benefits are considerable, both for those who can feel that there voice has been heeded and their understanding improved, and for those who have the opportunity to help make the services they provide safer, more effective and better matched with expectations. For conciliation to help achieve this worthwhile prize, it must be readily available, carried out well, and focussed on outcomes."
> *Sir Liam Donaldson, Foreword. In: Anne Ward Platt, Conciliation in Healthcare, Radcliffe Publishing, 2008.*

Complaints guidance and the academic literature highlight and encourage the use and benefits of conciliation:

> Mediation can be useful in complaints "which are more difficult to resolve."
> *Listening, Responding, Improving—A guide to better customer care, Department of Health, 26 February 2009.*
>
> Conciliation "gives space to resolve issues, preserve on-going relationships and time to defuse or calm heightened situations".
> *Department of Health, Handling complaints in the NHS—good practice toolkit for local resolution. Department of Health, 2005.*
>
> "Conciliation is often useful in resolving difficulties arising from a breakdown of a relationship, for example between a clinician and a patient."
> *Scottish Executive, Health Department. Guidance for NHS complaints: hospital and community health services. Scottish Executive, Health Department, 2005.*
>
> "[Conciliation] can be particularly useful where there are multiple issues involved or where the doctor-patient relationship has already broken down significantly."
> *Royal College of General Practitioners, Complaining and commenting in general practice. (Information sheet). RCGP, 2006.*
>
> Conciliation has a significant role in the healthcare complaints procedures of Australia, New Zealand, parts of the USA, Canada and parts of mainland Europe.
> *Anne Ward Platt, Conciliation in Healthcare, Radcliffe Publishing, 2008, p4.*
>
> "An indication of how beneficial conciliation is in resolving complaints at local resolution, is that of the 26 cases referred to conciliation, only two cases have not been resolved following conciliation."
> *Camden Primary Care Trust. Annual complaints report, 2004–05.*

2. *How Conciliation Works*

Conciliation is a confidential process in which a conciliator helps those involved to resolve the difficulties that have arisen between a patient and practitioner.

Conciliators are independent and impartial. They have been specially trained to help the parties involved to try and find a way to resolve matters that suits them both.

They have no legal power, do not offer advice or impose solutions and make no attempt to judge the situation.

Conciliation is a voluntary process, with the conciliator or either party having the right to end the process at any time.

The conciliation process—stage 1

The conciliator has an initial private meeting or discussion with each separate party, in order to explain how conciliation works and answer any questions. Those involved are asked to discuss how they see and feel about the situation. The main issues involved are clarified and ways of resolving them explored.

At the end of the meeting, the conciliator confirms with the party their agreement to continue with conciliation and discusses how they wish to proceed.

The conciliation process—stage 2

A face-to-face meeting between the parties can be arranged. This meeting can only take place if the conciliator and parties involved choose to participate and confirm their agreement to the meeting arrangements and procedures.

When facilitating face-to-face meetings, the conciliator ensures that they are safe and controlled, allowing those involved the opportunity to speak and respond to the issues raised.

A face-to-face meeting is structured. At the start the conciliator confirms how the meeting will be conducted, what the role of the conciliator is and what is expected from the parties.

Each of the parties is then given an opportunity to speak about the situation, without being interrupted. The issues to be discussed at the meeting are clarified and confirmed. The conciliator works through these issues with the parties, helping them to communicate and work towards their own agreement or understanding. Any agreement reached is the responsibility of the parties themselves and is not legally binding.

3. *Benefits of Conciliation*

Conciliators are independent and impartial with respect to **both** complainants and NHS practitioners.

Complaints or Patient Advice and Liaison (PALS) teams are directly employed by the NHS. Independent Complaints Advocacy Service (ICAS) workers help people who want to make a complaint about the NHS through the NHS Complaints Procedure.

The independence and impartiality of the conciliator is crucial to the process, because both complainant and practitioner will know that the process will be conducted fairly.

> "Mediation [Conciliation] can also save time and money and lead to quicker solutions".
> *Listening, Responding, Improving—A guide to better customer care, Department of Health, 26 February 2009.*

Normally, the conciliator will first meet the complainant and practitioner separately to discuss how they see and feel about the situation.

It is important to acknowledge that **both** complainants and practitioners can experience a variety of negative feelings associated with a complaint.

Complainants may feel upset or angry with regard to perceived poor performance in clinical treatment, staff attitude and communication/ information provided to them.

> "Negative experiences of a complaint [by General Practitioners] were shock, being out of control, depression, suicide, doubts about clinical competence, conflicts with family and colleagues, defensive practice, and a decision to leave general practice."
> *Key messages from: Jain A, Ogden J. General practitioners' experiences of patients' complaints: qualitative study. BMJ. 1999; 318: 1596–9.*

The conciliator is therefore able to explore the perspectives and feelings of each party separately, before facilitating a mutually acceptable resolution via a subsequent face-to-face meeting.

Initial separate meetings are also helpful because there may be "underlying issues", which are not apparent in the complaints correspondence. The conciliator can explore these issues and gain understanding into how they may be resolved.

Conciliation is a confidential process, which encourages parties to establish a more open dialogue, thereby improving the chance of a mutually acceptable resolution.

Conciliation may reduce the chance of litigation being initiated, because it enhances positive and open communication between parties, most often through a facilitated face-to-face meeting.

> "Many patients and/or their carers will often only make a litigation claim when they have not received any information or apology from the healthcare teams or organisations following the incident."
> *National Patient Safety Agency. Being open: communicating patient safety incidents with patients and their carers. (Safer Practice Notice 10). NPSA, 2005.*

4. *Funding and Promotion of the Constituent Parts of the Complaints System*

Despite the international recognition of the effectiveness of conciliation, it has received extremely limited funding and promotion in the United Kingdom compared to the other constituent parts of the complaints system eg PALS and ICAS.

> "In England, there is a significant requirement contained in the NHS complaints procedure (which came into force on 30 July 2004) that all NHS bodies (excluding Foundation Trusts) now have a legal obligation to ensure that conciliation and mediation services are available."
> *Anne Ward Platt, Conciliation in Healthcare, Radcliffe Publishing, 2008, p24*

Despite all the evidence and guidance, conciliation is not provided systematically or extensively in the United Kingdom.

From my experience this lack of provision stems from a limited awareness of the benefits of conciliation within the NHS.

Serious consideration needs to be given to the way in which we fund the constituent parts of the complaints system.

Is it appropriate to have unbalanced funding arrangements, resulting in conciliation, a key tool for health complaint resolution in many other countries, being under-utilized in the NHS?

This approach to funding and promotion in the United Kingdom appears to contrast markedly with health services outside the United Kingdom.

In the state of Western Australia, conciliation is considered to be the main process of resolution. Of the 289 formal complaints received in 2009–10, 145 (50%) underwent the conciliation process.
Government of Western Australia, Office of Health Review, Annual Report 2009–10, p18.

In New South Wales, Australia there is a Health Conciliation Registry.

> "There is currently a panel of 37 conciliators with extensive training in dispute resolution, conciliation and conflict resolution."
> *Parliament of New South Wales, Committee on the Health Care Complaints Commission. Discussion paper on the health conciliation registry. Report No. 4. Committee on the Health Care Complaints Commission, 2004.*
>
> "A range of options will be available to the authority for dealing with the complaint (eg, review competence, counselling, conciliation, or taking no further action)."
> *Minister of Health. Improving quality (IQ): a systems approach for the New Zealand health and disability sector. Wellington: Ministry of Health, 2003.*

5. *Proposal for the Provision of Local Resolution in the NHS*

Personal Experience of Conciliation Service Provision

I am a mediation consultant who has provided conciliation services to many

Primary Care Trusts and a limited number of Hospital Trusts in London over the last 10 years. I work from an office at home, so there are no overheads in this regard.

The complaints leads for these organisations offer me work on a case by case basis within an agreed costing framework. **The average cost per case (including travel) in 2009–10 was £402**. The fact that a high proportion of conciliation cases involve three meetings demonstrates that conciliation offered in this way is extremely cost effective.

The administrative requirement on the complaints team/ PALS who refer me the case is extremely small. The lead worker obtains agreement from the parties that they wish to participate in conciliation. Once agreement has been obtained, this worker will send me their contact details and a brief outline of the case. I will then facilitate and administer the case from start to completion.

Proposed Model for the Provision of Local Resolution in the NHS Complaints System

How can we improve the effectiveness of local resolution in the NHS Complaints System?

In the light of the previous evidence, we need to re-evaluate how local resolution should best be provided.

Despite conciliation being extremely effective in local resolution, as evidenced by international guidance, literature and adoption in many health service complaints processes, it remains remarkably under-utilized in the United Kingdom.

My proposal is that the emphasis and funding of the local constituent parts of local resolution should be **rebalanced.**

Complaints/ PALS teams should be responsible for administering complaints generally and attempting to resolve less difficult concerns or complaints.

Conciliation services should be generally promoted within the NHS and actively encouraged for complainants with written or more formal complaints.

A register of experienced and accredited conciliators could be generated, from which complaints leads could source conciliators for new cases when required. It is recommended that those recruited to this register will have had mediation training and experience.

ICAS should support those complainants who have a need for advocacy services. ICAS workers could develop more of an awareness of conciliation services and encourage clients with more formal complaints to consider the use of these services.

This model should provide a more effective and less expensive way to deliver local resolution. **The use of active, resolution-seeking and cost effective conciliation services should significantly reduce the budget requirement and improve both complainant and practitioner experience of local resolution within the NHS Complaints System.**

December 2010

Written evidence from Cedric Maddox (CAL 17)

INTRODUCTION

1. This submission is from Cedric John Maddox and I am a retired RAF Squadron Leader. I am 72 years old and for the last seven years I have been dealing with NHS and Government Agencies attempting to gain justice for myself and my mother who died of Alzheimer's. The purpose of this submission is to bring the attention of Parliament to the serious maladministration and unlawful treatment against the most vulnerable members of our society; the elderly mentally ill.

SUMMARY

2. In 2003 the Local Government Ombudsmen published a special report highlighting the fact that the NHS cannot charge for after-care for patients detained under the MHA(83). The report stated:

- That people who have paid for section 117 aftercare should receive financial restitution with interest.

3. I obtained a copy of the Mental Health Act and my incredible saga into incompetence, deception, lies and fraud by the NHS and government agencies began.

EVIDENCE

4. The evidence I have available covers every department that is involved in the NHS complaints procedure right up to the new Justice Minister and is impossible for me to cover in 3,000 words. Therefore I am only submitting evidence obtained from the Government's own statistics, this involves a massive fraud against the elderly mentally ill.

5. Two weeks after admission under Section 2 my mother's legal status was changed to INFORMAL. The Hospital Managers failed in their lawful duty to inform the Nearest Relative that this had been done and the consequences of this change in legal status.

***Note:** This change of legal status has very serious consequences on the after-care costs of a detained patient. This is because the maximum stay allowed under the Act for a patient detained under Section 2 is 28 days and the information provided by the government stated that if the doctor wants you to stay in hospital longer than 28 days the patient **will** be detained under Section 3 of the Act. But a Section 3 patient is entitled to free after-care under section 117 of the Act. Section 117 after-care is for as long as it is needed which would mean until death for a demented elderly patient. This free care is not available for Section 2 or INFORMAL patients.* **(LINK)**

6. A patient detained under Section 2 who is regraded to INFORMAL loses any chance of free after-care under Section 117 of the Mental Health Act.

7. Statistics show that over **156,000** Section 2 patients were regraded to INFORMAL status for the 10 years up to 2009. All lost any chance of obtaining the free after-care they would be entitled to under Section 117 of the Mental Health Act.

8. This fraud is simplicity itself as long as the details of the patient's and Nearest Relative's rights are kept secret by the Hospital Managers ignoring Section 132 MHA(83).

9. My submissions to the SFO and AGO can be seen at:

- www.nhsfraud.com
- www.compu-help.co.uk/ag2

December 2010

Written evidence from the General Medical Council (CAL 20)

INTRODUCTION

1. The General Medical Council (GMC) is the independent regulator of doctors in the UK. The GMC protects, promotes and maintains the health and safety of the public by ensuring proper standards in the practice of medicine.

2. We do this in four ways:

(a) By controlling entry to and maintaining the list of registered and licensed doctors.
(b) By setting standards for and co-ordinating all stages of medical education and training.
(c) By determining the principles and values that underpin *Good Medical Practice*.
(d) By dealing firmly and fairly with doctors whose fitness to practise is in doubt.

3. The GMC is pleased to respond to this inquiry into Complaints and Litigation. We note that the inquiry addresses a number of issues that fall outside the GMC's remit. We would however like to clarify the role of

the GMC as a regulator of the medical profession and our role in dealing with enquiries about doctor's fitness to practise. We have also submitted evidence detailing the rise in enquiries that we have received and the work that we have undertook to ensure that our procedures are more accessible and easier to understand.

THE ROLE OF THE GMC IN DEALING WITH COMPLAINTS

4. One of the GMC's four main functions is to deal firmly and fairly with doctors whose fitness to practise is in doubt. The purpose of our fitness to practise procedures is to consider whether action needs to be taken to protect the public interest for the future, by removal or restriction of a doctor's right to practise. The purpose is not in order to punish doctors or to provide redress for complainants. Where appropriate, in cases that do not require GMC action on registration, we redirect the complaint or enquiry to the NHS or other healthcare provider.

5. Listed below are examples of the types of cases where the GMC may need to act:

(a) serious or repeated mistakes in carrying out medical procedures or in diagnosis, such as prescribing drugs in a dangerous way;

(b) failure to examine a patient properly or to respond reasonably to a patient's needs;

(c) fraud or dishonesty;

(d) serious breaches of a patient's confidentiality; and

(e) any serious criminal offence.

INCREASE IN ENQUIRIES REGARDING A DOCTOR'S FITNESS TO PRACTISE

6. Anyone can make a complaint to the GMC if they have a fitness to practice concern about a doctor. We categorise the sources of these complaints into "members of the public", "people acting in a public capacity" and "other enquiry sources".

7. In 2009 the GMC received a total of 5,773 enquiries regarding a doctor's fitness to practise.

8. The majority of enquiries regarding a doctor's fitness to practise come from members of public. This accounted for 3,689 enquiries of the 5,773 received in 2009 (64%).

9. There has however been a notable increase in the proportion of enquiries referred to us by "persons acting in a public capacity" (an individual acting on behalf of a public organisation, most commonly health bodies or police forces). The number of enquiries received from persons acting in a public capacity has gone from 394 in 2006 to 1,030 in 2009, an increase of 160%.

10. The GMC has also experienced a marked increase in the number of Stream 1 cases (enquiries which appear to require GMC investigation into potentially serious concerns). The number of cases that the GMC investigated as Stream 1 increased from 1,465 in 2008 to 1,758 in 2009 (an increase of 20%).

11. The increase in Stream 1 cases in turn has resulted in an increase in the number and length of fitness to practise panel hearings. 270 Fitness to Practise Panel hearings took place in 2009 compared with 204 in 2008—an increase of 32%. As a result, a total of 68 doctors were erased from the Medical Register at Fitness to Practise Panel in 2009, more than in the previous three years.

12. The GMC is keen to understand what may be influencing this increase in enquiries, particularly the notable increase that we have experienced in enquiries coming from a "person acting in a public capacity". We have therefore commissioned a programme of research, which will include in-depth interviews and surveys among those responsible for referrals from public bodies. We expect this report to be finished by the end of Quarter 1 in 2011 and the GMC would be very happy to present this information to the Health Select Committee once it is published.

MAKING THE GMC'S PROCEDURES AS ACCESSIBLE AS POSSIBLE

13. We understand that it can be stressful for patients and members of the public who feel they have cause to complain about a doctor. The process of making a complaint can however be easier and less stressful if the complaints procedure is easy to understand and that patients complain to the right organisation the first time around.

14. The GMC has therefore developed our services to help patients, the public and organisations that employ doctors to know how and when to make a complaint. We provide a helpline service that ensures that potential complainants can discuss their concerns directly with us. Through our publications and our website we provide extensive information for those who wish to raise concerns about a doctor.

15. "*How to complain about a doctor*", a publication aimed at patients, includes information about the areas in which the GMC handles complaints, and when complaints are more appropriately dealt with at a local level and by other organisations. We have published separate versions of this publication for each of the four UK countries to take account of differences in local complaints systems. A Welsh language version is also available, and we have produced a consolidated version in Arabic, Bengali, Chinese, Gujarati, Hindi, Punjabi and Urdu. We have also published an Easy Read version.

16. In 2008 we launched *Patient's Help,* an interactive online information resource aimed at educating the public and advice organisations. It shows the public how and where to lodge a complaint about a doctor and includes an interactive map for local advice centres across the UK. *Patients' Help* provides case studies of typical complaints; an overview of the complaints process and what patients can expect if they make a complaint; and information on where they can go for more advice. Where a concern is outside our remit, the website signposts the reader to other complaints procedures.

17. We have also aimed to make the process of filling in the complaint easier; complainants now have the option of completing either an online or a hard copy complaint form.

18. We are in the process of developing regional services to improve our understanding of and relationships with regional healthcare arrangements. We are extending the local liaison model we currently have in Scotland, Wales and Northern Ireland to every region in England. The aim is to enhance relationships with our key interests and will enable us to work more closely with patient groups to explain our role, how and when to complain to us and to better understand local issues.

19. As part of this work we are developing an employer liaison service to enhance our relationship with the employers of doctors and, in particular, medical directors and responsible officers. We will be recruiting a team of employer liaison advisers, who will be fitness to practise experts, to work closely with medical directors in each region in England and in Scotland, Wales and Northern Ireland to share information about concerns about doctors and to improve the speed and quality of decision making. A key role of employer liaison advisers will be to work with medical directors to improve understanding of our threshold for when a case should be referred to the GMC rather than dealt with locally.

20. The GMC is committed to ensuring our complaints procedure as accessible as possible. We believe that if people know how and when to make a complaint about a doctor's fitness to practice their complaints will be dealt with more quickly and effectively. Ultimately this will therefore help the GMC towards achieving our aim of protecting the public by ensuring proper standards in the practice of medicine.

December 2010

Written evidence from Arthur Briggs (CAL 21)

1.0 SUMMARY—CONCLUSIONS & RECOMMENDATIONS

1.1 *NHS Care—Basic Statistics*

Because there are no guaranteed standards of care:

- Approximately one in 10 Acute Hospital in-patients suffer an untoward incident and one in 11 acquire an infection.
- Data gathering related to these incidents is poor.
- There are between 840 and 34,000 unnecessary deaths in Hospitals but in reality the NHS/DoH don't have an accurate figure.

1.2 *NHS Failure to Learn from Untoward Events*

Learning from SUIs is poor with basic problems such as medicine mismanagement, malnutrition, de-hydration, poor training and clinical standards not unusual.

The complacent attitude of the Health Ministers, Senior NHS and Regulator Managers, who ignore the statistics, results in a failure to learn from these incidents.

The ineffective complaints and regulatory system are symptoms of this complacent attitude.

1.3 *Negligence Claims—6,500/annum*

1.3.1 Despite the statistics for SUIs, the number of claims for negligence is very small ie For the year 2009–10 the NHSLA received only 6,652 claims under the Clinical Negligence scheme.

1.3.2 With the increase in the use of the internet and the realisation by complainants that the NHS Complaints System is a waste of time, the number of complainants suing will probably increase.

Unless the complacent attitude is changed at all levels, the number of claims for negligence will increase.

1.4 *Recommendations—Improve standards of care , introduce an Independent Complaints System and collect reliable data*

1.4.1 The Commons Public Accounts Committee proposed in 2002 the introduction of a programme for Trusts to achieve level 3 of the CNST standards. This should be introduced as a first step to achieving an improvement in clinical standards.

1.4.2 Serious untoward incidents and deaths should be reported to an Independent Complaints body operated via HSE/Riddor.

A database independent of the NHS and associated Quangos could then analyse complaints and determine if there was an indication of system/managerial problems and take the appropriate action as in any other industry.

1.4.3 Trusts Risk Management Databases such as Datix & Safeguard should be independently audited on a regular basis to determine whether:

(a) SUIs and other Risk Data is being recorded.

(b) Appropriate Action is being taken to resolve complaints and learn from incidents.

1.4.4 Previous DH, NAO and Select Committee reports on Patient Safety, Complaints and Litigation should be reviewed to determine why they have been ineffective.

2.0 Reasons for Complaints & Litigation

2.1 Complaints and Litigation are the result of patients' dissatisfaction with their experience of the NHS .

In 2008 The NAO stated that in the last three years, 88% of adults in England had contact with the NHS . 13% were in some way dissatisfied with their experience. Refer *Feeding Back? Learning from Complaints Handling in Health and Social Care*. This is not an unsurprising statistic considering:

(a) In Acute Trusts in England, one in 10 inpatients suffer an untoward incident (however, referring to Recommendation 4 of the Patient Safety Report Vol I 2008–09 session by the previous Health Select Committee—"neither the DH nor the NPSA could provide reliable data. No attempt has been made to produce reliable up-to-date figures").

(b) One in 11 patients acquire a Hospital Infection. (Refer to the Commons Public Accounts Committee 24th Report Session 2004–05—*Improving Patient Care by Reducing Risk of Hospital Acquired Infections*). While there may have been a reduction in MRSA and C.Difficile infections since then, these are only a small part of the infection problem.

(c) The NAO Report 2005 A Safer Place for Patients—Key Facts stated:

- A retrospective study of patient records in two English hospitals found 10.8 % of patients experienced an adverse incident in which around 5.2% were judged to have been preventable. These adverse incidents caused permanent impairment in 6% and contributed to death in 8%.
- In 169 Trusts that provided data 2,181 deaths were recorded. Other published estimates of deaths as a result of patient safety incidents range from 840 to 34,000 but in reality we don't know.

(d) One in three of 1,800 deaths investigated in 2005 by the National Patient Safety Agency were unnecessary—Refer summary of NPSA Report Safer Care for the Seriously Ill Patients: Learning from Serious Incidents PSO/5.

2.2 To reduce Complaints, they must be treated as the symptoms of the underlying problems as indicated by the statistics contained in section 2.1 above. Whatever complaint system is introduced will be ineffective until this basic fact is acted upon.

Simply adding to a series of reports from the DH, CMO, NAO and various Quangos has not prevented a series of disasters in Acute Trusts over the last 12 years.

2.3 Therefore the priority for Government should be to identify and resolve the problems, not simply deal with the symptoms. This requires a change in attitude to Patient Safety throughout the NHS including the DH.

2.4 Mrs. P. Hewitt told the Institute of Public Policy Research in September 2006 that one of the four key elements to the Government Reform was a Regulatory System to guarantee standards.

Lord Hunt, in response to a written question on this subject, referred me to *Safety First: a report for patients, clinicians and healthcare managers*. He advised in writing in January 2007 "The Government's commitment to patient safety is set out in recommendation 1 of the report" which states:

> "As the next round of national goals, priorities and targets are being established from the period from 2008, it is important that the NHS takes steps to ensure Patient Safety is further deeply embedded as a core principle that underpins those priorities".

Two years later the Mid-Staffordshire Trust Disaster demonstrated there is no programme for achieving these objectives.

2.5 We are still waiting for a system to guarantee standards and until an effective system is in place, the number of complaints will rise with more complainants proceeding to litigation.

3.0 Reasons for Sharp Rise in NHS Complaints

3.1 Over the last 12 years Health Ministers such as Mr A Milburn, Mr Burnham, Lord Hunt and Ms Keen had the attitude of paying lip service to Patient Safety and Quality of Care but doing little or nothing except make excuses and issue PR statements for the disasters. On each occasion we hear the stock phrases such as "lessons will be learnt" etc yet new disasters come to light.

3.2 12 years ago, a complainant could be isolated and made to feel that they were exaggerating the situation in a Hospital or effectively ignored. In December 1999, Mr A Millburn stated that people like myself, who had complained of Involuntary Euthanasia, were scaremongering.

Mr Millburn refused to answer my question of how many cases he had investigated before he made that glib statement, typical of the political attitude to Patient Safety over the last 12 years, and reflected down the line to NHS Complaints Managers.

3.3 With the rise in the use of the Internet and the setting up of Web Sites, it is easier for a complainant to get support and tackle the obstruction of the NHS Complaints system. Disasters such as the Mid-Staffordshire Hospital Trust can no longer be hidden and forgotten about.

This use of the internet will lead to more complaints being pursued in a more effective way as there is a growing body of complainants who realise the complaints system is a waste of time.

4.0 Effectiveness of the New Complaints System

4.1. The new complaints system is a repeat of the 1996 system without the "Independent Review" stage. There is no reason why it should be any more effective than the 1996 system. The principal defect still exists in that those responsible for creating the problem are those responsible for dealing with the complaints.

4.2 None of the variations of the complaints systems since 1996 has prevented the series of disasters in Brighton West Sussex, West Herts Hospital Trust, Stoke Mandeville, Mid-Staffordshire, Basildon & Thurrock and many other Trusts.

A common reason for failure is that the Trust's Complaint system is operated by the incompetent Trust managers responsible for many of the problems which are the subject of the complaints.

4.3 The NAO *Report Feeding Back? Learning from Complaints Handling in Health and Social Care 2008*—Conclusion 24—A good Complaints System needs to be accessible, responsive and demonstrate that that lessons are being learned.

The DH recognised in its June 2007 consultation document *Making Experiences Count*, that this was not the case in the NHS. A statement the NAO agreed with in its report.

4.4 Even if the Ombudsman upholds the complaints, she can only recommend actions which may be ignored by the Trusts.

4.5 The failure of the Regulators to enforce an effective Complaints system, including the CQC is the subject of the ongoing Francis Public Inquiry.

5.0 Experience of Complaints System—Local Resolution

5.1 I started off my complaints in relation to the death of my mother in the Sopwell Ward of the St. Albans City Hospital in July 1999.

After reviewing my mother's medical records, which took three months to obtain, I submitted 21 detailed complaints to Mr S Eames, Chief Executive of the West Herts Hospital Trust in November 1999.

One complaint was related to management failures and the lack of a QA/Risk Management system.

I was advised by Mr G Etheridge, Deputy Director of Nursing, that he and Ms A Farrer would investigate my complaints as a matter of urgency.

5.2 After months of delays and continuous assurances, I proceeded through the charade of an Independent Review when as part of the process the Legal Advisor of what is now the Herts Partnership Trust threatened to sue me for defamation.

As an example of the IR Panel's competency, the Chairman of the Panel, recommended that to solve management and QA/ Risk Management problems, Nurses and Doctors should communicate more often. Other recommendations were equally anodyne.

5.3 I found at the time, complaining to the HSE was the most effective route to get action taken on infection control. Unfortunately, that route appears to have been blocked.

5.4 As a result of my complaints to the Ombudsman and the HSE, Ms Horn, Chief Executive of the Dacorum PCT, and other managers had requested the Chairman of the Beds & Herts strategic Health Authority, to have me declared an inveterate complainant.

He refused to give me a copy of any such letter. With the evidence from CHI and the HSE confirming that Ms Horn, various Quality , Risk and Complaints managers were inveterately incompetent, an understandable decision.

6.0 EXPERIENCE OF COMPLAINTS SYSTEM—OMBUDSMAN STAGE

6.1 After the issue of the "Independent Review Report" in January 2001, I wrote complaining to the Ombudsman (PHSO) in February 2001.

To get a response I had to submit a complaint that the Senior Investigator dealing with my case, had failed to provide Terms of Reference for an investigation. He had not done so despite his repeated assurances over a period of three years.

A meeting was then arranged at Millbank in April 2004 at which he told me he had not prepared any Terms of Reference for a review of my original Complaints and the Independent Review as he was confused and he was still putting my correspondence into files.

6.2 After complaining to the Ombudsman about the report issued by him, theoretically undertaken under the supervision of the HSO Director, Ms Abraham personally reviewed the files and issued a statement that all my complaints had been upheld, which in addition to the original complaints to the West Herts Hospital Trust, included complaints about:

- the failure of the Chief Executive of Dacorum PCT, to comply with the terms of the Service Level Agreement including Joint Auditing of the WHHT Care of the Elderly Wards; and
- The Hertfordshire Health Authority Failure to Performance Manage the Acute Trust and PCTs.

6.3 However, Ms. Abraham in her letter HS- 3508 /0064 of 31 May 2005, while acknowledging that she upheld my complaints, refused to report the Chief Executive of the West Herts Trust to the Secretary of State for Health. The HSO has this power but she concluded that it was not appropriate to do so in this case.

As the HSE had concluded in March 2003 that Executives and non executives and Divisional Managers required adequate H&S training to enable them to discharge their responsibilities, and issued an improvement notice to the Trust to that effect as well as several others, Ms. Abraham's conclusion was rather illogical.

6.4 Ms. Abraham did arrange for her Director of Clinical Advice to check on the conditions within the Sopwell Ward, confirming they were satisfactory, but refused to check on the Care of the Elderly wards in the West Herts Hospital Trust. As by that time the Ward was being managed by the St. Albans PCT, in terms of checking the management that had created the problems, it was rather irrelevant.

Other clinical, system and management failures, she also refused to get involved in.

6.5 After having my complaints upheld by the Ombudsman, and after further correspondence, the Chief Executive of the St. Albans & Harpenden PCT, advised in June 2006 that:

- the PCT does not have operational responsibility within either the Acute Trust or the Partnership Trust;
- she could do no more about my complaints; and
- I should continue discussions with the West Herts Hospital Trust.

6.6 My experience was not unusual. Anyone who has gone through the complaints system will know it is corrupt, weighted heavily against the complainant and ineffective.

6.7 The net result was that the West Herts Hospital Trust continued to blunder on from one crisis to another, caused mainly by mis-management, some of which I highlighted to the Hertfordshire County Council Health Scrutiny Committee.

Obviously, there were many other complaints made during this time which in real terms were ignored resulting in further unnecessary deaths and damage to patients.

7.0 ROLE OF PALS

7.1 I was advised by the St. Albans PCT PALS representative that she would not get involved in complaints against the Trust managers. I have no doubt this is correct, and indicates PALs is of limited use for serious complaints and have no experience of it.

8.0 GOVERNMENT'S PLANS FOR FUTURE COMPLAINTS HANDLING

8.1 Any system that relies solely on internal review of complaints is a waste of time and will not resolve problems for the reasons already outlined. In general it falls into the same category as the Self Assessment Health Check.

8.2 For local authorities and Links to get involved is of limited benefit as it is unlikely they will have the resources to challenge Acute Trusts on Management, system and clinical failures as Trusts have proved they are experts at covering up even large scale cases of negligence.

8.3 Where local authorities are in partnership with NHS Trusts, an effective complaints system using this route may lack independence.

9.0 Data from Complaints will Feed into New Commissioning System

9.1 The NAO has already commented on the lack of valid data in respect of the Number of Untoward Incidents causing permanent damage and death. Without strong regulators there is no reason for Trusts to change.

9.2 Without accurate Data, how do we know if the NHS is reducing the deaths and damage to patients, outlined in paragraph 2.1?

9.3 Based on recent FOI Requests:

(a) The CQC relies on data from the NPSA , which relies on data being submitted by Trusts. There is no penalty if Trusts provide misinformation or don't provide any.

(b) The CQC does not investigate individual Deaths or SUIs. Nor does it audit Trust Risk Management Databases such as Datix or Safeguard which should be used to record Complaints and SUIs and corresponding actions.

(c) The HSO does not analyse data from complaints to allow identification of incompetent managers and system failures.

(d) The NHSLA does not audit the Trust Datix or Safeguard Risk Management Database which should be used to record Complaints and SUIs.

(e) The HSE during inspections of Trusts does not audit Trust Datix or Safeguard Risk Management Databases.

(f) Riddor, a branch of the HSE does not gather information on Hospital Acquired infections and other SUIs.

9.4 Therefore, if the existing corrupted data from complaints is used, the new Commissioners will be no more effective than the PCTs, especially if the new commissioners are ex PCT staff.

Which is why data should be collated and analysed by a relatively independent body such as the HSE/Riddor.

10.0 Litigation

10.1 *NHS Litigation Authority (NHSLA)*

Referring to the NHSLA , created in 1995, it introduced a set of Clinical Risk Management Standards in 1997 and developed them over the years. The principle being that Trusts working to the higher standards (entailing lower clinical risk) paid a lower premium. For each level attained a Trust could obtain a 10% reduction up to a maximum of 30%.

A Trust working at level 3 is inherently safer than one working at level 1. Unfortunately for Patients, 40% of Acute Trusts in England are still at level 1. See NHSLA Factsheet 4.

The basic contribution for the West Herts Hospital Trust (WHHT) a Trust I became involved with in 1999 was £4.2 million/annum in 2004,

10.2 *Number of Cases of Litigation*

In 2009–10, the NHSLA received 6,652 claims (including potential claims) under its clinical negligence schemes and 4,074 claims (including potential claims) in respect of its non-clinical schemes. The figures for 2008–09 were 6,088 and 3,743 respectively.

Set against the background of the unnecessary serious untoward incidents, deaths and hospital acquired infections, this number of claims is very small.

Generally, complainants, including myself, are not looking for compensation. At the start of the complaint process I stated that I was not wanting to sue and would sign a document to that effect.

With the recent disasters such as the Mid-Staffordshire and Thurrock and Basildon Trusts it is probable people see the litigation as the best method of complaining, a view I now agree with.

10.3 *Reducing the Incidence of Clinical Negligence*

10.3.1 Litigation is handled by the NHSLA. In 1997 a set of CNST Risk Management Standards was developed for Trusts which included maternity and mental health services.

10.3.2 One proposal to reduce Litigation was made in May 2002 by Sir Edward Leigh who recommended a programme for Trusts to achieve level 3 of the CNST standards. This would be of benefit to Trusts and Patients as it would ensure a higher standard of care, reduce contributions to the scheme and result in less litigation and the resulting litigation and compensation costs—Refer Public Accounts Committee Report—*Handling Clinical Negligence Claims in England.*

10.3.3 I also suggested to Mr. A. Burnham in October 2006 that he should introduce a programme for all Trusts to achieve level 3. However, he was not prepared to make these standards mandatory. Apparently, he could not understand the benefits of having all Acute Trusts working to level 3 or he was not prepared to enforce the standards.

10.3.4 In response to a recent FOI request and correspondence, the NHSLA was unable to provide any disadvantages of Trusts working at level 3.

10.3.5 At present 40 % of Trusts are at level 1 so there is still a long way to go. Considering the CNST standards have been in place since 1997, it will be many years before all Trusts are at level 3, during which time the damage to patients will increase with the inevitable increase in litigation.

10.3.6 Litigation costs would also be reduced, if the DoH & Ministers identified and got rid of the incompetent Trust , Strategic Health Authority and PCT managers instead of making excuses for them.

The attitude of Ministers is indicated by Ms A Keen's statement in April 2008 that it was not in the Public Interest to prosecute incompetent NHS Managers. Hopefully this attitude has changed with the change of government.

11.0 Cost of Litigation

11.1 The NHSLA factsheets can provide the details of these costs for each Trust. Presumably the bulk of the costs will be justified or will not have been paid. Bearing in mind the damage done to patients in the NHS—see section 2.1 above these costs are a relatively small percentage of the cost to the NHS and DWP via the Disability Benefits payments.

11.2 While there are no doubt unscrupulous lawyers who take advantage of the system, £100 million could be saved by replacing the incompetent NHS managers, a recommendation I made to the House of Commons Health Committee Patient Safety Inquiry in September 2008. See House of Commons publication HC 1137 October 2008 for written evidence.

12.0 Reasons for Inflation of Litigation Costs

12.1 The NHSLA should be able to advise the details of the inflation, whether justified or not. If it is related to the numbers of cases, then the increase is relatively small compared with the damage done by the NHS to Patients.

12.2 If the NHSLA drags out the proceedings as long as possible in order to wear down the claimant and settle out of court or withdraw the claim, the cost of litigation then increases.

13.0 The Effect of Litigation on an Open Reporting & Learning Culture

13.1 At the start of the complaints procedure, I offered to provide a written statement that I would not sue the Trust. This certainly had no effect on the reporting culture with the complaints procedure being obstructed and corrupted by the Trust personnel.

13.2 The locum SHO responsible for my mother's care had advised his Medical Defence association . The Trust Legal Advisor was appointed as the secretary for the Independent Review, though I was not advised he was the Legal advisor until the Independent Review Hearing.

13.3 Mr Sweetman sat in the hearing with his secretary to record the minutes. After the hearing, I asked him how he could be independent when he was the Trust Legal advisor. He refused to answer and threatened to sue me for defamation. Mr Macintyre stated in writing that Mr Sweetman had got confused about his role and as he was an independent contractor the threat was a personal matter.

In addition:

(a) Reports sent to me by Ms A Farrer, the Complaints/QA Manager were checked by Capsticks.

(b) Statements obtained from Nurses, were returned to the nurses for amendment by Ms Farrer.

(c) Mrs Farrer advised Mr McIntyre that I should not be kept informed of progress on actions (and inactions) resulting from the Independent Review.

(d) After initially agreeing to my meeting with the individuals involved in my mother's care to review my complaints, the meeting was refused by Mrs Farrer and Mr Macintyre.

(e) Lies and misinformation were an integral part of the culture of the Complaints system, issued not only to me, but to other parts of the complaints system.

13.4 When complaints are made against Managers, it is not surprising they will not be willing to admit they are incompetent. The effect of Litigation will have very little effect in such cases as there will be a concern about the managers continuity of employment and career prospects and the same obstruction will be used by those affected.

14.0 REDRESS ACT—GOVERNMENTS INTENTIONS

14.1 (a) The Commons Health Committee inquiry into Patient Safety recommended in 2009 that the Redress Act was put into effect—see recommendation 13 of Patient Safety Report 151i—The committee stated for several reasons that it was appalled at the failure of the DH to implement the NHS Redress Scheme three years after Parliament had passed the necessary legislation.

(b) The excuse apparently is that the DH is awaiting the new complaints system to be embedded.

(c) In response to a FOI request, the DH advised it has no report explaining why the previous complaints systems failed.

(d) Also, the Ombudsman recently advised that she does not analyse complaints to determine which have elements of underlying management and system failure but passes them to the DH for analysis. I have yet to inquire about the action that results from the analysis, if any.

14.2 Mr A Burnham's response to the Inquiry criticism that it was unnecessary indicated his lack of understanding of the function of the Act. It may not be perfect, but better than the present situation, though how much it will cost obviously has to be assessed.

15.0 RIGHT TO COMPENSATION FOR TREATMENT INJURY

15.1 If the Complainant has suffered permanent or even temporary disability, preventing the person from working, he should be entitled to compensation as in any other industrial accident.

If he is not given compensation, he will be entitled to claim a disability benefit from the state. Ms A Keen in 2008 was unable to tell me how much it cost the country to pay for patients suffering permanent disability from NHS Treatment. This was one of several written questions via my MP, Sir Robert Smith, which she refused to answer.

December 2010

Written evidence from Mr & Mrs Cowling (CAL 23)

THE PRESENT COMPLAINTS SYSTEM DOES NOT WORK—READ ON

- We have followed the NHS complaints process but have had no remedy.
- The death of our daughter resulted in a Coroner's Rule 43 applied to South Essex Partnership Mental Health Trust (SEPT) in March 2010.
- We know that other patient s have died and as well as a member of the public as result of a homicide by a patient who was supposed to be under the care of South Essex Partnership NHS Trust. These were preventable deaths if people had received the appropriate care, treatment and monitoring from this Trust.
- South Essex Partnership NHS Mental Health Trust failed to listen to our concerns and did not review adequately the substance of our complaint and the Serious Untoward Incident Report was not given the necessary attention.
- We have not had an apology from the Trust which continues the harm and distress already caused.
- There are echoes of "Baby P" and reckless governance by this Trust, similar to the findings of Robert Francis in the Mid Staffordshire Inquiry. However, this has been a deliberate strategy of SEPT, self promotion at the expense of patient safety.
- There is evidence of manipulation of the self assessment system in place at the time that resulted in cash bonuses paid to the Chief Executive and other employees, which is tantamount to fraud.
- The Chief Executive had been part of the investigating team into the failings of West London Mental Health Trust.
- http://www.sept.nhs.uk/Boards-and-Members/Board-Meetings/~/media/SEPT/Files/Board%20Papers/Governor%20Minutes/BoG%202009%20Nov.ashx
  The BoG had been advised that a report would be received on behalf of the BoD following a seminar meeting of SEPT's response to the failings at West London Mental Health Trust.
  However, LC said she gives her assurance that Dr Patrick Geoghegan, Chief Executive (PG) was on the panel of the London investigation, he would have certainly already implemented any changes needed. LC advised governors will be updated once the report is done.
- The above assurances were false, he had not implemented changes or recognised the deficiencies in our daughter's SUI hence patients remained at risk. This is indicative of a lack of robust scrutiny by Trust governors, a concern highlighted again by Robert Francis at the Mid Staffordshire Inquiry.
- There has been lack of compliance with the NHS code of conduct for managers as we know that false information has been passed onto the monitoring bodies on a number of occasions to provide assurance which we know has been false.

- The monitoring bodies appear to be impotent and suggest that the relationships are too “cosy” and do not appear robustly objective, in particular, we are concerned about the Care Quality Commission.
- South West Essex PCT recognised that it had relied on the concept of “good faith” to the detriment of patient safety.
- The Parliamentary Health Service Ombudsman (PHSO), despite awareness of our hardship and resulting illnesses caused by our distress and despair due to the loss of our daughter and our concerns regarding patient safety, declined to investigate.
- On obtaining Freedom of Information from the PHSO regarding our case, it was clear that there was a complete lack of clinical expertise in reviewing our case with an unreasonable “Wednesbury” decision making process.
- PHSO does not have patient safety at the heart of its principles which is a serious flaw.
- As only 2% of complaints are investigated by the PHSO, what happens to the remaining 98%? Like us, there is no remedy.
- There is a lack of data regarding safety and quality in mental health provision and this should be addressed. Patient suicides should be considered “never” events.
- There is a lack of choice of providers of care for patients suffering from mental health conditions and therefore we are unable to use local services.
- This Trust was allowed to expand, further diminishing patient choice (imagine Mid-Staffordshire taking over another acute Trust!).
- An independent investigation should be carried out to ensure that investigations have been carried out properly and that lessons are indeed learned, otherwise patient safety cannot be guaranteed under this Trust’s leadership.

1. Our 19 year old daughter died whilst a patient of South Essex Partnership MHT (SEPT) in March 2008. Her Inquest in March 2010 resulted in a Coroner’s Rule 43 applied to this Trust:

http://www.justice.gov.uk/publications/docs/third-summary-coroners-reports-rule43a.pdf

2. The Trust subsequently engaged lawyers in an attempt to launch a Judicial Review of the verdict on the basis that the Trust had increased the likelihood of her death rather then caused it! We are pleased to say that the futility of this action was recognised and further waste of taxpayers’ money was avoided.

3. “I’m the first to say we have to hold up our hands if we get things wrong...” http://www.guardianpublic.co.uk/patrick-geoghegan-dudman

4. This statement is false; we have not received an apology. If the harm has not been acknowledged, then patients remain at risk.

5. On obtaining our daughter’s medical records it was clear that the Care Programme Approach (CPA) was not adhered to nor were a number of Trust Policies and Procedures. It was also clear that National Guidelines regarding risk highlighted by the Confidential Inquiry into Suicide and Homicide and appropriate treatment as advocated by NICE guidelines were not being followed. The many professionals who saw her kept separate records; she was never seen with full information despite signing a sharing information agreement. On reading the “Baby P” tragedy, we could draw similar parallels of poor communication and system failure. It was also apparent that following two high profile homicides under HSG(94)27 that Action Plans had not been followed through, a similar finding by Robert Francis QC in the Mid Staffordshire Inquiry indicating failures of governance at Board level. At Inquest, again, there was a finding that Action Plans had not been followed through regarding the Trust’s own Serious Untoward Incident (SUI) into our daughter’s death.

http://www.eoe.nhs.uk/news_archive.php?area_id=9&id=72

http://www.eoe.nhs.uk/news_archive.php?area_id=9&id=71

6. We made an official complaint in July 2008, this was answered in January 2009. This was not to our satisfaction as a number of questions remained unanswered but it stated it was final so we had to go to the next stage, which by the time we pursued this, was the Parliamentary Health Service Ombudsman (PHSO).

7. The SUI was made available to us in October 2008. Again, it was clear that Trust Policy was not followed in undertaking the investigation itself, no root cause analysis. Whilst there was recognition of the failure of the CPA and lack of a carer’s assessment, there was no alignment of her care to a number of Trust Policies or National Guidelines. In fact, the deficiencies in this report were similar to those found following the Investigation into West London MHT.

http://www.cqc.org.uk/_db/_documents/Investigation_into_West_London_Mental_Health_NHS_Trust_FINAL_200907171608.pdf

8. What it quite disturbing is that the Chief Executive of this Trust was part of the investigating team into West London NHS Mental Health Trust . However, he did not appear to recognise these deficiencies of which he was supposed to have been an expert. Freedom of Information appeared to show a review at Board level.

No concerns were found! You do not have to be a trained Psychiatrist to appreciate the appalling care, or lack of care, provided so this would an unreasonable finding. We were told this review at board level was not documented.

9. We wrote to the Trust regarding our concerns of the SUI in November 2008. In May 2009, the Coroner's Expert Witness confirmed our findings of the poor and unsafe care. We received a reply to our letter regarding the SUI shortly after. The Clinical Director and Psychiatrist from the Trust were not in agreement with the Expert Witness. They were of the opinion that information regarding a patient's instability was not relevant when treating that patient!!!! We were now very, very concerned. This was not a safe Trust. In the three years between 2006 and 2009, there were 17 unexpected deaths or otherwise known as preventable deaths. If this was an Acute Trust rather then a Mental Health Trust, there would be a public outcry. There were indications that patients were not being adequately risk assessed and were being discharged prematurely into the community, as in our daughter's case. This was dangerous as Care Co-ordinators were working in excess of the Department of Health recommended 35 client limit. In fact, in 2007 the Trust had identified shortages in community staff but this had not addressed nor identified in the SUI. In April 2009, there was a homicide, at a time identified as unsafe by the Coroner. East of England SHA have confirmed that there will be an Independent Investigation under HSG(94)27 in 2011 into the care provided by SEPT to this patient.

10. We pursued our complaint to the PHSO late 2009. They were aware of the Coroner's Expert witness report but due to court protocol, were not allowed to take this into consideration. However, this should have been enough to alert that something was wrong and we emphasised our sincere concerns regarding patient safety. From our experience, communication was mainly done over the telephone with no follow up written correspondence to confirm what was said and actions to be taken. We did email eventually our concerns and that we had suffered hardship in that we were unable to use our local services as we knew it was unsafe and had to pay for private care. We also reiterated the inadequate Trust investigation with similarities to those found at West London MHT. However, the PHSO turned down our complaint. On obtaining Freedom of Information, they had wheeled out a so called "expert" who simply stated that the Trust had undertaken an investigation and had fulfilled its obligations. The fact that this investigation was inadequate was not explored, nor were the patient safety issues or our hardship. We have lost faith in this process.

11. We had also alerted the EOE SHA. Again, under a FOI, the monitoring of Action Plans following independent investigations under HSG(94)27 was merely obtaining updated Action Plans. However, Dr Paul Cosford did contact Barbara Stuttle of West Essex PCT to undertake an investigation. Following the Inquest, we did meet with Barbara. She apologised that they had taken SEPT at face value when their response should have been more robust.

12. We are now awaiting the terms of reference for a review regarding the implementation of the Rule 43. However, there will be no root cause analysis of why the system failings occurred so there is potential for areas of concern remaining. For example, why did the Care Co-ordinator have 37 clients? Why, after two years, did the Care Co-ordinator and others still not know what a crisis and contingency plan were? Why were letters from other professionals not copied to the Care Co-ordinator? How many other patients were receiving poor and unsafe care? There is also going to be a review of the SUIs whereby the PCT are already suspicious that the quality and fitness of these reports are questionable and that patients may have been harmed.

13. How did this Trust manage to get an "excellent" rating you may well ask? It is probably down to self promotion, manipulation of the ratings system and passing on false information to provide assurance. We have documentation to support this view.

14. It is also down to a failure of the monitoring bodies. These relationships appear too "cosy" where the concept of "good faith" is abused by this Trust. We have pointed out blatant lies to the Care Quality Commission, such as after the Inquest the Trust passed on assurance that our daughter's SUI was undertaken by Personnel trained in root cause analysis when this was not true. You would think we would be thanked but they don't seem to care and act as "apologists" for the Trust.

15. Our position is that we have followed the NHS complaints procedure. This has been a complete failure with the lack of an apology by the Trust and failure by the PHSO to undertake an investigation and a lack of a remedy despite our hardship. Our only option now is to take legal action.

16. Outside of the NHS complaints system, the Coronial system has, as a finding of fact, found SEPT to be an unsafe Trust. The SHA and PCT eventually recognised that there were serious concerns. But in the meantime, SEPT were allowed to empire build and allow this unsatisfactory culture and leadership, the pursuit of self promotion at the price of patient safety, to be enforced upon others.

17. We hope that it has become apparent that there is a serious lacunae in the NHS complaints system. The PHSO does not have patient safety as a main guiding principle. It does not have this as a principle at all! If we had not obtained the medical records, then these serious system failings would not have been identified as the Trust were either incompetent and did not recognise these failings or deliberately decided to ignore them. Any of these scenarios are indications of failings of governance at board level. If our daughter had the appropriate care, treatment and monitoring, she would be alive today.

18. Please take into account the vulnerability of patients and their families and the probable under reporting of poor and unsafe care.

December 2010

Written evidence from Anne Ward Platt (CAL 24)

1. My name is Anne Ward Platt. I am director of AWP Associates and of WP Medical and Professional Services Ltd., and I am a Non-Executive Director of Northumberland, Tyne and Wear NHS Foundation Trust. I am author of "Conciliation in Healthcare: managing and resolving complaints and conflict", foreword by Sir Liam Donaldson, former Chief Medical Officer (Radcliffe Publishing 2008). I have been involved in healthcare conciliation since 1997 and I have experience as a conciliator in relation to both primary and secondary healthcare.

2. I make this response to the Health Committee Inquiry in a personal capacity.

3. The headings under which I am submitting evidence are:

- The effectiveness of the constituent parts of the complaints system
- Encouraging the use of mediation before litigation is instigated.

4. To this submission I append the following articles I have written,[18] which highlight best practice in complaints handling, including the use of conciliation:

Ward Platt A. Handling complaints. British Medical Journal 2010;340:98–9.

Ward Platt A. Say you want a resolution: conciliation in general practice. Management In Practice 2008;14 (with permission from Campden Publishing).

Ward Platt A. The new complaints procedure in general practice. Management In Practice Web Exclusive. 20 April 2009 (with permission from Campden Publishing).

The Effectiveness of the Constituent Parts of the Complaints System

5. The Ombudsman's office is now receiving more than twice the number of complaints compared to the period before April 2009, which suggests that problems remain with resolving complaints at a local level. I would like to suggest that wider use of independent conciliation could be instrumental in preventing the escalation of complaints to the Ombudsman. The current NHS complaints arrangements remove the need for a rigid timetable to be applied to handling complaints, and in principle this greater flexibility should also enable the wider use of conciliation.

6. The potential value of using conciliation within both primary and secondary healthcare is not sufficiently recognised in the UK. However, conciliation is already used extensively in relation to healthcare complaints in a number of other countries; I have highlighted examples of best practice in "Conciliation in Healthcare: Managing and resolving complaints and conflict".

7. Complaints often originate from situations that are distressing for all concerned. Where these occur following the death of a patient, an adverse event, a side-effect or reaction arising from clinical treatment, or where mistakes have been made, conciliation offers an opportunity for the issues to be addressed in a way that is supportive for both the complainant and the clinician. The process can enable more effective communication between the parties, which may in turn facilitate resolution of the complaint.

8. Conciliation can provide a supportive process for staff as well as for those making a complaint. Complaints can have a deleterious effect on a health professional's clinical practice, particularly if they are engaged in a long and protracted complaints process. If not properly managed, seemingly minor issues can escalate and have far reaching consequences. Some doctors practise more defensively and others lose their enjoyment of work, and these effects can still be evident in the long term, with consequent damage to patient care.

9. Key aspects of conciliation are:

9.1 It is undertaken by a neutral intermediary who is independent of the parties concerned.

9.2 It is a voluntary process, and the parties can withdraw at any time.

9.3 It is a confidential process (so conciliators need to comply with the relevant NHS guidance).

9.4 It allows for apologies to be made.

9.5 Further explanations or information can be provided, which may include independent clinical advice.

9.6 It can be used in relation to complex clinical complaints as well as complaints involving the attitude and manner of healthcare staff.

9.7 It is not essential for the parties involved in the complaint to meet together during the conciliation process unless a desired outcome is a restoration of the relationship between them.

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[18] Not printed

9.8 Where appropriate, redress may be agreed.

9.9 Service improvements can be identified or other actions can be taken as a direct result of the complaint.

9.10 It is cost effective, as expensive litigation is often avoided.

ENCOURAGING THE USE OF MEDIATION BEFORE LITIGATION IS INSTIGATED

10. Where appropriate, the use of mediation/conciliation in relation to claims can be invaluable. It is worth bearing in mind that some claims have their origins in a poorly handled complaints process; some claimants pursue litigation because they have not received satisfactory explanations, particularly where there has been an adverse clinical outcome.

11. Although there are some variations in the models used in different contexts, conciliation and mediation share these characteristics:

11.1 The use of a neutral intermediary who acts as an impartial and independent facilitator using specific skills aimed at bringing about a resolution of the dispute to the satisfaction of the parties concerned;

11.2 the process is based on an agreed framework or code of conduct;

11.3 any information that is disclosed during the process is "without prejudice", which means that it cannot normally be used in any subsequent court proceedings;

11.4 the parties agree to take part in the process voluntarily;

11.5 the parties can withdraw at any time;

11.6 the mediator or conciliator does not impose a solution on the parties;

11.7 the private sessions between the mediator or conciliator and each party are confidential (within certain limits), and only such information as is agreed is passed on to the other party;

11.8 there is opportunity for joint sessions involving both parties;

11.9 the process provides a "safe" environment in which the participants can express their feelings and emotions;

11.10 the outcome may include apologies; explanations; evidence of organisational change (for example, action plans); evidence of individual change (for example, learning or re-training); or restoration of relationships between parties; as well as financial settlements where provision is made for this; and

11.11 the outcome is not legally binding, but where the process is being used as an alternative to a court hearing, the parties may agree subsequently to a legally binding contract.

RECOMMENDATION

12. I hope that the Committee's Inquiry will recognise that the potential benefits of conciliation are considerable, and that conciliation/mediation should be widely promoted as an effective means of resolving complaints and claims.

REFERENCES

1. Ward Platt A. Conciliation in Healthcare: Managing and resolving complaints and conflict. Oxford: Radcliffe, 2008. Foreword by the Chief Medical Officer, Sir Liam Donaldson.

2. Ward Platt A. Say you want a resolution: conciliation in general practice. Management In Practice 2008;14.

3. Ward Platt A. The new complaints procedure in general practice. Management In Practice Web Exclusive. 20 April 2009.

4. Ward Platt A. Handling complaints. British Medical Journal 2010;340:98–9

December 2010

Written evidence from Gerry Ferguson (CAL 25)

This submission is sent in my personal capacity but based on my experience over 30 years with Mowbray Woodwards and Withy King as a solicitor acting for claimants in clinical negligence claims. I was also involved in setting up the ICAS Pilots for BANES and Swindon with NHS representatives.

1. *Summary*

Every time there is a change of Government previous unworkable or discredited schemes are rehashed and published as if the new executive is the first institution ever to think of the proposals, completely oblivious to the fact that these issues have been suggested and found to be unworkable again and again over the years.

COMPLAINTS

2. *The reasons for the recent sharp rise in NHS complaints*

I would suspect that the main reasons for the sharp rise in complaints are:

(1) the supposed creation of an internal market within the NHS; and

(2) the effects of the European Working Time Directive. Because care is increasingly undertaken by clinicians and nurses from outside agencies, there is no continuity of care and no one accepts responsibility for the overall care of patients. Serious deteriorations in the patient's health are not noticed until far too late, because there is no continuity of nursing and no continuity of care by junior doctors. When adverse events take place very often no one records them and no one takes ownership of the problem to learn from the errors and put protocols in place to prevent a repeat, because there is no financial incentive to take preventative steps within a target-driven system where throughput dictates remuneration under contracts. This situation will get worse with GP commissioning, as they have even less understanding of the acute Trusts' structure and financial drivers than the PCTs.

3. *The effectiveness of the new complaints system*

The new complaints system seems no more effective than the old system. The basic problem is that, because there is no duty of candour when something goes wrong, the clinicians and nurses do not feel they need to report what has happened. The Trust management have other priorities and simply assume that no adverse incident records must mean there are no adverse incidents. Judging from my own experience over many years, the culture of "deny, deny, deny" remains as ingrained as it ever has been and the modification of the system has not changed that mindset. It is the same in General Practice where the GPs are advised by their defence societies to make no admissions and in hospitals where the NHSLA give the same advice. The situation will get even worse if the complaints and litigation function is outsourced to a commercial company as the cost-effectiveness of their contract with the DoH will depend on stonewalling and denying claims.

4. *The effectiveness of the constituent parts of the complaints system*

The first stage of the complaints system is universally ineffective because there is no independent advice for patients and no independent assessment of what took place and so the response to any complaint is dictated entirely by the individuals who are to blame for the situation in the first place. So in General Practice the individual GP tells the Practice Manager that there is nothing in the complaint and the practice manager replies accordingly. The same happens at NHS Trusts, the nurses or clinicians deny they are to blame and the Chief Executive replies denying the complaint. In private medicine or surgery, or in dentistry, the defence societies' response is entirely dictated by the subjective view of the clinician concerned.

5. *The effectiveness of Local resolution/ICAS*

Because the first stage of the process is entirely controlled by the people who mistreated the patient in the first place it is well-nigh impossible to obtain a satisfactory resolution of a serious complaint under local resolution. ICAS is without exception drastically underfunded and today support workers leave regularly and the organisations do not have enough funding to enable caseworkers to accompany patients to act as their advocates at one-sided meetings, where the patient or family is confronted by a team of clinicians, managers and administrators, whose whole approach is often intended to cover-up and mislead and simply results in a denial of anything the "outsider" asserts took place. Often the staff who witnessed an incident are not called to the meeting, so they cannot be questioned. unsurprisingly, the patient feels that they are not being believed and so they then tend to resort to seeking independent legal advice. Even in the most gross and obvious circumstances, where it is patently obvious that substandard treatment has led to death or injury, an open admission of liability is rarely made. Even if a settlement offer is made, the NHS defendant will usually pitch the offer ridiculously low, in the hope that a claim can be bought off before the patient or family can obtain detailed independent medical evidence and a proper analysis of the financial effects of the negligence on the individual or family concerned from a lawyer.

6. *The effectiveness of referral to the Ombudsman*

On the whole, the cases take far too long to get to the Ombudsman and since there are insufficient resources for the ombudsman to properly value a claim and award compensation, following a favourable ruling the injured patient or the dependents still have to go to a lawyer to receive appropriate advice on the right expert to analyse what has gone wrong and the right team of experts to set out in cash terms exactly what needs to be paid to put the patient or family into the position they should have been in, if they had been treated competently in the first place.

7. *PALS as a gateway to the complaints system*

When PALS was set up it was intended to be entirely separate from the complaints process and was not intended to have any role within it, as a gatekeeper or otherwise. PALS officers were simply intended to aid communication between patients, their families and the treating NHS trusts, and defuse misunderstandings, because they would know who (within the monolithic administrative structure) was the right person to address the patient's concerns. However, because the PALS service was underfunded many Trusts decided to effectively make PALS officers the first point of contact for the complaints system and there is no uniformity of approach between NHS trusts. They do not have the same structures, so the patient has no idea whom to contact to register a simple concern or make a formal complaint. Some Trusts subsume Complaints and Litigation within the same department; others don't. Some Trusts subcontract this function to another Trust altogether.

8. *Foundation Trust failures to report complaints*

Because of the way Foundation Trusts have to present their data to preserve their status there is every incentive to deny that there are any complaints. Until this perverse incentive to misrepresent the true position is removed they will not address the problem. Until they are given credit for recording each complaint and showing that it has been successfully addressed and the results communicated to Trust staff to improve processes, the simplest thing is for the management to continue to deny the problem, until you get to the Mid Staffs scenario.

9. *Health Watch*

It seems patently obvious that if ICAS is not properly funded, this scheme will not be properly funded either. The Local Authorities' budgets are being slashed for core services, so I can hardly imagine they are going to put a lot of time and effort into creating from scratch and funding a peripheral service that does not directly affect their own targets or outcomes, except where there is a joint health/social services community care plan in place. Probably all that will happen is that redundant former ICAS employees will join Health Watch and you might as well keep ICAS and avoid all the unnecessary upheaval, branding and transaction costs of a PR-driven "new service".

10. *Data from complaints and the new commissioning arrangements*

GPs are not used to keeping their own data on complaints against individual GPs, so I fail to see why anyone would imagine that (in addition to all their other unfamiliar commissioning roles) they will successfully create and introduce from scratch a new universally accessible database of complaints in relation to all the institutions with whom they are expected to contract and be able to make any sort of meaningful assessment of whether the recorded complaints affect the viability of their contracts in the remotest way.

Litigation

11. *The cost of litigation against the NHS*

The cost of litigation against the NHS is, in my experience, almost entirely dictated by the culture of blame-avoidance and denial within the NHS itself, rather than any external factor. If the complaints system was properly resourced and run by an outside body with access to independent medical experts, then patients would not feel driven to consult solicitors. Despite all the incentives offered to the NHSLA to settle cases early: the pre-action protocol for the resolution of clinical disputes and the front-loading of the costs of investigation and preparation introduced by the Woolf reforms, the NHSLA still deny, deny, deny. They don't respond to Letters of Claim under the protocol in time or at all. They then farm the cases out to panel solicitors once the time for response has expired. These panel firms have to carry large caseloads because of the punitive costs agreements imposed on them by the NHSLA, who can distort the market by their buying power. They do not have the resources to form an early assessment of the merits of any complex claim, so the Letter of Response is another denial to buy time. Because they do not seek independent evidence early they simply accept what the treating clinicians say, when it should be obvious that their evidence is often tainted by conflict of interest. It is only months (or even years) down the line that an independent opinion may be sought and even then it is usually from a small cadre of defence experts who are notorious within the industry for their disingenuous evidence. Inappropriately reassured, they continue to defend very usually until the defence expert capitulates at the joint meeting of experts, two thirds of the way through the litigation process. That's why the costs are higher and the increase is exacerbated by the cuts to Legal Aid eligibility that mean that a lot of cases now cost almost twice as much to settle in costs, because solicitors are forced to use CFAs if there is no BTE legal expenses insurance or public funding available. The costs will rise further exponentially, if Legal Aid for Clinical Negligence is removed from scope altogether as planned.

12. *Reason for the inflation of litigation costs in recent years*

The reason why costs have increased is because of the determined assault by successive Governments on the Legal Aid scheme, failing to recognise that by slashing the Legal Aid budget they are forcing solicitors to inevitably use alternative funding mechanisms that are twice as expensive. Because costs follow the event, the Government makes a rod for its own back by creating a system whereby the only way injured patients who do not qualify for Legal Aid can bring claims is under CFAs and because the NHSLA deny even obvious cases the claimant's solicitors have to recover high success fees to reflect the increased risks, according to a straightforward risk assessment template. Because Government asserts that solicitors must not cherry-pick only sure fire winners, in order to preserve the appearance of access to justice, it follows that the solicitors and barristers on CFAs have to make enough money on the success fees in winning cases to pay for the losers. Solicitors do not issue and serve cases unless they think they are going to win, but the statistics do not show the numbers of meritorious claims that have to be abandoned, where the entire costs have to be written off and own disbursements met.

13. *The impact of CFAs on litigation against the NHS*

As set out above, this negative impact results almost entirely from a lack of joined-up thinking between the MoJ and the DoH when seeking to cut the small proportion of the total Legal Aid budget attributable to funding clinical negligence investigations and litigation. Ministers seem to think that there will be no political fallout from this initiative, but seem oblivious to the fact that by squeezing the balloon by reducing funding to the Legal Services Commission they were (by their own tinkering with a finely balanced system) creating a new "market" exploited by ATE insurers who offer indemnity for CFA cases with premiums based on perceived risk at each stage and bearing IPT almost all of which additional cost falls on the CNST, defence societies and other defendant insurers.

14. *The effect of litigation on the development of an open reporting and learning culture in the NHS*

The assumption here seems to be that if it was not for negligently injured patients trying to bleed the NHS dry with their unmeritorious claims the clinicians and managers would not need to be so defensive and this would encourage an open reporting and learning culture. The truth is that the over complex way NHS contracts and targets are structured encourages "gaming" with data to produce the best financial result for the individual clinicians, institution or GP surgery. Unless there is a positive financial incentive to promptly admit liability, where it is known from the outset that substandard care has resulted in injury or death, the culture of denial and delaying payment will continue and blight the NHS. Junior doctors are afraid to admit to errors as it will damage their career paths; senior clinicians don't admit errors because it affects their performance bonuses; managers don't want to hear about errors as they take up management time and adversely affect the statistics of the unit concerned and Trusts that admitted the true extent of their complaints and negligent injuries would not qualify for Foundation Trust status and would not be able to be more "creative" in selling services to each other to maximise income without regard to the unfortunate "transaction costs" of the politically driven changes in medical and nursing practise which cause the injuries and deaths that cost the Government and other institutions such a significant amount each year.

15. *Government's intentions regarding the implementation of the NHS Redress Act 2006*

The objections to the in-built conflicts of interest involved in this cheap and cheerful "rough justice" proposal led to the legislation being kicked into the long grass in 2006 and the simple passage of time has not made the arguments in its favour any more attractive or diminished the very real objections to this deeply flawed scheme.

17. *No fault compensation*

Every time this supposed panacea is suggested proper research demonstrates in an instant that it is unaffordable because any saving in lawyer's and experts' fees would be dwarfed by the hugely increased number of individual awards of modest compensation where patients presently remain uncompensated. Coupled with a duty of candour, such a proposal might be made to work, if the political will and the funds were there, but they are not. To introduce such a scheme without a duty of candour would simply add another expensive blind alley to the existing unwieldy process.

18. *Mediation*

You can lead a horse to water but you can't make it drink. Unless and until the culture of denial and obfuscation by the NHSLA and defence societies is changed, claimants' lawyers could ask them to attend mediation until the cows come home, but the defendants' representatives would have to refuse until they had managed to assemble a half-way credible supposed defence to the claim, to preserve their bargaining position to try and reduce the damages properly payable. For reasons set out above, there is no reason to suppose that imposing a compulsory mediation step would do anything other than delay the process and add another unnecessary layer of cost. If the will is there to try and achieve a settlement, the current system works perfectly well, with "round table" ADR leading to settlements every week without the necessity for an intermediary, far less a trial before a judge.

December 2010

Written evidence from the Medical Defence Union (CAL 28)

BACKGROUND—INDEMNITY AND ASSISTANCE PROVIDED TO MDU MEMBERS

1. The Medical Defence Union (MDU) is the oldest and largest of the UK's three medical defence organisations (MDOs). In common with the other MDOs we are a non-profit-making mutual membership organisation and we have members in the UK and Ireland.

2. In the UK we provide a wide range of benefits of membership to over 50% of doctors in hospital and primary care, and around 30% of dentists. Practising medical members receive an insurance policy providing them with £10 million indemnity for clinical negligence claims. Members also have access to advice and assistance with a wide range of medico-legal matters including the NHS complaints procedures.

3. The insurance policy is provided principally for GPs members and hospital doctors working in the independent sector. Hospital doctors working in the NHS are indemnified by the NHS but we also provide them with an insurance policy for their work that is not NHS indemnified. For example as part of their clinical duties they may need to write a medico-legal report about an NHS patient, but NHS indemnity does not apply to such work.

4. The MDU is not an insurance company and the insurance policies provided to members are underwritten by SCOR UK Company Limited and by International Insurance Company of Hannover Limited. MDU members can also seek advice and assistance on a discretionary basis for negligence claims outside the insurance policy, for example if they have retired. The MDU's other medico-legal benefits, including advice and assistance with the NHS complaints procedure, are available on a discretionary basis.

SUMMARY

5. Our analysis of data from the first year of the complaints procedure suggests there has not been a dramatic rise in the number of complaints against our GP members who continue to resolve the vast majority of complaints locally to complainants' satisfaction.

6. However, complaints that are referred to the Ombudsman are an indication that lessons still need to be learned: such as the need for doctors to apologise when things have gone wrong, and to follow relevant guidance if a relationship with a patient breaks down to the extent that the practice is contemplating removing that patient from the list.

7. It is clear that many complainants are unfamiliar with the procedure and, while practices should have to assist them, complainants also need independent advice and assistance and do not always seem to get it. We do not know if the problem arises because assistance is widely available but some complainants are not aware of it; or whether there are not enough sources of assistance in some places. Either way, we believe this is something the Committee may wish to consider.

8. We have always believed that patients who are negligently harmed should be compensated appropriately for any losses. However, it is inappropriate and unfair for the Ombudsman to recommend financial redress for matters that should more properly be addressed through the clinical negligence procedure, other than in exceptional circumstances.

9. We believe the report of the review of the requirement for healthcare professionals to have insurance or indemnity is potentially misleading in part and many of its recommendations are flawed. We are concerned that the Government has recently accepted most of the review's recommendations when it did not even consider the adequacy or appropriateness of discretionary indemnity to protect the public. We urge the Committee to start a debate on this matter to ensure the public is properly informed about decisions that are taken on its behalf.

THE EFFECTIVENESS OF THE NEW COMPLAINTS SYSTEM

10. Given the MDU's experience is primarily in assisting members to respond to complaints we confine our comments to the effectiveness of the procedure.

11. We tend to get most requests from GPs for advice about responding to complaints because the patient or complainant contacts the GP or the practice direct. GPs are usually involved in investigating and responding to complaints, whereas in NHS bodies complaints managers usually co-ordinate complaints responses. Hospital doctors may be asked to participate, for example in investigations or by providing information or attending meetings with complainants, but they are not usually involved in drafting responses and liaising directly with complainants.

12. In order to prepare members for the new complaints procedure from 1 April 2009, we produced a series of factsheets covering:

- An introduction to the NHS complaints procedure.
- Stage 1—local resolution.
- Writing a response to a complaint.
- Stage 2—Parliamentary and Health Service Ombudsman.

13. These factsheets explain the new procedure and provide advice to members. Because it was so important to ensure that our GP members were aware of the new complaints procedure, we sent the factsheets to all GP members in April 2009 and they are available on our website. We also send them to individual members who seek assistance with complaints.

14. In addition to setting out the detail of the procedure and the specific regulatory requirements upon doctors and others who respond to complaints, the introductory factsheet contains additional advice on "Saying sorry" and a page explaining the Ombudsman's "*Principles of Good Complaints Handling*". We believe it is important to draw members' attention to these principles, which they are expected to apply at the first, local resolution stage. The factsheet on local resolution highlights the principle requirements of the regulations and this forms the basis of our advice for members:

15. "(2) The arrangements for dealing with complaints must be such as to ensure that:

(a) complaints are dealt with efficiently;

(b) complaints are properly investigated;

(c) complainants are treated with respect and courtesy;

(d) complainants receive, so far as is reasonably practical:

  (i) assistance to enable them to understand the procedure in relation to complaints; or

  (ii) advice on where they may obtain such assistance;

(e) complainants receive a timely and appropriate response;

(f) complainants are told the outcome of the investigation of their complaint; and

(g) action is taken if necessary in the light of the outcome of a complaint."

16. Not all members seek the MDU's advice when responding to complaints and we are generally contacted where the complaint is not straightforward or because it raises matters GP members have not come across before. Our advice ranges from explaining the procedure and how GPs are expected to respond, to advising about meetings with complainants or seeking independent medical advice, to discussing draft responses. With the old complaints procedure over 90% of complaints notified to us by GP members were resolved to the complainant's satisfaction at local resolution. It is too early to produce definitive information about the new complaints procedure, but preliminary research suggests our GP members are continuing to resolve the vast majority of complaints locally and to the complainant's satisfaction.

17. We looked at complaints that were referred to the Ombudsman as these complaints are a useful indicator of problem areas. We identified the main reasons for them so that we could provide members with risk-management advice drawing upon the lessons learned.

18. We analysed complaints between 1 April 2009 and 31 March 2010 when we received 2,300 notified by GPs and 580 from hospital doctors. Of these only 38 were referred to the Ombudsman: 32 were complaints against GPs and the others concerned hospital doctors. The four main reasons for dissatisfaction were:

- Delay or failure in diagnosis (16)
- Problems in communication (7)
- Dissatisfaction with the standard of care (5)
- Removal from a GP's list (4).

19. After initial consideration, the Ombudsman investigated 11 of these complaints formally and not all the investigations are concluded. The Ombudsman either referred the other complaints back to the practice or hospital to look at again, or closed them without action. In these cases the complainant is informed of the reasons for these decisions.

20. It is not surprising that the themes from members' complaints echoed the findings of the Ombudsman's report of her office's first full year of complaints handling under the new procedure. For reasons of confidentiality we cannot provide details of individual cases but we found in some there were problems with the way in which complaints were managed, for example, the practice did not explain the complaints procedure fully or help the complainant to understand what to expect at the outset. In some cases where it would have been appropriate to apologise, the patient did not get an apology. In others a decision to remove a patient from the practice list was either not handled in line with accepted guidance, or the decision to remove that patient was not proportionate to the matter that gave rise to the decision. For example, a patient who was removed from the list was not warned in advance.

21. Given the number of interactions between patients and GPs, the number of complaints and those that proceed to the Ombudsman are very low. However, that is no comfort to the complainant or to the GP or hospital doctor who is the subject of the complaint. We believe it is important to allow members to learn from complaints and provided them with risk-management advice drawn from our analysis.

22. Our analysis suggests there has not been a dramatic rise in the number of complaints against our GP members, and that they continue to resolve the vast majority of complaints to complainants' satisfaction at local level. However, the problems that are referred to the Ombudsman are an indication that lessons still need to be learned in some areas such as the need to apologise when things have gone wrong, and to follow relevant

guidance if the relationship with a patient breaks down to the extent that the practice is contemplating removing that patient from the list. It is clear that many complainants are unfamiliar with the procedure and, while it is right that practices have a duty to assist them, complainants also need independent advice and assistance and do not always seem to get it. We do not know if the problem arises because assistance is widely available but some complainants are not aware of it; or whether there are not enough sources of assistance in some places. Either way, we believe this is something the Committee may wish to consider.

Ombudsman's Recommendations—Unfairness to GPs

23. We are currently in discussion with the Ombudsman because, since the new complaints procedure began, her office has started to recommend financial recompense in respect of complaints against some practices, which in the context of singlehanded practices means individual GP members. We appreciate that clinical matters are within the Ombudsman's jurisdiction and that her recommendations cover maladministration and service failure, and we encourage members to accept redress recommendations that would address any failings on the part of their practice appropriately. We have always held the view that patients who are negligently harmed should be appropriately compensated for any losses. However, we believe it is inappropriate and unfair for the Ombudsman to recommend financial redress for matters that should more properly be addressed through the clinical negligence procedure, other than in exceptional circumstances. Section 4 of the Health Service Commissioners Act 1993 provides that the Ombudsman shall not investigate a matter if the aggrieved person has a remedy through the courts, unless it is not reasonable to expect that person to resort to that remedy.

24. The Ombudsman is required to be equally fair to both parties yet we believe that by recommending financial redress outside the negligence procedure, the Ombudsman is being unfair to GPs. If professional men and women find themselves being asked to provide compensation for adverse consequences sustained by complainants, on the basis that those consequences have been caused by any failings in their clinical judgement, it is only fair they are able to challenge this through proper channels.

25. The document *Responsibilities of the Health Service Commissioner* (1995), which reflects the views of parliament when the power to investigate clinical judgement was conferred on the Ombudsman, makes it clear that the intention was to allow delivery of remedies such as apologies and explanations that courts cannot deliver. It was clearly not the intention to sidestep the jurisdiction of the courts.

26. Civil claims provide protections for doctors who are said to have made negligent clinical judgements and it is only fair that a GP who is faced with an allegation can make use of these. Without this it could be said that doctors' rights to be treated fairly is being denied, with no adherence to open justice including by public scrutiny of the process leading to the award.

27. We are discussing this matter of principle with the Ombudsman and covered it in our submission to the recent Law Commission consultation paper 196 on public service ombudsmen, which we would be happy to show the Committee.

Clinical Negligence—Need for Debate about Discretionary Indemnity

28. The Committee's terms of inquiry focus on litigation in the NHS and its impact. We would like to comment on one aspect of litigation that is mentioned in this inquiry's introductory comments and which relates to the protection of the public. That is the way in which indemnity is provided. There must be certainty that valid claims are paid and there is not that certainty at present. Although the certainty that indemnity will be provided should be a matter of public concern, it is only known about and understood by very few. We hope the Committee will open up debate and give it the wider publicity it deserves.

29. It is wrong to assume that NHS indemnity is insured because it is not: it is discretionary. In England, the individual NHS employer or the NHS Litigation Authority (NHSLA) acting on their behalf, can decide not to pay a claim. Claims are not made against individual clinicians, but against the employer, and in theory it is possible for that body, or the NHSLA, not to pay the claim. In practice, because it is a "state guarantee" and because it is right that patients who are negligently damaged by the NHS must be compensated, claims are paid.

30. This distinction is important because discretionary indemnity also exists outside NHS indemnity. Discretionary indemnity is not insurance. Doctors and dentists who rely on discretionary indemnity have no contract and no written or other undertakings that they will be indemnified if a patient makes a claim. While discretionary NHS indemnity is underwritten by the state, it is a concern that some GPs, dentists and private practitioners rely only on discretionary indemnity, especially as there have been cases where patients alleging negligent harm have not been compensated because discretionary providers did not indemnify practitioners. We would be happy to provide examples.

31. Doctors and dentists are not legally required to have indemnity but of the majority who do, fewer than 50% of GPs and hospital doctors, and around 70% of dentists are not insured. They rely only on discretionary indemnity and will not know until they ask for assistance with a claim whether they will be indemnified, and to what extent. Doctors and dentists with an insurance policy have a contract to pay claims according to terms clearly set out in the policy whereas doctors and dentists relying on discretionary indemnity have no right to assistance. They can only ask for assistance and expect that request to be considered reasonably. Insurance

companies are regulated by the Financial Services Authority. With discretionary indemnity there are no policies, no guarantees in writing and the providers are not regulated by the FSA.

32. This is an important matter of public interest as patients do not buy insurance but if they are negligently harmed they will need to rely on it. Patients need to know that the right decisions are being made on their behalf.

33. Our research and experience shows that many doctors and dentists who only have discretionary indemnity think they are insured, and it is not surprising that most of the public do not know that discretionary indemnity even exists. They assume doctors and dentists are insured. Recent research conducted on behalf of the Department of Health (*Insurance and Indemnity Policy Review Stakeholder Engagement Exercise*—conducted by Pricewaterhouse Coopers, April 2010) sought the views of patients and NHS service users and the general public throughout the UK. It aimed to explore the perception of patients and the public towards the question of healthcare professionals being insured or indemnified as a requirement of registration. The conclusions found an overall assumption that healthcare professionals are covered by insurance and it was felt to be important for them to have insurance. However, the research missed an important point of clarity in failing to distinguish between insurance and discretionary indemnity. Questions put to participants did not mention that some doctors and many dentists only have discretionary indemnity. The research did not seek participants' views on whether they would consider discretionary indemnity adequate and appropriate for clinical negligence claims. We believe this is a matter of considerable concern as the research informed the report and recommendations of the review on indemnity which have been presented to and recently accepted by Government. We believe the report is potentially misleading in part and many of its recommendations are flawed.

34. This inquiry on NHS litigation is not the place to put forward all the arguments about the inadequacy and inappropriateness of discretionary indemnity to protect the public and patients, but we believe it is essential it is debated. We urge the Committee to consider this matter formally, in the interests of patients and the public who may be cared for or treated by a healthcare professional who only has discretionary indemnity.

December 2010

Written evidence from The Carers Federation (CAL 30)

1. Introduction

1.1 This submission is from **The Carers Federation** in response to the Health Select Committee call for evidence on complaints handling in the NHS .This response is in addition to a joint response the Carers Federation have submitted in partnership with POhWER and SEAP, the other two providers of Independent Complaints Advocacy Services (ICAS) in England.

1.2 The Carers Federation is a registered charity, it has been delivering services including independent advocacy to individuals and families since 1992. In 2004 The Carers Federation was one of the original ICAS pilot sites commissioned to deliver Independent Complaints Advocacy in the East Midlands.

1.3 In 2006 the Carers Federation took over the Department of Health's ICAS regional contracts in The North West, North East and Yorkshire and Humberside in addition to the East Midlands region—since this time Carers Federation ICAS has provided independent professional advocacy services to over 21,000 people, the majority of those being from the most vulnerable groups in our society.

1.4 The philosophy of the Carers Federation is to go the extra mile in all aspects of its operation, to treat people with dignity and respect recognising that "People don't fit in boxes".

2. The Recent Rise in NHS Complaints

2.1 Since 2006 Carers Federation/ICAS have seen an overall increase in the numbers of referrals by 54%. The reasons for the increase will vary from Trust to Trust and will depend on their interpretation and adoption of the new regulations.

2.2 There are some examples of Trusts not adopting the new regulations in the spirit in which they were intended which has in fact led to a decrease in referrals. However this is not due to less people complaining to the Trust, it is in fact due to a lack of understanding of the ICAS role and the NHS complaints process. Lack of understanding could stem from staff turnover within the complaints team, the amount of funding available and the value and importance that Trusts place in the complaints process.

3. Effectiveness of the New Complaints System

3.1 From an ICAS perspective one of the key changes that has proved beneficial for all parties is the extension of the time allowed for making a complaint from six months to 12 months. This alleviates the time pressure on clients, especially those who have been bereaved or have been ill themselves.

3.2 There is now the facility for NHS bodies to offer complainants a meeting or discussion at the point the complaint is received, this can help to clarify details of the complaint, the outcomes the client is seeking and the timescale in which the NHS body will respond. However, in practice not all NHS bodies engage with the client in this way.

3.3 Another positive change in the regulations has been the introduction of the single complaints process; this means that a complainant can make one complaint involving issues relating to a number of organisations. Prior to this change the complainant would have needed to make an individual complaint to each organisation. This has obviously made the process of complaining easier for clients.

3.4 The new regulations encourage a more Person Centred Approach to complaints handling, as well as a focus on the outcomes a client would like to achieve, the NHS body should also negotiate with the client a timescale for the investigation and the response. Formerly, there was a set timescale for the response of 25 working days. Since 1 April 2009 NHS bodies have been able to set a realistic timescale for the response, which is usually within 25–60 working days. This is particularly beneficial when complaints are complex and/or involve a number of organisations. Should the NHS body not be able to meet the target it set for the response then they have a duty to give the complainant a reason and they should then negotiate a new timeframe. However, there is a feeling that some NHS bodies have not taken the new legislation in the spirit it was intended. For example some NHS bodies always set a long time limit even for a simple complaint.

3.5 In theory the complaints process has been streamlined by the abolition of the Healthcare Commission making it a two stage process. This has shortened the process for many complainants as prior to this it wasn't unusual for a complaint to be ongoing for a number of years. However, because different NHS bodies have interpreted the regulations in different ways this has led to variations in the way complaints have been dealt with making it harder for ICAS advocates to manage.

3.6 Since the introduction of the new regulations some Trusts and PCT's have been slow to embrace the New Complaints Regulations. Many continued to work to the previous regulations timeframes whilst they sought clarification from their Chief Executives on how best to implement the change. A significant turnover of staff in some complaints departments has further added to the slow implementation. Many departing staff have not been replaced and this has led to a backlog of response letters going out to complainants.

3.7 In contrast, Trusts in the "Early Adopter" regions have responded well. Many of these Trusts continue to meet as service providers and share good practise to further improve their service. In some cases, these joint providers have signed "joint working protocols". In these regions, Trusts report that they have been able to use the new regulations to resolve problems quickly and in many cases these are dealt with satisfactorily prior to ICAS support being sought by complainants

3.8 ICAS has seen an increase in clients becoming frustrated with the slow responses from Trusts. These frustrations have been raised as an issue to the PHSO by the clients. It would seem, however, that the PHSO has not always set the Trusts deadline dates in which they need to respond. Relatively few complaints to the PHSO have been upheld and the decisions not to investigate have not always been consistent in the eyes of clients.

4. The Effectiveness of the Constituent Parts of the System

4.1 *Effectiveness of local resolution*

- Complainant is able to submit their concerns directly to the organisation they are complaining about.
- Complainant is able to discuss their concerns with the complaints handler before the investigation begins.
- Timescales for investigation and when responses will be received are (or should be) negotiated with the complainant.
- Complainant has a right to ask for further information or an answer to questions after an initial response has been received.
- Local resolution meetings are a very effective way of resolving complaints as it allows the complainant to ask questions directly to those involved in the complaint. A lot of NHS bodies are now digitally recording local resolution meetings and providing a copy of this to the complainant at the end of the meeting. This has been especially effective and complainants appear to be more satisfied once the meeting has taken place.
- Complainant can still ask for a further response following a local resolution meeting if all concerns are not fully addressed or a meeting has highlighted other issues.

4.2 *Effectiveness of PHSO*

- Independence of service.
- Complainants may have an independent clinical adviser review their complaint and give their professional opinion on whether there have been any failings in care.
- NHS bodies are more likely to implement recommendations made by the PHSO and change processes following a complaint.

4.3 ICAS can and does assist with all of the above; the services are pivotal in relationship building and managing a complainant's expectation throughout the NHS complaints procedure.

5. The Role of the Patient Advice and Liaison Service

5.1 Patients, relatives or carers may have questions or concerns about the level and quality of care they receive from the NHS. Anyone using the NHS should feel they can raise such concerns with a member of staff at the time of their concern and the NHS expects that the person they approach will do their best to help. However, this does not always resolve those concerns and if the person is not satisfied by their response, or would prefer to talk to someone not directly involved in their healthcare, the Patient Advice Liaison Service (PALS) can help seek further answers.

5.2 PALS will aim to provide improved satisfaction and reduce any confusion or anxiety caused and will act as quickly as possible to support patients, their carers and families to deal with concerns, before they become any more serious.

5.3 An important part of PALS is to help people to talk through their concerns so that they can identify the nature of the problem and work out options to resolve it. Concerns may be resolved by listening, providing relevant information, or by liaising on behalf of the individual with relevant colleagues. However, there are times when issues cannot be resolved as quickly or fully by using this route and in those cases one option for consideration is to make a complaint. When this happens PALS staff should advise how to get free, confidential and independent support with the complaint from the Independent Complaints Advocacy Service,(ICAS) who can assist further in providing assistance and support with any NHS complaint.

5.4 The Carers Federation ICAS experience of PALS is that where Chief Executives of Trusts are fully engaged with the complaints process and new regulations, the PALS service is sufficiently resourced and consequently works well and fulfils its objectives.

6. The Failure of Some Foundation Trusts to Report Numbers of Complaints

We prefer not to speculate.

7. The Government's Plans for Future Complaints Handling

7.1 Carers Federation's ICAS clients and stakeholders (professionals who interact with ICAS, such as NHS complaints managers) were surveyed to gauge public opinion on the proposals for HealthWatch to provide advocacy services in the future—837 ICAS clients and 287 ICAS stakeholders responded to the survey. A consultation event was also held at the Leeds Royal Armouries on 21 September 2010, with 70 ICAS staff, clients and stakeholders in attendance.

7.2 *Results*

Many concerns were raised about local HealthWatch assuming responsibility for advocacy services, including:

(a) *Concerns about loss of expertise:* Respondents feared a loss of professional relationships, person-centered care, consistency, local knowledge base and good practice from the existing ICAS service.

(b) *Concerns about the evolution of LINks into HealthWatch:* Respondents had concerns about:

- *Consistency*—each LINk is run differently.
- *Professionalism*—LINk members are volunteers.
- *Bias*—danger that volunteers may have too many personal opinions, and may unfairly target certain services.
- *Representation*—feelings that LINks only reflect "white, middle-class views", and focus on groups of interest to them, rather than the wider population.
- *Viability*—no formal evaluation of LINk effectiveness and suitability to take on the envisaged role of HealthWatch.

(c) *Concerns about loss of independence:* Respondents felt strongly that complaints advocacy would not be perceived as independent if provided by HealthWatch. 99% of clients and stakeholders felt it important that advocacy is seen to be independent.

(d) *Concerns about conflict of interest:* 51.6% of stakeholders thought that HealthWatch staff could be placed into a conflict of interest if asked to provide impartial advice as well as provide advocacy services; 65.9% of clients believe that HealthWatch staff providing complaints advocacy need to be different to those providing information; 55.10% of stakeholders believed that advocacy services should be provided independently of HealthWatch.

(e) *Cost implications:* Respondents questioned the wisdom of creating a new service from scratch in an era of vast public spending cuts.

8. How Data from Complaints will Feed into the Planned New Commissioning Arrangements

8.1 The Carers Federation would hope and expect that part of the new commissioning arrangements would include reporting back mechanisms that will allow complaint data including; serious issues, trends, repeat complaints, seasonal complaint variations and historic complaint patterns to be presented to the relevant commissioning body. This would promote and enable commissioners to identify a corrective course of action, implement preventative measures or identify training or other practical interventions. The timely and sophisticated use of this data will improve the quality of care, reduce the number of complaints being made and ultimately save money and resources.

9. Litigation and Redress

9.1 The experience of Carers Federation ICAS is that advocacy avoids litigation in many cases. The desired outcomes for clients are predominantly explanations, apologies or changes in procedure. The provision of advocacy alongside an efficient complaints process achieves this.

9.2 A key element of advocacy provision is communication. If clients are well informed on timescales and next stages or actions clients have no need to seek legal assistance.

9.3 There is a limit however to the amount of communication and information advocacy can provide to clients. This is dependent on the level of engagement from the NHS body within the complaints process.

9.4 Where a client is intending to proceed with litigation advocacy can still play a key role. Taking a complaint through the NHS complaints process means that by the time it gets to litigation it is in a more prepared state. This saves money in the amount of time legal teams have to spend on the case.

December 2010

Written evidence from the Care Quality Commission (CAL 33)

The Care Quality Commission (CQC) welcomes the opportunity to respond to the Committee's inquiry. Our key role is to tackle poor quality care using risk-based regulation, responsive to the views of users, in order to reduce the likelihood of harm.

In April 2009 a new integrated system for handling complaints about the NHS was introduced. This new two tier system was intended to simplify the NHS complaints procedure providing swifter recourse within the system for complainants to the Parliamentary and Health Services Ombudsman (PHSO).

The Local Authority Social Services and National Health Services Complaints Regulations place the responsibility on the provider to investigate and report on complaints. They must produce an annual report and as the regulator we can request a copy of this report. This information can help us to target our inspection work with trusts. This is a relatively new arrangement: the NHS became subject to formal regulation under the Health and Social Care Act from April 2010.

Joint working protocols and a Memorandum of Understanding between the PHSO and CQC ensure that intelligence is shared where appropriate. When a complaint is upheld the outcome is shared with us and where the PHSO have asked that the provider produces an action plan this too is shared with us.

This system allows the individual to receive an apology, the service provider to incorporate the findings into their service improvement agenda, and CQC to monitor the service and take action where appropriate. We can point to instances where information on complaints has triggered CQC action to assess whether or not the service is in breach of the relevant regulations. However intelligence about complaints is just one source of information. Other sources are health care staff (e.g whistleblowing) and intelligence gained by inspectors in the course of local engagement and assessment, along with a range of comparative data, eg on mortality rates. While CQC does not have a role in handling complaints about providers it does input any information received from service users and the public directly into our intelligence gathering systems to help target our regulatory activity.

Putting people who use services first is at the heart of CQC's model of regulation. In line with this, CQC is building extensive relationships with LINks and the voluntary sector and is always looking for ways to improve our interaction. CQC therefore supports the recent initiative by the PHSO to bring together key stakeholders, including National Voices, CQC, Monitor and the Information Centre to promote better learning from complaints in the NHS.

The role of the user voice in our regulatory model means that we see HealthWatch as a natural partner of CQC. Setting up HealthWatch as an effective body will require careful thought—there are many questions to address, ranging from governance and funding, through to ensuring that HealthWatch is an effective partner to the range of bodies already looking at quality and safety. CQC is working closely with the Department of Health on its development. CQC and HealthWatch England both need to be able to demonstrate an independence from any selective voices or influences. It is in both organisations' interests to work together to ensure all groups and individuals who use or need services in a community have their views and experiences heard and acted upon by commissioners and providers of services.

Locating HealthWatch England in CQC will build on our existing focus on user experience and user view, and will offer a cost effective approach. HealthWatch England will have powers to propose that CQC investigate poor services based on information received from local HealthWatch services. This gives local people a strong voice within regulation. The way this power is exercised will need careful consideration; however we welcome the intention to use HealthWatch as a means to ensure we are always alert to the concerns of local people. HealthWatch has the potential to strengthen our "early warning" response to concerns, and we intend to work with them to make sure we are making best use of local intelligence.

We support the principle that there should be every effort made to find resolutions to local disputes through dialogue between the local GP Consortia and health and well being boards. The progression to the PHSO allows for individual remedy and redress and the sharing of information ensures that we build a holistic picture of services.

December 2010

Written evidence from SEAP (CAL 34)
(Provider of the Independent Complaints Advocacy Service (ICAS) in the South of England)

1. Introduction

SEAP (Support, Empower, Advocate, Promote)—is a registered charity providing advocacy and related services to a wide range of client groups. Our highly specialised independent advocacy support assists clients, particularly those who are less heard in our society, in having a voice in the way they are cared for, in the services they receive and in decisions that are made about their lives, helping them to safeguard their rights and choices. SEAP have been providing the ICAS service in the South of England since 2003.

In addition to ICAS, SEAP also provides all statutory advocacy services, eg IMHA, IMCA, IMCA DOLS, as well as advocacy to many other clients groups, including older people, children/young people, those with disabilities, and people living in secure establishments. We provide advocacy support in a variety of settings such as Secure Units, Hospitals, Day Services, Adolescent Psychiatric Units, Children's Homes, Forensic Psychiatry Units, Care Homes, Prisons, Respite Units and Community based projects.

SEAP is a widely recognised training provider and is supporting over 500 learners, internally and externally, in achieving the Qualification in Independent Advocacy.

2. Summary

Increase in Complaints and in Demand for ICAS Support

2.1 SEAP ICAS believe that patients, carers and families are increasingly better informed about their right to make complaints, raise concerns or express a view about their NHS care and treatment. People are also more aware of the advocacy support that is available, to help them to engage with the NHS complaints process. Although not every NHS complainant accesses the ICAS service, at any one time over 10,000 people are supported by the service nationally to raise and resolve complaints about their NHS healthcare. This year SEAP ICAS has out performed our Department of Health year-on-year growth targets by an average of 9.6% across the South of England, seeing 4,061 new client complaints and contacts.

From our complaints data 1 April 2009 to 31 March 2010, SEAP ICAS attended 676 Local Resolution Meetings and received 54 complaints from prisoners. It is interesting to note that the same grievances appear year on year. These include: multiple aspects of clinical treatment, attitude of staff, all aspects of clinical mental health issues, misdiagnosis and communication with and information for, patients.

However, we are conscious that even when ICAS supported clients access our service, the outcome is not always as satisfactory as it could be.

2.2 To give an example, a SEAP ICAS advocate attended a Local Resolution Meeting (LRM) recently at the Mineral Hospital in Bath. Our client told us that she had not been informed of ICAS in any letters from the Trust after making her complaint. At the meeting, the consultant appeared to have no knowledge or understanding of the complaints process and asked why the ICAS advocate was there. Further, the Trust had initially advised our client that they would be sending a Trust lawyer to the LRM. Fortunately, through our involvement we were able to influence this process and make the meeting a viable option for the client, increasing the potential for effective resolution.

3. Effectiveness of the New Complaints System

3.1 Whilst in some Trusts the new arrangements introduced in April 2009 are being effectively implemented and communicated to NHS staff, there are some examples where progress has been limited, and our experiences have highlighted not only differences in application of arrangements in Trusts but also differences in knowledge and interpretation of the new regulations. It is fair to say that some Trusts and PCT's were slow to embrace and implement the new complaints regulations, and many continued to work to the previous arrangements, whilst they sought clarification from their Chief Executives on how best to implement the changes. In one example, regarding the role of the PCT when handling complaints about a GP surgery, when the client did not want to deal directly with the surgery the Complaints Manager indicated that it was not their role to investigate such complaints. Following information from one of our advocates on Regulation 7, the PCT discussed with the client a way forward and has since changed its approach to handling requests to investigate complaints relating to GP surgeries.

3.2 We have been proactive in working jointly with the NHS for the benefit of timely complaints resolution for the benefit of our clients. For example, we were invited by the Complaints Team at Plymouth Hospital Trust in Devon to give a presentation on SEAP ICAS and the new NHS Complaints Regulations to front line staff from the Clinical Directorates responsible for complaints handling. One of the outcomes of the presentation was that a new complaints pathway was agreed for Plymouth Hospital. The hospital also agreed that all acknowledgement letters to clients from the Trust would contain a named contact with their e-mail address. This may seem a relatively small outcome, but is hugely important and effective for clients and results in their feeling valued and listened to as complainants.

3.3 Unfortunately despite the new Regulations we are still seeing delays in complaints handling across the South of England, due in some part, we believe, to the turnover of staff in NHS Trusts. For example, we found that the Royal Devon & Exeter Foundation Trust was extremely slow to respond to client complaints and were failing to keep clients informed of the reasons for the delays. In March this year we met with the Patient Services Management to discuss the problems facing our clients. As a result, new complaint handling protocols were discussed and agreed which have resulted in more timely responses, keeping patients better informed of the progress of their complaints.

4. The Effectiveness of the Constituent Parts of the System

4.1 At SEAP ICAS, we have found that the proportion of clients attending local resolution meetings, as a subset of the overall new cases and contacts received each year, has been steadily rising and there has been an overall increase of approximately 10% between April 2006 and March 2010. Of the clients taking part in local resolution meetings, the success or satisfaction rate with the outcome has increased dramatically over the last four years, with 76% happy with the outcome in 2009–10 compared to 56% in 2006–07. This may be at least partly owing to improvements in complaints handling and more positive attitudes to organisational learning and service improvements within Trusts.

4.2 In a recent case, we attended a Local Resolution Meeting (LRM) with a client at Bristol Out of Hours service. The service representatives struggled to engage with the client, despite having some good substantive outcomes to offer, leading to an unsatisfactory conclusion. With the client's permission, our ICAS advocate returned to the practice following the meeting to talk generally about good and effective complaints handling. Subsequently, the client received a further letter from the service apologising for the LRM and re-emphasising the outcomes achieved and lessons learned. This case was a phone call away from legal action prevented, the client said, by ICAS' support.

4.3 The second stage of the complaints process is handled by the Parliamentary and Health Service Ombudsman (PHSO). Their reports state that ICAS supported cases are more likely to be assessed and investigated than non-supported cases. A specific benefit for our clients is the independence of the PHSO: complainants may have an independent clinical adviser review their complaint and give their professional opinion on whether there have been any failings in care, and NHS bodies are more likely to implement recommendations made by the PHSO and change processes following a complaint.

ICAS works hard to manage a complainant's expectation throughout the NHS complaints process. We are also able to support clients who are not satisfied with the outcome or the process of investigation at the Ombudsman's office to make a further complaint about that, should they wish to do so. This enables ICAS to support clients and provide consistency through an "end to end" process.

5. The Role of the Patient Advice and Liaison Service

5.1 Patients, relatives or carers may have questions or concerns about the level and quality of care they receive from the NHS. Anyone using the NHS should feel they can raise such concerns with a member of staff at the time of their concern and the NHS expects that the person they approach will do their best to help. However, this does not always resolve those concerns and if the person is not satisfied by their response, or would prefer to talk to someone not directly involved in their healthcare, the Patient Advice Liaison Service (PALS) can help seek further answers.

PALS aims to provide improved satisfaction and reduce any confusion or anxiety caused and will act as quickly as possible to support patients, their carers and families to deal with concerns, before they become any more serious.

5.2 Our evidence from client evaluations is that PALS is a valued and useful service for patients and carers. From 1 April 2006 to 31 March 2010, SEAP ICAS have received 2,474 referrals from PALS from the South East and South West of England. However, PALS are not perceived as being independent nor able to offer advocacy support independent of the employing Trust. There are some concerns about PALS being more of a "gatekeeper" than a "gateway" to the complaints process in some Trusts. For example, we have had feedback that the "informal" PALS led approach to initial complaints at the Avon and Wiltshire Mental Health Partnership (AWMHP) does not lead to effective resolution, and following subsequent referral to ICAS, the client then has to revisit their concerns again, which is understandably very frustrating.

5.3 In September 2010 we surveyed 100 of our stakeholders including NHS Chief Executives, complaints staff and voluntary and charitable organisations, and a Trust commented:

> *"Close working relationship with PALS enables speedy and effective referral of clients".* Devon/Cornwall/Isles of Scilly

6. The Failure of Some Foundation Trusts to Report Numbers of Complaints

6.1 At SEAP ICAS, whilst we have evidence of a number of Trusts and PCTs not logging issues as complaints, there is no specific evidence in our data to show that this is any more prevalent or likely in Foundation Trusts than in other Trusts.

7. The Government's Plans for Future Complaints Handling

7.1 The issues and concerns raised in the joint ICAS providers' responses to the Government's White Paper have been clearly recognised in the DH response published on 15 December. Paragraph 42 notes that *"there was clear unease about proposals for local authorities to commission local HealthWatch to provide advocacy services for NHS complainants".*

The results of our client survey carried out in July 2010 exemplifies this. We sought clients' views on questions relating to the establishment of local HealthWatch, including how clients want to see advocacy services delivered in future, and what has been important to them in pursuing and resolving their complaints about NHS healthcare. We are currently in the process of carrying an extensive further survey.

An overwhelming 87.5% said that local HealthWatch should not take on the wider role of responsibility for complaints advocacy and supporting individuals to have choice in NHS care and treatment. The key concern that SEAP ICAS clients voiced in relation to this question was that lack of ring-fenced funding for complaints advocacy, together with Local Authority autonomy in deciding priorities, will reduce the level of complaints advocacy services and resultant improvements in the NHS. There were well voiced fears that this would result in the loss of a nationally equitable, independent and impartial service, increase regional inequalities and leave those most vulnerable without support and disempowered in raising their issues, complaints and concerns.

> *"It is inconceivable that it should be up to any local authority to decide whether or not advocacy services are a priority. An independent, fully resourced organisation to aid in addressing complaints is essential if lessons are to be learned and improvements made in the health service. A local service is, I feel, unlikely to be able to ensure that any lessons learned are disseminated nationally".* (SEAP ICAS client)

96.7% of SEAP client responses stated that independence of an advocacy organisation is important. Many stated that it was essential, crucial, vital, fundamental or paramount. 80% had had no previous contact or experience of LINks in their area.

We would urge the Select Committee inquiry to look again at proposals to attach specialist functions to LINks—with a view to considering the potentially negative impacts on cost, quality, a patchwork of delivery, public and patient confidence and willingness of local people to engage.

8. How Data from Complaints Handling will Feed into the New Commissioning Arrangements

Complaints are difficult to categorise and the NHS does not have a strong track record in working with experiential evidence. In conjunction with the other two national ICAS providers, we suggest that research be commissioned to identify practical ways of capturing key issues from complaints in order to inform local service improvement and commissioning in general.

In the meantime much can be learnt from consistent analysis and open discussion of simple measures such as:

- Feedback from complainants about the process.
- Numbers of complaints received per specialty, clinical area and per clinical team using:
  - the current classification of issues;
  - demography of complainants; and
  - number of complaints resolved informally and those that "went the distance".

We are concerned about the extent to which GP Consortia will engage effectively with the complaints and patient experience agenda. Many of our clients do not regard GPs as speaking for them nor do they feel that GPs universally understand their needs, and advocates often find considerable defensiveness amongst GP practices with regard to complaints. We feel therefore that GP consortia will need considerable support and scrutiny if complaints and the patient experience, especially the experience of vulnerable people, is to be a genuine feature of future commissioning.

9. LITIGATION AND REDRESS

We cannot offer a great deal of comment on litigation issues as we do not support clients through legal processes. However, most clients do not want to pursue litigation and do not seek compensation. What they want is to be listened to, believed, have an explanation and acknowledgement of hurt and an apology. They want to avoid others having a similar negative experience. We have given an example in paragraph 4.2 above, of an ICAS supported complainant who did not proceed to legal redress following a successful local resolution meeting.

CONCLUSION

An increase in the numbers of complaints should not necessarily be seen as a “bad thing”; it may reflect a greater trust in the system—and we believe that there is reason for some optimism. However, consistency between Trusts is still a problem as is attitude amongst medical staff in particular. Resources for complaints handling are still very limited and people in the equality groups still face too many difficulties and too many system and organizational boundaries. We are also concerned about the commitment and knowledge amongst GP Consortia to listen to patients learn from patient experiences rather than assuming that GPs can represent patient views.

However, the changes being introduced by the new government emphasize an equalizing of power between patients and professionals and commit to support for the most vulnerable. They represent a new opportunity for ensuring that more is learnt from complaints and that complaints handling systems are more responsive to those they are there to serve. We hope that in making this submission to the Select Committee we can help ensure that the new opportunities translate into better services and outcomes for patients.

December 2010

Written evidence from Jane and Dennis Bannister (CAL 36)

This is a personal report from Jane and Dennis Bannister in connection with the death of their son, Simon Bannister.

- Complexity.
- Communication.
- Inefficiency.
- Details.

1. The reasons for complaints of the NHS services are to be found in the complexity and resultant incompetence of the top heavy management and administration.

2. Communication between departments and personnel is inefficient, prone to mistaken instructions and hence loss of lives.

3. We feel that this inefficiency cost us the life of our son, with false information being offered beforehand and at his inquest and inspires us to lodge a complaint to the Mental health Department of Dorset National Health Trust.

4. Our son suffered from schizophrenia and was under the care of Dorset Mental Health Trust. I was alarmed about the condition of our son and tried to get emergency help. Messages were misunderstood by the team and our son took his own life before help was available to him. The director, under whose care our son’s health remained, showed little interest in the failings of the system.

December 2010

Written evidence from Martin Jeremiah MBA (CAL 37)

INTRODUCTION

I am a carer for my daughter and we have had a complaint in the complaints system since March 2004 which is still unresolved. We are currently seeking Judicial Review of the Parliamentary & Health Service Ombudsman’s decision to not publish the final report after allegedly investigating the complaint from January 2007 to April 2010. The original complaint against the health trust concerned was not raised by us, but by the ward manager.

THE REASONS FOR THE RECENT SHARP RISE IN NHS COMPLAINTS

(i) This is likely in my view to be as the result of the existence of the PHSO and how it sees its remit. Rather than “resolving complaints between the two parties” the PHSO sees itself as a judge. However, the PHSO does not have the resources to substitute the legal system and therefore selects very few cases (circa

300 a year) to investigate. The outcome is intended to be a sometimes lengthy written report. This means that over 98% of cases brought to the PHSO are effectively rejected and nothing is achieved from them.

(ii) Therefore, if NHS employees get into a messy situation and are confronted by unhappy patients there is an easy way out. Hand the patient a "complaint form" and advise them to raise a written complaint to the trust's Complaints Department. If the patient or their representatives do not take the advice and start pursuing other avenues, raise an official complaint for them. There is a 99% chance that the Complaints department and the PHSO if necessary will see that you never have to face the issue.

(iii) The hard pressed Complaints Department have the choice of investigating the complaint in detail or not. If they deny everything no matter what the situation or the evidence it is much easier. There an estimated 50–90% chance that the patient will give up (depending on factors such as sociological background, class of medical condition etc). An expected minority will pursue the complaint at the PHSO.

(iv) In the event of an escalation to the PHSO there is a 98% chance that there will not be an investigation. Thus the risk to NHS employees and Complaints Departments of "facing down" a complaint having steered it in an official direction is negligible.

(v) The consequences of rarely being on the end of an upheld decision by the Ombudsman are also very small. Since the Trafford Council decision to refuse to pay a £100,000 settlement as recommended by the LGO, both the LGO and PHSO have quietly ditched the Principles of Remedy for quietly negotiating "acceptable recommendations to the body complained of, in advance of sharing the final draft report with the complainant. Thus an embarrassing public refusal is avoided; although this means that the recommendations are nothing to do with principles or justice. Recommendations from the PHSO are not mandatory of course. The PHSO also generally writes inane recommendations so as to avoid any comeback to them."

Eg "I recommend that the trust explains to Mr. Jeremiah why they did not …."

If the trust refuses to explain and the patient protests to the PHSO, the PHSO can simply answer "It is up to the trust to implement our recommendation I suggest you take it up with the trust".

(vi) The grounds for rejection of an investigation is generally that it is deemed by the PHSO that "there is no useful outcome" to the complaint. This is a subjective decision taken by the Assessment Panel which mainly consists of the Ombudsman, her Deputy and her Directors. Thus the decision to investigate is mainly a high-level, political or managerial one, rather than a medical one. This is seen as a vastly unfair situation as compared to the process driven system previously operated by the Healthcare Commission. It ends up with the PHSO investigating roughly the same number of complaints as they did when they were handling complaints against the Healthcare Commission. The HC kept improving until they were widely acknowledged by the health charities and Independent Advocacy Service to be of a good standard. However there were always a few complaints that slipped through the net for the PHSO to criticise. Enough to be, perhaps unwisely, given back control of Stage Two handling (escalation after Local Resolution) in April 2009.

(vii) It can be demonstrated at greater length that the Healthcare Commissions handling was superior and more transparent in every way. The PHSO regularly misinterprets the Health Commissioners Act 1993 in order to protect herself as far as possible from this realisation. This will soon be tested in the High Court.

Possible Solutions

(viii) Abolish the PHSO. This would mean that Local Resolution handling by trust complaints departments would be immediately subject to Judicial Review. It would provide an incentive for fair handling at Local Resolution and save the taxpayer £34 million a year into the bargain. There is likely to be a short-term "hit" in terms of publicised scandals as a result of removing the protective mechanism of the PHSO but this is equally likely in my view to be outweighed by a growth in quality of provision in the medium to long-term. Thus the risk of highly publicised scandals will be likely to diminish.

(ix) Provide some other incentive for trust complaints departments to get it right, or penalties for escalation. For example, health trusts pay into a pool to cover the costs of handling escalated complaints proportional to the number of complaints out of the total that they have escalated.

NHS Employees and Their Complaints Departments

(x) ICAS say that a large proportion of health complaints that they deal with involve missing medical notes. The complaints system is out of synch with civil law in that the balance of probability is replaced by the PHSO with the burden of proof being on the complainant. Therefore if the notes go "missing" the PHSO eg rules "no useful outcome" rather than ask where the notes went. NHS staff and complaints departments can also rely on a perceived credibility gap between an official body and an individual complainant. PHSO investigation reports can also play on this credibility gap by eg failing to mention ICAS involvement in the complaint.

Another stock phrase is that "there is no evidence that….". Whilst this may be technically true it is often because the evidence has not been pursued. For example, in my case the Second Opinion Approved Doctor wrote "the patient refused Clozaril". However, in the psychiatrists report it said "I considered offering Clozaril but felt the patient would not co-operate with the blood tests". The PHSO declined to pursue the line of enquiry because it would have inevitably opened up a can of worms on the Second Opinion and a breach of the Mental

Health Act. NHS employees currently seem to understand that as long as evidence is not handed to the PHSO on a plate they can face down a complaint with impunity. Thus there is no learning and improvement from all but less than 1% of complaints. In my own health trust there were 48 complaints escalated to the PHSO in 2009–10 and zero were investigated.

The effectiveness of the new complaints system introduced on 1 April 2009

(xi) Healthcare Commission declared no conflict of interest and was totally open with its handling. It had to be effective because the PHSO was breathing down its neck if they got it wrong. Many would therefore welcome more detailed scrutiny of PHSAO handling by the Health Select Committee and Public Administration Select Committee. The PHSO does not declare "no conflict of interest" which is much more likely because of their similar lack of empowerment to investigators. Management can therefore interfere in an investigation up to Director of Health Investigations level. As predominantly ex-health employees working at this level they might have a natural affinity to those complained of and even know health trust CEO's personally from past encounters. Customer satisfaction questionnaires are not issued to the complainant as a matter of course as was the case with the HCC because it is thought that the PHSO would get the answers they deserved from complainants. The quality of PHSO medical advice is what one mental health charity politely called "variable". Sometimes it is just plain wrong eg "it is normal practice to start with a low dosage and continue to maximum allowable dosage" (for an unlicensed drug). This is not the case for psychiatric drugs (even licensed ones), especially when there was no difference in efficacy between 10, 15 and 30 mg for the drug in question. The PHSO makes this evidence unchallengeable by refusing to make the advisers reports available under an alleged misinterpretation of Section 15. If a successful challenge under judicial review to an investigation is likely they maintain that they can "discontinue the investigation" under a misinterpretation of Section 3(2). Another method that the PHSO uses to divert judicial review is to offer a PHSO review. This comes up with the same answer in often many more months time, but leaves the complainant up against two decisions instead of one. The reviews are skilfully written for a potential judge and generally seizes on one small aspect of the complaint to eg write a PHSO letter. Thus more delay and frustration is created to put complainants beyond the limitation period for challenge. Fortunately, a recent High Court ruling in the case of the Blue Flash Music Trust v LGO means that complainants should be advised not to accept a PHSO review.

The effectiveness of the constituent parts of the complaints system: local resolution (supported by the Independent Complaints Advocacy Services); and referral to the Ombudsman

(xii) As above, local resolution is thought to be ineffective because the PHSO process offers virtual immunity. ICAS are often treated with similar disrespect as the complainants themselves therefore.

The role of Patient Advice and Liaison Services as a "gateway" to the complaints system

(xiii) ICAS are more effective because they are not funded directly by the trust. He who pays the piper calls the tune. PALS were initially involved in our case but backed off.

The failure of some Foundation Trusts to report numbers of complaints

(xiv) This is not surprising.

The Government's plans for future complaints-handling arrangements (the White Paper says, on p. 19, "Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support...supporting individuals who want to make a complaint")

(xv) It will not make any difference while the current complaints system operates.

How data from complaints will feed into the planned new commissioning arrangements (the White Paper says, at Para. 2.26, "Building on existing complaints handling structures, we will strengthen arrangements for information sharing")

(xvi) The data will not be meaningful while the current complaints system exists.

LITIGATION

The cost of litigation against the NHS

(xvii) Is likely to rise as people increasingly realise that they will gain nothing from the complaints system.

Reasons for the inflation of litigation costs in recent years

(xviii) The failure of the complaints system.

The impact of conditional fee ("no win, no fee") arrangements on litigation against the NHS

(xix) There is therefore less stress in litigation than pursuing a complaint in the complaints system. Less risk of being victimised too.

The effect of litigation on the development of an open reporting and learning culture in the NHS

(xx) Assumes that the complaints system is open and learning by contrast for example. There is strong evidence to the contrary.

The Government's intentions regarding the implementation of the NHS Redress Act 2006

(xxi) A complicated bureaucratic mix of complaints and litigation. Abolishing the PHSO and making local resolution immediately subject to judicial review is likely to be more effective in my view.

The possible benefits of a statutory right to compensation for "treatment injury" from an independent fund, without the need to prove negligence, as required under tort law

(xxii) Best left to the courts I feel.

Encouraging the use of mediation before litigation is initiated

(xxii) Can be offered as a solution at local resolution as a matter of course in a complaint.

December 2010

Written evidence from Mencap (CAL 39)

Mencap is the UK's leading learning disability charity, working with people with a learning disability, their families and carers. We want a world where people with a learning disability are valued equally, listened to and included. We want everyone to have the opportunity to achieve the things they want from life.

EXECUTIVE SUMMARY

Mencap have extensive experience in supporting families through the NHS complaints system, both pre and post the changes. Mencap's submission is based on the experience of these families, and does not touch on the structures such as ICAS, Healthwatch or PALS.

Mencap believes that both in its previous, and current incarnation, the complaints system is complex, bureaucratic, defensive and time consuming. Power at all stages of the NHS complaints system is too heavily weighted in favour of health professionals, resulting in families being denied answers and justice. In essence the system fails to learn lessons and so many bereaved families of people with a learning disability continue to struggle to achieve justice, even years after a death.

Mencap wants a complaints system that is quicker to reach decisions, that is more equitable and understands the legal context in which it makes decisions. Mencap broadly backs the Patients' Association call for a new independent complaints system.

Mencap would welcome the opportunity to appear in front of the Health Select Committee to discuss the system's shortcomings and discuss how these could be addressed for the benefit of all patients.

(a) *Mencap's experience of supporting families through the complaints system*

Mencap are well qualified to comment on the gross inadequacy of the NHS complaints system, having supported many families through all stages of this labyrinthine process, both in the old and new models.

In 2007, Mencap published the Death by Indifference report, which highlighted the six avoidable, premature deaths of loved family members with a learning disability in the NHS. The report alleged that the NHS was institutionally discriminating against people with a learning disability, because it did not equally value their lives.

> CASE STUDY—Tom Wakefield
>
> Tom Wakefield was just 20 when he died. He had profound and multiple learning disabilities and complex health needs. Tom died of aspiration pneumonia and reflux oesophagitus. A hospital consultant had recommended that the underlying causes of Tom's distress be investigated by a gastroenterologist, a year before he died. No action was taken, until it was too late, with the pain being ascribed to Tom's anxiety about leaving his residential school. Tom's family complained to the GP, PCT, Hospital and Healthcare Commission.
>
> Tom's dad, Paul, was a teacher and said this of going through NHS complaints:
>
> > "My health has continued to suffer; I had a heart attack in May 2007 and then another stroke. I have not returned to the daily life of the classroom, nor am I working elsewhere…."
> >
> > "Please note the absolute lack of assistance for the carers in this world of Tom's. The only third party that was even prepared to listen to this story, until our complaints were taken up by the Government Health Ombudsman, were Mencap, who I think fetched this family back from the brink of a form of insanity.

> At least we had someone who believed the unbelievable, at last…”

Mencap’s Death by Indifference report identified that for people with a learning disability, their families and carers the NHS complaints process was slow, bureaucratic and defensive. This allegation was based not just on Tom’s family experience, but also on that of the other five families. Even to date, bereaved families, supported by Mencap, still make very similar criticisms of the NHS complaints system.

The claims made in Death by Indifference were so stark, that on the day of publication, the then Secretary of State for Health, Patricia Hewitt, agreed to an immediate independent inquiry, to be led by Sir Jonathan Michael. This led to his 2008 report, Healthcare for All, in which the author stated that while evidence was hard to come by on the national state of the complaints system, witnesses had reported that:

> *“Not only did complaints take a long time to be responded to, the information and explanations they received were perceived to be inadequate”.*

In 2009, the Health Service Ombudsman responded to the six original “Death by Indifference” cases, investigating each death individually, in her report, Six Lives. While many of the complaints were upheld, Mencap still has real concerns about the way in which the Ombudsman makes decisions. This is currently subject to judicial review (outlined in the “Ombudsman complaints” section below).

Mencap is qualified to comment on the complaints system, given our ongoing work supporting these families. Many families told us that they felt they were getting nowhere until Mencap got involved and started to advocate on their behalf. While it would be tempting to see this as an endorsement of Mencap, it should instead be read as a damning indictment of a complaints system that leaves families waiting for answers, hoping for justice.

(b) *What do families want from the NHS complaints system?*

After a bereavement, families want answers and an understanding as to why their loved one died. They want to understand how it happened and if anyone was negligent. Bereaved families want poorly performing healthcare professionals to be held responsible for their actions. They also want organisations to learn and for individuals to be comfortable in reporting poor practice.

The NHS complaints process rarely achieves any of these ambitions, leaving families hanging, uncertain as to whether the care their loved one received was sufficient. While the Death by indifference report pre-dated the 2009 changes, the complaints system was (and remains) poorly functioning, unfair and disjointed.

Very soon after launching into a complaint, families usually quickly appreciate that any NHS complaint will take time (often years) and require huge emotional effort and persistence. Families have described their experience as fighting a system that isn’t fair with all the power being in the hands of someone else.

Fitness to practice arrangements for healthcare professions are also totally inadequate. Although not within the scope of this inquiry, this is important because to date no individual health professionals have been sanctioned under the fitness to practice arrangements of the respective registering bodies around poor care delivered to people with a learning disability. For families, this compounds the tragic loss of a loved one and is a powerful symbol of the perceived overriding value placed on professional expertise over the rights of patients with a learning disability and their families.

When these factors come together, it means many bereaved families receive neither answers nor justice—through either the fitness to practice or complaints systems.

(c) *NHS complaints—a dysfunctional system*

Despite what the NHS complaints system says it will do, it often fails to deliver. At both local (stage 1) and Ombudsman (stage 2) level, timescales are often missed and decisions deferred. Premature, avoidable deaths of people with a learning disability have continued, despite efforts at all levels to stop them. Until the complaints system functions better, a crucial part of this answer will be missed and it is hard to see how lessons can truly be learnt and deaths prevented.

Despite a stated desire to learn and improve (see Ombudsman complaints section), the starting position for the NHS complaints system is usually one of defensiveness.

As previously highlighted, Mencap has much experience in dealing with these cases and the table below provides a sample of cases Mencap has dealt with since Death by Indifference launched in 2007. There are however, many, many more families that Mencap are also aware of and are supporting. Mencap would be happy to talk, in more detail, at an oral evidence session on patterns within this data; in summary however:

- Complaints take a long time, often years, to be completed.
- Even at the conclusion of the complaint, whether at local or ombudsman stage, complainants (usually the bereaved family) rarely perceive justice has been done or lessons learnt.

Age and gender of deceased	*Date of death*	*Complaint resolve date*	*Current status*
49—male	1 January 2009	Incomplete	No answers as yet
43—female	21 June 2008	Ongoing	Ombudsman refused to investigate, Mencap had to appeal for an investigation to happen
52—female	2 October 2006	Ongoing	Still no conclusion from ombudsman
9—female	10 October 2005	Ongoing	Ombudsman just about to publish final report (expected February 2011)

(d) *Local level complaints*

Among the families that Mencap has supported, not a single family has ever said they felt that justice had been achieved through the local complaints procedure. A much cited complaint is the power inequity inherent in the local complaints procedure.

On one hand there is a well funded, and defended NHS trust (or provider) with a desire to stand up for their staff, on the other, resources for bereaved families tend to be meagre.

After a death (or serious untoward incident), most local complaints are investigated by members of NHS staff working within the same Trust. Occasionally, investigators may be drawn from even the same unit (or specialty). Both pose possible conflict of interests.

Very rarely, a Trust will bring in an external expert to adjudicate on a complaint, and pay for this to happen. This again calls into question the investigation's impartiality.

Families have also reported that the people investigating their claims often don't understand what learning disability is. They are too often prepared to let their own beliefs colour the decisions they make—particularly placing subjective values on the lives of people with a learning disability.

> FAMILY—Jane Kemp's daughter, Emma, died after doctors failed to treat an aggressive cancer that eventually killed her
>
> "Emma was a fun loving young woman who loved her life and all of the people in it. She was denied her chance of life by doctors who discriminated against her. One doctor actually used the word 'if she was a normal young woman we would not hesitate to treat her'".
>
> "When I agreed that Emma should only receive palliative care treatment, I did so because I was told that Emma only had a 10% chance of survival and that it would be cruel to treat her. I now know that this was not true, that I was misled in to agreeing with the decision that cost my daughter her life".
>
> "I completely reject the Ombudsman's findings. She has condoned the discriminatory practice of the doctors whose actions were founded on ignorance and prejudice".

The death of a loved one, and a complaint, leaves families at a power disadvantage in others ways too. In addition to the use of external experts, Trusts also tend to:

- Support their own staff, legally, emotionally and sometimes financially for the full length of the complaint.
- Make use of lawyers and Medical Defence Union to manage complaints and provide legal input, even when this is not available to the families.
- Adopt a defensive "we cannot comment, till the investigation is over" view.

All the while it is "business as normal" for the Trust and professionals whereas families are often left on their own, with little support whilst dealing with a huge burden of grief.

Often in resolving local complaints, Trusts do not admit liability in individual complaints but will agree to change processes. A common tactic will be for a Trust to deliver an action plan, but it is fair to say that this rarely equates to a change in front line practice as the clusters of deaths of people with a learning disability, often over a number of years, in the same hospital will attest. Mencap has been involved with complaints concerning the deaths of four people with a learning disability over a number of years at the Basildon and Thurrock NHS Trust.

The local complaints process is not fit for purpose and needs substantial reworking if it is to fairly investigate complaints and ensure that lessons are learnt.

> THE UNSATISFACTORY NATURE OF THE COMPLAINTS SYSTEM
>
> Mark Cannon was a 30 year old man, who had severe learning disabilities and epilepsy. He had very little speech, but was able to communicate with his family and sister, Jane, to whom he was very close.
>
> Mark lived at home with his mother and stepfather and attended a day centre, 5 days a week. He occasionally stayed at a council run care home.

> During June 2003, for reasons unknown, Mark broke his femur while staying at the care home. He was subsequently in and out of hospital. His condition continued to deteriorate and in the middle of August 2003, he had a heart attack while on the High Dependency Unit in Hospital. At the end of August 2003, his life support machine was switched off.
>
> The family believed Mark's death was avoidable and despite an inquest (which found a cause of "accidental death"—which the family contested) and complaints against the council, Mark's GP practice and the Healthcare Commission—none of these were upheld.
>
> When the Ombudsman investigated the family's complaints, they were upheld. The report said:
>
> "Mr Cannon's parents said they were appalled by what happened to their son. At one point in the complaints process they said:
>
> 'All of Mark's 30 years had been a struggle for equal rights to health care, support and the services within the society he lived. We battled continuously with virtually no progress'".

(e) *Ombudsman complaints*

In order for the Ombudsman to investigate a complaint it has to fall within their jurisdiction and have had a completed investigation at the local level. In understanding the difficulties in securing satisfaction at a local level, one can see this is far from a foregone conclusion. Indeed without a functioning, and fit for purpose, local complaints system, many of those families wanting answers will be denied.

Many of the criticisms levelled at the local complaints process can also be levelled at those conducted by the Ombudsman.

> BASIS OF JUDICIAL REVIEW AND CURRENT STATUS
>
> Mencap disagree with some of the ways in which the Ombudsman reaches her decisions. Mencap are currently proceeding with a Judicial Review to establish that that in future cases, where the ombudsman has found that reasonable adjustments were not made, they should conclude that there is service failure.
>
> The Judicial Review is currently in the Administrative High Court, with a hearing expected in early 2011.

When dealing with the Ombudsman, Trusts have disproportionate access to Medical Defence Union, Expert Witnesses and pastoral support, as opposed to patients. Doctors and Trusts are well defended and it has been suggested anecdotally that in some cases, there have been efforts by Trusts' representatives to water down findings at various stages of the Ombudsman process, in favour of the Trust, though this is very hard to prove.

Timescales are also longer than initially promised. Mencap currently has two cases that have been with the ombudsman for three years. The previous three cases that were with the ombudsman also took three years to complete.

Mencap also believe that those that conduct investigations on behalf of the ombudsman often don't understand the importance of reasonable adjustments, the Mental Capacity Act, Disability Discrimination Act and crucially how these should be applied in day to day practice.

Despite some robust findings in the majority of cases, the power inequalities and sometimes flawed judgements at which it arrives, it is easy to understand why the perception persists among families and charities that the system is biased in favour of the status quo.

(f) *Summary*

The NHS complaints system has major problems which need to be addressed.

At a local level providers often fail to investigate in a timely and appropriate fashion. It is not unknown for years to elapse between a death and the completion of a complaint. Not only is the local complaints process lengthy, but it is also defensive. This means that local NHS providers often truly fail to learn the appropriate lessons and make changes.

Families want hospitals to listen harder, for lessons to be learnt, and the same mistakes to be avoided. They also want healthcare professionals to be held to account.

The question is does the NHS, at a local level, appear to learn? Mencap's view is that in emphasising "business as usual" Trusts are often too busy to learn from previous mistakes. As a result, the NHS complaints system has failed to play its part in stopping the deaths of people with a learning disability.

Mencap remains very concerned about the length of time the ombudsman takes in reaching her conclusions, as well as the method by which she makes her decisions.

All parts of the NHS complaints system need fundamental overhaul if it is to become a fairer, more impartial and more reflective system to drive up health outcomes across the NHS.

December 2010

Written evidence from National Voices (CAL 40)

Summary and Recommendations

1. Effective complaints handling is a vital impetus to improving quality of care. Providers of care need to collect and act on complaints and other feedback information swiftly to resolve issues before they escalate to formal complaints, referrals to the Ombudsman and litigation.

2. They also need to be transparent about the work they are doing to resolve complaints and concerns, and what results from it. This material needs to be in readily understandable form and consistent so that data can be aggregated and compared.

3. We have recommended in this paper and elsewhere a statutory duty of candour. This will build on the rights and pledges to patients in the NHS Constitution.

4. We also recognise that staff need to see themselves as partners in the process of quality improvement and not the victims of the internal fall-out from complaints or other events such as the disclosure of service and clinical quality failures.

5. We want the work of the NHS Litigation Authority on the appropriate use of apology more widely acted upon and further recommend the development of incentives for staff to reward early recognition and action when patients and families express dissatisfaction. The Mid-Staffordshire Foundation Trust enquiries show what can happen when staff do not hear and act on these views.

6. More attention should be paid to measurement: we should stop simply counting numbers of complaints, which tells us little if anything, and start counting whether people feel their complaint was well handled. We should also measure the ratio of informal and formal complaints to understand organisational effectiveness at resolving issues at minimum financial and human cost.

Introduction

7. National Voices welcomes the opportunity to submit evidence to the Health Select Committee inquiry on complaints and litigation. We are the coalition of national voluntary organisations with a mission to strengthen the voice of patients and citizens at all levels in health and social care.

We have structured our submission as follows: (a) A general observations section and (b) specific responses to the questions set out in the Committee's call for evidence.

General Observations

8. We are not a complaints handling body. Our interest is in making it much easier for people to voice concerns, to be heard and in turn to hear back on whether their contribution has improved matters. We support moves to create more responsive and listening services. That is the best guarantee that things will go right more of the time.

9. But we recognise that in complex care systems delivering care to millions of people, things will still go wrong. When that happens we want a system in which:

- User and staff voices can be easily raised and something is done about it early.
- People are clearly aware of and supported to exercise their rights in the NHS constitution.
- There is transparency about serious lapses, so that people can understand and learn from them—we support a statutory duty of candour.
- Everything is done to make a formal complaint less necessary, through a culture of listening and mechanisms of real-time feedback—while still inviting complaints if that is what people choose.
- Where harm is done, there is apology, redress and demonstrable learning at local level.
- Formal complaints are handled so that a key measure is the complainant is happy with the process.
- The process is easy to navigate and there is support for people who do not speak English, have a learning disability or impaired capacity and others who may be excluded from a process that is not designed around their needs.
- The process is also easy to navigate regardless of where in the system the problem emerges—primary, secondary, social care, personal budget holder, carer etc—because the basic process is the same.
- All key metrics concerned with above are published by all providers, appear in Quality Accounts etc.
- A smaller proportion of formal complaints go to the Ombudsman, because they have been satisfactorily resolved earlier in the system.
- Complainants make choices in favour of low cost dispute resolution/mediation/restorative redress systems and no longer feel it necessary to go for litigation to meet their needs.

10. All these elements are included in our observations that follow. Before considering the issues as set out in the Committee's invitation to provide evidence, we consider complaints and litigation together as parts of a wider redress system and look at whether the system as a whole provides good choices to the dissatisfied user who persists with his/her request that their problem is resolved.

General Observations on Complaints and Litigation

11. We welcome the Health Committee's decision to consider these topics together. Complaints handling has been defined as bargaining in the shadow of the law with the law and litigation remaining as an option (in theory). Litigation, although very much more expensive, can be considered a sub-set of the complaints world and as one route amongst many for users looking for resolution. The hoped for outcome is the same whatever the route taken towards it—individual redress and system improvement.

12. We agree with the views expressed in June 2007 by the Health Ombudsman in a speech to the Institute of Advanced Legal Studies. There Ann Abraham argues for a rationalisation of the routes to redress, placing the Ombudsman system in the context of the justice system as a whole, and making the point that the Ombudsman option "although different, is complementary to the courts and tribunals on the one hand and to negotiated forms of alternative dispute resolution on the other: different from, yet receptive to elements of both".

13. In contrast to the cases considered by the NHS Litigation Authority, where judgement can trigger large payments, pecuniary remedies are low. The Ombudsman scores by intervening and achieving more tightly focused change in health delivery process—for example in the provision of weekend care in a particular Primary Care Trust—an intervention of benefit to many more than the individual complainant. The high degree of compliance with the findings and recommendations of the Ombudsman is practical proof of the confidence in the findings of the process.

14. National Voices will support a rationalised system that recognises the need to ensure that "disputes find their way to the forum that is most likely to deliver the right level of adjudication, the right remedy and the best prospects of future prevention." (Ann Abraham—same speech).

15. One of the primary goals in complaint handling is the avoidance of escalation with first time, front line, local resolution. Escalation is expensive and is generally more time-consuming and emotionally draining for all involved. It is not clear that it generally delivers better outcomes for individuals or health systems. An impetus to better and swifter local resolution would be created by clear evidence of its benefits. National Voices finds it frustrating that there is little publicly available data on what comes out of the initial stages of the complaint management systems of the NHS. Such information would allow us to see whether the outcomes of complaints do add value by providing resolution for individuals as well as achieving change of benefit for all who use health and social care services.

The Health Committee's List of Issues

16. *The reasons for the sharp rise in NHS complaints* is not known. A rise in formally logged complaints can indicate a number of things—a decline in quality, an improved and more accessible complaint service which is widely promoted, data which are more comprehensively logged, a failure at the front line to address concerns at the time and on the spot, users with higher expectations and more confidence in pursuing perceived failures in service. So a rise in complaint numbers can be a positive indicator—increased public confidence that the complaints system is worth using. This together with the publicity about the "new" system and the rights and pledges embedded in the NHS Constitution may have encouraged people to pursue an issue formally. The Ombudsman is reporting a rise in complaints reaching her office as a result of the removal of the middle stage—has this also resulted in a backwash into the formal complaint systems of acute trusts and PCTs?

17. One of the most distressing aspects of the Mid Staffordshire NHS Foundation Trust event was the failure of staff to pass on the concerns of patients and their families. The NHS Constitution in its section on complaint handling gives patients specific rights and pledges including the pledge that "the fact that you have complained will not adversely affect your future treatment". We would recommend that the group of citizens who are employed in the health service receive a similar reassurance in the context of their future career that their recognition and reaction to causes of dissatisfaction will not "adversely affect your future treatment". The Constitution has a role to play in encouraging staff and patients to work together in the interests of patient satisfaction and quality improvement. This joint commitment would support the practical implementation of a statutory duty of candour and would share many features with the "Being Open" initiative of the National Patient Safety Agency.

18. Equally, where complainants have had the confidence to come forward, we note the possibility that front line staff have an incentive to encourage citizens to "go formal". Referral onwards and upwards gets rid of the issue for a while at least (it may disappear altogether if the complainant gives up). "Outsourcing" the management of the complainant to others could be seen as a strategy to protect internal relationships and the institutional status quo as well as externalising costs. This attitude towards the complaint—get rid of it—might help explain why staff attitudes feature so strongly in any analysis of complaint cause. The policy implication is that managers need to be alive to the possibility of these and other cultural and behavioural barriers, when seeking to improve and embed local resolution procedures.

19. *The effectiveness of the new system introduced in April 2009* is not yet established. The impact on the Ombudsman Office is beginning to be seen with a rise in contacts or enquiries but a lowering in the percentage of those contacts which are taken further. 58% of closed complaints in 2009–10 were not "properly made" or were premature. About 10% of all formal complaints were referred to the Ombudsman. This seems quite high.

20. The removal of the middle layer will eventually contribute to the lowering of one cause of complaint—there were 513 complains about the Healthcare Commission itself which will disappear from the statistics. (It is always a significant finding if parts of the complaint process itself show up as an engine of dissatisfaction and further complaints in their own right.) Discussion of effectiveness is hampered by the absence of comprehensive data from the early stages both before dissatisfaction or a problem hardens into a formal complaint and also in the early stages of that formal process.

21. In considering the *effectiveness of the constituent parts of the complaints system,* we must draw attention to the absence of any generally agreed and applied means of measuring that effectiveness. The Ombudsman's Office has developed the Principles of Good Complaint Handling but no organisation is currently assessed against them. The *ICAS* service although supported by the Ombudsman is divided between three suppliers in England and there is no consolidated data available. Similarly *PALS* offices operate independently of each other and while there is a national body, lack of funds and resources limit their activities and their ability to combine in the interests of advocating improvement. We see merit in using the Ombudsman's principles to help frame the public accountability requirements that should be met by care organisations in relation to complaints handling. We propose the adoption of some key metrics, including, in particular, measures of the success of informal resolution in avoiding escalation and of individuals' satisfaction with the handling of their concerns and complaints.

22. *The failure of some Foundation Trusts to report numbers of complaints*—Foundation Trusts that take advantage of their dispensation not to publish complaint data are not fulfilling an important part of their accountability to their members and the NHS generally. We believe that no organisations providing services funded by the taxpayer should be exempt.

23. Aspects of the *Government's plans for future complaints handling arrangements* were welcomed by National Voices in our response to the consultations on the Health White Paper. We welcome a role for HealthWatch in complaints advocacy, but also support the Government's latest published intention (Command Paper 7993) that local authorities should be able to judge where best to source advocacy services at local level. This is consistent with our White Paper response in which we said that HealthWatch should be seen as a service rather than necessarily a single organisation and that new arrangements should support and not displace existing arrangements for involving patients and citizens if these are working well.

24. We support the Government's proposal in the Command Paper to legislate to strengthen the arrangements for the Ombudsman to share information on complaints handled by her office. We would have preferred to see a more wholehearted endorsement in that paper of the importance of local, responsive resolution of complaints.

25. On the issue of *how complaint data will feed into the new commissioning arrangements*, we would expect commissioners to insist that providers report against agreed metrics on complaints handling.

26. We note that in comparison with the well scrutinised hospital sector, primary care is a complaints "black hole" from which very little data emerges. Far fewer formal complaints are made. We do not know how much this is because of higher rates of satisfaction in primary care and how much because patients and families find it more difficult to complain about GPs and other primary care professionals because of feelings of dependency, deference and fear of the personal consequences—a particular risk for older patients with long term conditions who are both more at risk and less likely to complain. We know even less about the handling of informal concerns and complaints. Primary care professionals and managers need to consider what steps need to be taken to make a reality of the NHS Constitution pledge that patients will not suffer adverse consequences as a result of making a complaint.

27. The costs of litigation against the NHS are high and divert resources away from patient care. We support moves towards no fault compensation and the option of a statutory right to compensation without the need to prove negligence. Conditional fee arrangements are of potential benefit, but we note that intensive marketing by legal firms (readily observable by googling the NHSLA) could distort people's choices. The test here is that individuals (who may well be in a state of emotional distress) need the information and guidance to make the right choice for them, and to make full use of their legal rights to redress if that is their choice.

28. We would urge the Government and NHS to explore other means of diverting people away from litigation.

29. In answer to the Committee's question about *the effect of litigation on the development of an open and learning culture* we note that there appears to be a widespread belief, despite the Authority's guidance to the contrary, that apology amounts to the acceptance of legal liability. More effort is needed to bust this myth and more generally to empower and equip care staff to issue early and appropriate apologies. There might be scope for a campaign led jointly by professional and patient and civil organisations to change attitudes and behaviours.

December 2010

Written evidence from Mrs Ros Phillips (CAL 42)

I am giving evidence in a personal capacity being recently bereaved by a hospital incident though I have a wider interest in health matters. I am the Chairperson of the Robbie's Law Trust (RLT). Details of membership and a mission statement are attached below my submissions. I am also a consultative member of the Council for Healthcare Regulatory Excellence (CHRE) who regulate the GMC and RCN amongst others and an active member of the Patients Association (PA) and Cure the NHS (CNHS).

The determination of the Cause of Death of my mother is to be delivered by HM Coroner on the 6th January 2011 and I therefore must be discreet about identifying the hospital or using names. I am told it may be that charges will follow concerning the withholding of material needed by the Coroner to make his decision.

If it is possible, I would like the opportunity to give evidence in person.

NB. Subsequent to this statement the Coroner delivered his determination of the cause of death of my mother. It is two and a half years after the death but was virtually identical to the statements both written and verbal that the family made to the Coroner within SIX days of the incident and stated below in my submission.

The points on which I have a view are as follows:

Complaints

1. *The reason for the sharp rise in NHS complaints being linked to understaffing of care workers as well as the increase in public awareness of poor standards in other regions than their own*

My experience in listening to other people's stories has been that this increase in complaints is largely driven by public awareness of similar shortfalls to their own observations occurring in other regions and this is through organisations such as the PA and Cure the NHS, Investigatory TV Programmes and Newspaper Reports. People used to feel that their negative experience must be unusual but now they can turn on a computer and find they are not alone.

I had a very revealing and in depth conversation with the Matron in charge of Elderly Care at the hospital where my mother suffered a number of life threatening incidents prior to her death and she frankly and openly told me that she could not recruit enough care staff as the rates of pay were unattractive. This leads to elderly patients being told to urinate and defecate onto a pad in their bed and be cleaned up when the staff have time. This is why bells are put out of reach and why this complaint is such a frequent one in all regions. It is degrading and mortifying to the patient and horrific for the relatives, many of who are carers, to watch. The same lack of care staff is responsible for the lack of help with feeding. It stresses the staff and makes them defensive to the point of rudeness. This conversation was reported to a senior management person by another member of the hospital and the following week, the Matron said she "could not recollect any such conversation". I was not complaining and actually trying to find a way of helping but the bullying culture in this particular hospital silenced even someone as senior as the Matron. The NHS Choices website alone has hundreds of complaints of this nature under "Patient Feedback".

Margaret Haywood was struck off the nursing register for undercover filming for *Panorama*. The public voted her Nurse of the Year in an online vote. That genie is out of the bottle and the public are aware of their power.

2. *Effectiveness of constituent parts of the complaints system with reference to mediation v arbitration and the need for a new system*

Any complaints system that allows an internal investigation into an incident without the complainant or their legal representatives being allowed to question the witnesses is doomed to failure. Staff do not have to swear or affirm and their version of events frequently reads like a novel. Notes go "missing" (this happened to us and is a common event) and staff are "helped" to make statements by their legal department although this is meant to be a process without lawyers on both sides. There is no organisation of any credibility that can carry out an investigation into an individual complaint even if this is about a patient death. The Ombudsman has proved ineffective and the system is such that the hospital already has prior knowledge of the details of the complaint as the complainant must have already gone through the hospital system prior to reaching the Ombudsman.

In no other area is one party allowed to have complete control over evidence that might prove the complainants allegation while the other party has to beg for access to information. Almost all the Incident Reporting Protocols that I have read say that in the event of any incident that all notes, statements etc should be immediately captured electronically but this wealth of material, which cannot be altered, is almost never made available to the complainant. In all cases of death the Coroners Officer would appear to be the proper person to *immediately* seize and hold originals of all patient records whether paper or electronic while a decision to proceed to an Inquest or not is being made. In our case, the notes were held at the hospital's own litigation department for nearly six weeks before the Coroner requested a copy. This is highly unsafe as an evidential chain and we have never received *all* the material requested.

Mediation is often recommended but this infers a concession by both sides. In medical error or bad practice complaints any concession can only possibly benefit the hospital.

Arbitration with prior agreed terms of reference, for instance that should the finding indicate that criminal or civil proceedings may be appropriate and that these should not be ruled out by the parties entering into Arbitration, would be more effective and may satisfy the complainant without them taking recourse to litigation.

3. *Investigation of the current use of PALS as a patient/relative liaison group (Being within the hospital trust remit and not independent)*

PALS is only as good as its individual members and as independent as the hospitals where it works allow it to be. In our case the hospital had amalgamated PALS and their own Complaints Department under the control of two very senior board members. They were applying to become a Foundation Trust and wanted full control over any incidents. The PALS representative seemed to us to be a very self important woman who took it upon herself to misinform nursing staff that we had complained about them when we had actually said they were short staffed and this created a lot of hostility. When we saw what she had written about us after my mother's death, it shocked us to the core. It seems likely that this PALS representative reported my discussion with the Matron on Care Staff recruitment difficulties to senior management at board level. She also involved the legal department in the prevention of the imaginary Medical Negligence case. (This is written in the hospital notes). Each time there was a life threatening error in my mother's care she created conflict and mistrust that contributed to the hospital cancelling my mother's bed at a superb private facility in a panic as they thought we would obtain a Personal Welfare Power of Attorney and carry out this imaginary legal action. We were not told that they would do this. The Trust Board Member told me that he would have my mother declared incompetent if we attempted to obtain a PWPofA. This was witnessed by the same Matron who, at present, is finding it difficult to recollect the precise details. My mother was moved to a ward that had no proper facilities for her care with a written note that she was not to be allowed to sign legal documents and died, in an accident that we had warned might happen, less than 48 hours later. The PALS representative made misleading statements to the Coroner that caused massive disruption to the Inquest as they inferred that we were serial complainants who had unrealistic expectations of NHS care. We NEVER complained nor is there any official record of us doing so. I am unsure as to whether PALS can ever be reformed with its divided loyalties. Many other people have told me similar accounts of their contact with PALS. It is not a patient centered organisation. I should add that although elderly my mother was an amazingly fit and alert person who was sitting in bed doing crossword puzzles and having physiotherapy. She was in no way so ill that she would have died at that time.

4. *The need for a totally independent group to assist patients/relatives in their concerns/complaints and where necessary assist or advise on advocacy and the need for an Independent Medical Accidents Investigation Authority directly answerable to the Secretary of State for Health*

It would solve many of the problems of the Hospital Complaints System if an independent authority investigated such complaints. Several organisations including RLT are suggesting voluntary first point of contact (retired legal and medical personnel and members of reputable patients organisations such as CNHS who are rolling out regional groups, the PA and others). This group could filter those complaints that need major investigation and should be escalated to a group with legal and medical experience from those that could be resolved more easily. It is certainly cheaper to pay expenses for regionally based independent groups to investigate complaints within their NHS area and a second tier of advisors for perhaps one paid week a month than to fund "overview" authorities.

Several people have quite independently come up with a structure for such an organisation that is based on the Air Accidents Investigation Branch and the Marine Accident Investigation Branch both of which are answerable to the Secretary of State to the Department for Transport. It would be an independent Medical Accidents Investigation Authority answerable to Parliament or the Secretary of State for Health. Its investigators would have to have real powers to compel production of evidence and Civil Proceedings, if any, should be a separate matter. This is part three of the RLT suggested Legislation.

An independent Medical Accidents Investigation Authority answerable to Parliament or the Secretary of State for Health.

Although a regional structure to mirror the NHS areas would be practical, any person or persons making a final decision about a case should not be local as sometimes it is inevitable that senior hospital staff, police and local lawyers will know each other and this can cause a lack of public confidence. Some system like Circuit Judges could be set up.

5. *The need for statutory absolute disclosure to patients/relatives about their care, errors in said care and other non-medical issues as in a Duty of Candour*

There is a need for absolute statutory disclosure when things go wrong in a hospital setting. A Duty of Candour (Robbie's Law) would simplify the matter of what is an acceptable but regrettable error that needs to be admitted so the problem can be addressed and hopefully become part of a learning process. The fear of financial repercussions and loss of reputation can tempt hospitals to cover up errors. This is much worse in the long run.

Withholding medical notes and other communications has to come under the same legal provisions as any other intention to pervert the course of justice or affect the outcome of an Inquest. Intimidation of witnesses is not tolerated so why do we allow hospital management to bully staff into making dubious statements? Even consultants are threatened, as we know from several ongoing cases. The Hansard record of The Duty of Candour Adjournment Debate (1 Dec 2010) covered many of the points but basically a Duty of Candour would comprise the following which is also part one of RLT's proposed legislation.

A civil legal duty fully and truthfully to inform and answer when questions are asked.

6. *The accurate recording by dated electronic and (post) unalterable means of all material relating to patients and relatives*

The use of Electronic Capture of notes and other information should be the norm in any medical setting. The information can be backed up, loss is very unlikely and alteration without detection is almost impossible. Consultants frequently write up their notes from bedside rounds that evening or even on another day and can in some cases legitimately and in others deliberately plead that they "do not recollect" matters that they believe might reflect badly on them. A Palm Pilot or similar is easy to use, contemporaneous and has instant down load capability. We had appalling experiences of the most outrageous "spinning" of medical records (highly dangerous to the patient) by staff who had been told by PALS the substance of our concerns about her care. These concerns were suddenly negated by additions and possible new pages inserted into my mother's records. The medical profession still has no statutory duty not to falsify records. This would fit in with part two of RLT's proposed legislation.

Criminal offences of falsification and alteration of medical records.

Litigation

1. *The cost of Litigation against the NHS*

The cost of litigation against the NHS is twofold. The financial cost is borne by the taxpayer. All hospitals (who are funded by tax money) pay into a fund for the National Health Service Litigation Authority (NHSLA). This is close to *£ one billion* per annum which could be better used on other resources.

The cost to the reputation of the NHS is incalculable. The knowledge that there is such a vast pot of money on which hospitals can draw, tempts them to defend even the most indefensible errors and calls the whole NHS into disrepute. Very few litigants are vexatious but the majority are treated as if they are. Most people just want the truth, an apology and the hope that whatever went wrong will not happen to anyone else.

We decided we did not wish to sue the hospital for Medical Negligence both before and after the death of my mother but have been treated at all times as the enemy and had a legal team ranged against us, advising the hospital and withholding evidence (some was only produced *during* part one of the Inquest, some was produced two weeks before part two the Inquest, some only 24 hours before part three). We had to get lawyers and a QC ourselves in order to get any kind of justice. For a death that occurred on 13 June 2008, the cause of death will only be finally determined on 6 January 2011 and has incurred two and a half years of legal costs on both sides.

Nothing has changed factually about the death or our version of how it occurred since the day it happened. The only changes are that we are exhausted and cynical about the regulation of the NHS, quite a bit poorer and the NHSLA have at last allowed their clients to reveal almost the same version of the death as ours but with some unaccountably "missing" corroborative material that I still hope to acquire.

NB. I believe I am entitled to disclose the information below. (In my statement to the Coroner's Officer about 14 hours after the death and in my written statement made six days after the death, I copied a misuse of the word "prone", when "supine" was the correct term, from a medical source on PEG feeding. A doctor from the hospital made the same error but all parties knew that "supine" was indicated).

> *19/06/2008*
>
> *Dear **************
>
> *Thank you for your help and advice this morning. We are still trying to find a pathologist to represent the family, but knowing that our concerns can be put to the corner's office and be formally requested is a great relief.*
>
> *Listed below are our points of particular concern.*
>
> *1 There were repeated warnings, both written and oral, given by the nurses, dietitians and SALT team at ************* ******** Hospital, that when being fed using the PEG, my mother's bed should be elevated to an angle not less than 35 degrees to prevent reflux from the feed.*
>
> *When she was moved to the ********* ***** Hospital for rehab, she was placed in a non-elevating bed. Her daughter noticed this and pointed out that we had been told it was dangerous for feeding.*

> *The hospital say the she vomited and aspirated vomit.*
>
> *We think perhaps she suffered reflux in the prone (correctly supine) position and effectively drowned in the liquid feed.*
>
> *Could the pathologist take particular note of this? Is there any test that could ascertain what the cause may be?*

The following is the Coroner's determination of the cause of death delivered on 6/1/2011

> *Although "natural causes" were a significant factor as evidenced by the background conditions from which she suffered it might equally be said that the aspiration of her feed derived from an "accident" in the sense that if she had not slipped down the bed she would almost certainly not have aspirated in the first place. However neither of these short form verdicts really does justice to a case of some complexity and I propose to record a short narrative verdict in the following terms:*
>
>> *"*********** *********** died as a result of aspirating her liquid feed into her lungs whilst being fed by the PEG procedure in hospital on a non-profiling bed on which she had lost the safe positioning of thirty/forty-five degrees required by hospital policy. Her age and general state of health minimised the likelihood of recovery from this event".*

2. *The reason for the inflation of litigation costs against the NHS and the part played by the structure of NHSLA funding and NHS legal representation at inquests and the underlying reason for this*

I have no direct experience of Civil Litigation of any sort or Medical Negligence Litigation. However, experience of the influence of the NHSLA on a simple and straightforward Inquest (as demonstrated by the similarity between our immediate account and the Coroner's verdict above), is that the costs were grossly inflated by their behavior and this is what I have been told by people who have been up against their tactics in Med Neg cases. My experience is that they outspend the opposition to buy immunity from justice for their clients. This makes a mockery of our pride in our legal system. Had I not had Barrister and QC friends and my daughter scraped together the money to pay their discounted fees, the hospital attempt to have "natural causes" on the death certificate would have succeeded.

It is my intention to make an FOI request to uncover the cost of this indefensible defence. The guess is that it could be as much, with solicitors and paralegals as well as several counsel and the ineffective internal "investigations", as £200,000 to £250,000. A possible quarter of a million pounds to deny the truth to a bereaved family who would have settled for an apology and an assurance that no one else would die in the same circumstances.

However, when we had realized that the hospital version was mostly based on uncorroborated criticisms of the family that the Coroner seemed inclined to believe, we did instruct Lawyers and Counsel and the NHSLA had to change tactics accordingly. They drifted away from calling us liars and fantasists and used delays and "missing" paperwork instead. As this missing material was selective and only happened to information that would corroborate our version, it finally worked against them, not in their favour. The delays and the constant late production of any evidence in our favour escalated our costs. The NHSLA must have been very familiar with the material to know exactly what to drop on us so late in the hearing. It must have taken many weeks of close attention at hundreds of pounds per hour by the solicitors let alone the Barrister's fees. The Inquest was split into three parts and we had to go over everything again. They didn't mind; they had a bottomless purse to dip into.

The hospital told the Coroner that there was no need for a Jury as the errors that had caused my mother's death had been corrected but then admitted in their last day of evidence that they had changed no protocol whatsoever.

If they also try to outspend Medical Negligent claimants to make them go away it does not surprise me that the greater part of the Billion Pound Budget goes on legal fees.

3. *The effect of litigation on an open reporting and learning culture in the NHS*

In my mother's case the massive hysteria generated amongst the management at the idea of being sued speaks for itself. When my mother slipped into an unnoticed diabetic coma (I noticed it and was severely criticised for bringing it to the attention of staff) the notes hardly mention it. However, close attention to the medication list shows that she received emergency Hypostop (medication for diabetic coma) twice.

When she was hypoxic with undiagnosed pneumonia (we saw this and had to beg for treatment for which we were criticised) the notes say that they knew but the medication list shows a two-day delay before she had any treatment.

When she was thought to be dying of undiagnosed dehydration (I noticed it and the staff devoted several pages to criticising me for saying so) it doesn't appear in the main notes. However, the medication records show that she received many litres of blood and fluids and the nurses' notes show that the Chaplain was called and I was told to come to the hospital immediately to be there when she died. This incident should have resulted in a Serious Untoward Incident (SUI) report but we have not found one yet.

Someone put food with crushed pills in it into her mouth when she was slipping in and out of consciousness from the dehydration and caused Aspiration Pneumonia. Again, this was not logged and ultimately I was accused of feeding her although it was me who asked the staff to be careful the day prior to the incident.

This is just the tip of the iceberg but it gives an idea of the panic and muddled thinking that resulted from a fear that being sued might affect the trust's application for foundation status.

None of the many incidents could ever be used as a learning tool as all of them were minimized or denied altogether. The fact that no one would take any responsibility for any error even though we attached very little blame and were actually helpful made me wonder if staff are trained in a culture of denial. They said things like "We are sorry you think that this or that happened" which is very strange phraseology and has to be imposed.

Sir Liam Donaldson said "To err is human, to cover up is unforgivable".

How can anyone learn when there is a culture of denial from the ward to the board?

4. *Encouraging the use of mediation before litigation is initiated*

I have covered mediation versus arbitration in the complaints section. My reservations about Mediation prior to Litigation are the same.

ROBBIE'S LAW TRUST

The Robbie's Law Trust (RLT) has been formed to disseminate information about the issue of a "Duty of Candour" and co-ordinate the campaign within all the groups who are supporting this becoming law.

This piece of proposed legislation is usually known in the media as "Robbie's Law" as it was Robbie Powell's civil case that highlighted the absence of a Duty of Candour in 1996. It was the circumstances surrounding the death of 10 year old Robbie from dehydration caused by undiagnosed but suspected Addison's Disease and the findings that the doctors subsequently falsified the child's medical records that has driven his parents Will and Diane Powell to pursue their 20 year campaign to have a duty in law for all health care workers, whatever their status, to tell the truth when things go wrong.

The law as it stands today is best summarised by the European Court of Human Rights in the erroneous Judgment of Inadmissibility of Robbie's case, which states:

> William and Anita POWELL v. the United Kingdom—Application no. 45305/99
>
> 4 May 2000
>
> *"Whilst it is arguable that doctors had a duty not to falsify medical records under the common law (Sir Donaldson MR's 'Duty of Candour'), before Powell v Boladz there was no binding decision of the courts as to the existence of such a duty. As the law stands now, however, doctors have no duty to give parents of a child who died as a result of their negligence a truthful account of the circumstances of the death, nor even to refrain from deliberately falsifying records."*

In response to the Court of Appeal judgment in July 1997 the British Medical Association stated [GP Magazine 11/7/97]:

> *"GPs could now put a gloss on the cause of death without fear of litigation."*

RLT Mission Statement

Unquantifiable distress and harm can be caused by health care workers' lack of perceived candour to patients and relatives and lessons from adverse outcomes of medical treatment are often not learned.

We seek to achieve three objectives:

(1) A civil legal duty fully and truthfully to inform and answer when questions are asked;

(2) Criminal offences of falsification and alteration of medical records;

(3) An independent Medical Accidents Investigation Authority answerable to Parliament or the Secretary of State for Health (cf The Air Accidents Investigation Branch and the Marine Accident Investigation Branch, which are both answerable to the Secretary of State to the Department for Transport).

Truth, Evidence and Accountability in Healthcare

Several organisations have now incorporated our suggestions for legislation into their own submissions and we intend to help rationalise the wording into one powerful and compelling proposal to lay before Parliament.

RLT Committee and Advisors

The present RLT committee comprises Will Powell (Robbie's father), members of his legal team (a Q.C. and lawyer with experience in medical negligence), a barrister with legislative drafting experience, a filmmaker who has made an award winning programme on the subject, a drama producer (myself) an ex MP, a businessman who has suffered a personal loss and senior medical personnel. As and when we require specialist expertise, additional members are co-opted onto the committee or attend to advise us as with a senior retired Police Detective with forensic investigation experience of medical notes.

January 2011

Written evidence from NALM (CAL 43)

1.0 NALM

1.1 NALM represents members of LINks (Local Involvement Networks). LINks have statutory duties in relation monitoring the NHS and social care and making recommendations. Over the next two years LINks will develop into HealthWatch and are likely to take on the role of complaints advocacy. NALM has about 700 active members across England and has in membership 50 LINks. Our members interface with the NHS and social care and service users continuously and have a great deal of experience about the current state of the NHS and the effectiveness of systems.

2.0 Complaints

2.1 We believe that complaints have risen partly because of the publicity around Mid Staff NHS Trust and partly because the quality of information about making complaints has improved. However, we do not have any confidence in the quality of complaints data. This is because the distinction between complaints services and PALS had becomes confused and terminology has changed eg hospitals talk about "enquiries" and "feedback" and sometime omit the work complain from their website. So what is being recorded as complaints has become quite obscure.

2.2 Feedback on responses to complaints tends to show that these are often rather institutional and explain what went wrong in terms of pressures on the NHS body rather than focussing on improvement that have been introduced as a result of the information gained from the complaint. Evidence of enduring improvements as a result of complaints is slim and rare in our experience.

3.0 ICAS

3.1 ICAS services are poorly advertised and despite working on very large numbers of cases their existence is not know about generally in the community and they are not pro-active in relation to LINks or community organisations. You have to know a lot about the system to know about ICAS. Whereas their predecessor the CHC was on the high street, very few people know how to find ICAS. That is not to diminish the quality of their service.

3.2 There is a big gap in services between what is provided by ICAS, PALS and LINk. This includes advice about "fitness to practice", legal cases and coroner's cares. We hope that a reformed ICAS/HealthWatch service will provide this kind of information and this should include signposting to Action Against Medical Accidents.

3.3 It has not been possible to get information from ICAS about recommendations from complaints and ongoing action.

3.4 The model of advocacy used by ICAS varies and it is not possible for the complainant to choose the model of advocacy they would like to access.

4.0 Independent Review of Complaints

4.1 The two-stage complains process is a cause for concern because of the limited capacity of the Ombudsman. Their Ombudsman work is outstanding but cannot meet the needs which so clearly exist.

4.2 The Healthcare Commission dealt with 7,827 independent reviews in 2007–08 and we are not sure what is happening to the people that the Ombudsman's office cannot support. Being referred back to an NHS body that has already failed to deal with a complaint is not very reassuring. High quality information from complaints also needs to be fed back to the CQC and LINks.

5.0 Guidance on Complaints

5.1 Guidance on the NHS complaints procedures need to be substantially improved and presented in a form that more accessible to the public. There have been improvements but there is insufficient, coherent information available to the public about complaints and in particular in relation to their outcomes. We have tried to get information on the outcomes of complaints for many years without success. The public needs to be advised how their complaints have helped to improve services and NHS bodies must produce evidence of enduring improvements as a result of complaints.

6.0 PALS

6.1 PALS do a brilliant job in many parts of the country providing information to patients, resolving issues quickly, signposting to other services and provide expert advice on how services work.

6.2 However, many NHS bodies have confused the public by joining PALS and Complaints into a single organisation. They are used in some cases as the first stage of a complaint and may not even explain how the complaints system works. So the patient may believe they have initiated a complaint whereas the NHS body has diverted their issue into a PALS enquiry. PALS should be a point of entry and access not a barrier, and should provide information on how to complain and access ICAS, LINks/HealthWatch and AvMA as appropriate.

7.0 HealthWatch

7.1 HealthWatch will provide a significant opportunity to strengthen the system of PPI and complaints advice and advocacy. Moving ICAS into HealthWatch will go some way to providing the "one stop shop" that the public badly need. HealthWatch needs data from ICAS and joining them into a single organisation would provide this. The walls erected by the DH to prevent to passage of information from ICAS to LINks are profoundly damaging to patient safety and welfare.

7.2 The government's intention to commission ICAS separately HealthWatch is in our view muddled and potentially harmful. This will lead to even more inconsistency, confusion and damage to the patient advocacy. We need a joined up system not even greater chaos.

7.3 Local Authority commissioning also creates a major conflict to interest to the complains system as health and social care become joined through Health and Wellbeing Board.

8.0 Primary Care

8.1 GP consortia should be registered and regulated by the CQC in our view and this should include complaints handling. We think the lack of any independence in the proposed consortia system will make it almost impossible to make a complaint against a GP. The role of ICAS/HealthWatch needs to be expanded in this respect and consortia monitored for complaints handling by the CQC.

9.0 Duty of Candour

9.1 The Committee's previous report on Patient Safety recommended reconsideration of a statutory Duty of Candour towards patients and families. The government has consistently resisted the implementation of a Duty of Candour despite its commitment in the NHS White Paper to "require hospitals to be open about mistakes and always tell patients if something has gone wrong". The requirement to always tell patients when something has gone wrong must an enforceable statutory duty if the Secretary of State's statement "nothing about me without me" is to be realised.

December 2010

Written evidence from NHS Confederation (CAL 44)

Introduction

The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS.

We have over 95% of NHS organisations in our membership including ambulance trusts, acute and foundation trusts, mental health trusts and primary care trusts plus a growing number of independent healthcare organisations that deliver services on behalf of the NHS. We also have a steering group working on behalf of our acute trust members.

We are pleased to have the opportunity to submit evidence to this inquiry.

1. *Executive summary*

- NHS Confederation members recognise that the NHS cannot afford to be complacent about complaints. Healthcare organisations should regularly be seeking feedback from patients as well as listening to unsolicited views. Complaints and clinical negligence must be seen as part of a continuum that is integral to an organisation's wider focus on the quality of care and services it provides.
- A high number of complaints can be a reflection of an accessible complaints system or an open culture in an organisation. It is important that an overly simplistic focus on the number of written complaints is not allowed to undermine the innovation and good work being carried out to improve the NHS's approach to complaints.
- Feedback from NHS Confederation members shows that they are working to make their complaint handling as comprehensive, patient focussed and accessible as possible, in accordance with the new complaints system. Although fully embedding the necessary change in culture will take some time, there are some excellent examples of good practice.

- The NHS Confederation is concerned that complaint functions currently performed by Primary Care Trusts (PCTs) will not pass on to another body when they are abolished. The abolition of PCTs will result in the loss of their Patients Advice and Liaison Service (PALS), which currently act as an accessible entry point for complaints as well as informally resolving concerns. It will also mean the loss of a central collection point for complaints, particularly for those about primary care providers.
- A new litigation model is needed to provide fair access to justice and compensation for patients who have been harmed by negligent treatment. Although the principles behind the NHS Redress Scheme are good, consideration of how the scheme will be funded and implemented is needed.
- There are significant questions about the feasibility and affordability of a no–fault compensation scheme for treatment injury, particularly in the current climate. We are especially concerned that such a scheme would be funded by diverting resources from existing NHS care and would do nothing to diminish many high-value claims.

2. *Complaints and clinical negligence as part of a wider quality focus*

2.1 The NHS Confederation believes that complaints and clinical negligence should be seen as part of a continuum that is integral to an organisation's wider focus on the quality of care and services it provides. We believe that NHS organisations should regularly be seeking feedback from patients as well as listening to unsolicited views and complaints. This is vital information to help the organisation and the board to fulfil their responsibilities for delivering high-quality care.

2.2 Complaints are an important source of feedback, which can and should be used positively and constructively to improve services. But formal written complaints are just the tip of the iceberg. Organisations should also be considering issues raised with their Patient Advice and Liaison Service (PALS) as well as gathering feedback more widely, particularly from the vast majority of people who will never make a complaint no matter how dissatisfied they are with the service they receive.

2.3 Similarly, recognition of the importance of getting initial complaint handling right is essential. There is strong evidence that if something goes wrong with their care or treatment, most people want an apology, an explanation of what went wrong, and an assurance that the problem will not recur. Getting these things right makes it less likely that the complainant will seek further, formal redress. This approach is supported by the NHS Litigation Authority (NHSLA), which encourages NHS organisations to offer patients explanations and apologies.[19]

3. *The reason for the recent rise in NHS complaints*

3.1 We understand the Committee's and the public's concerns about the rise in the number of written NHS complaints. However, we do not accept that the increase automatically reflects deterioration in the quality of care. The 13.4% increase in complaints about hospital and community health services in 2009–10 compared with 2008–09 could be due to a number of factor:

- 2009–10 was the first year of the new complaints procedure, which was intended to make complaints processes more accessible. This makes it difficult to compare year on year complaint numbers in a meaningful way.
- The number of patients treated by the NHS has increased significantly during this period. For example the outpatient total attendances increased by 11.23% between 2008–09 to 2009–10 while A&E attendances increased by nearly 5%.[20]

3.2 Healthcare organisations with high reporting of patient safety incidents and "near misses" tend to be higher quality organisations, with an open culture and focus on learning from adverse events to improve services. This is an important lesson the NHS has learnt from the aviation industry where there are high levels of incident reporting. A high number of complaints or PALS inquiries can result from the accessibility of complaints procedures and an organisation's willingness to encourage complaints in order to improve services.

> As a previously poor performing trust, *Whipps Cross NHS Trust* adopted a range of measures to get feedback from patients and improve patient experience. As part of a more open and accessible approach the email address of the current Deputy Director of Nursing Patient Safety and Quality was made widely available to patients and the local community. As a result complaints and PALS inquiries "went through the roof", despite significant improvements in all ten key indicators of the 2009 CQC Inpatient Survey, and improvements in 43 of the 63 indicators since the 2008 survey. The trust focuses on analysing the complaints it receives to identify what needs to change.

3.3 This point is made by the Health Services Ombudsman (HSO) in her latest report "Large numbers of complaints received…..could be the result of good signposting to the Ombudsman, or an open and accountable approach to handling complaints." And "A high number of complaints about a particular body need not imply

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[19] The NHS Litigation Authority *Report and Accounts 2010*

[20] Department of Health Hospital Episode Statistics

poor service while a single investigation may identify serious consequences arising from a failing in clinical care."[21]

3.4 An overly mechanistic focus on the number of written complaints, year on year, particularly at a national level, could undermine much of the good work to change the approach of NHS organisations to complaint handling. Changing the culture and attitudes so that complaints are valued is fundamental to improving services and patients' experiences of care.

4. *The effectiveness of the new complaints system introduced on 1 April 2009*

4.1 The vision underpinning adoption of the new NHS complaints system in 2009 was to transform complaint handling so that it became more comprehensive, accessible and patient-focused, with an emphasis on using local resolution. There was also a desire to ensure that there was much better learning from complaints resulting in improvements to services.

4.2 The new complaints system has been in operation for 18 months, and it will take time to fully embed the cultural change and develop front-line capacity needed to improve complaint handling. Feedback from our members indicates that they are working to embed the principles of the new complaints procedure into their practices and we highlight below some examples of good practice. This includes taking steps to ensure that effective complaint handling is embedded as a routine part of everyone's work across the NHS.

> *Cambridge University Hospitals NHS Foundation Trust* has adopted an integrated approach to its PALS and complaints service, with the PALS office open outside office hours and on weekends. This is part of a strong organisational focus on delivering high quality care and creating a culture of openness with its staff, patients and the public. A Patient Experience Committee, which includes patients, reviews all complaints and feedback. If necessary, a ward may be referred to their Patient Experience Support Team to help identify any challenges and what needs to change. All areas that have worked with the team have demonstrated a significant reduction in complaints and an improvement in patient experience survey results.
>
> *London Ambulance Service* has embraced the new complaints system's principles across all service-user and stakeholder engagement and recognises the need to take on the full range of enquiries received from patients and the public, as well as complaints and incident reports from other health and social care agencies. A range of examples which demonstrate how they have used complaints to change their service can be seen on their website.
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> *Barts and the London NHS Trust,* in common with many other London trusts, receives a relatively high number of complaints, with many complainants taking their complaint to the HSO, although most are not subject to an investigation. By working with the Ombudsman, the trust has taken significant steps to improve its complaints resolution and to ensure that learning from complaints is consistently implemented across the organisation.

5. *The role of Patient Advice and Liaison Services (PALS) as a "gateway" to the complaints system*

5.1 The NHS Confederation believes that PALS have an important role in making the complaints process more accessible to patients. PALS exist to advise, support and listen to patients, their families and carers, and are often the first point at which people raise their concerns. They are well-placed to flag up areas where services can be improved, and often work to achieve quick resolution of problems without having to resort to the formal complaints processes. However, to fulfil their role effectively PALS offices need to be visible, well-publicised within a trust and open at convenient times.

5.2 Feedback from some of our members highlights the value of an organisation's complaints handling staff working closely with PALS. Some such as Cambridge University Hospitals NHS Foundation Trust have integrated their PALS and complaints service. South Devon Healthcare NHS Foundation Trust, which was an early adopter of the new NHS complaints procedure, suggests that it is important to think flexibly about the boundaries between complaints and PALS staff and of creating a patient services function rather than a separate complaints service and PALS.

6. *Foundation Trusts' approach to reporting numbers of complaints*

6.1 The NHS Confederation agrees that all parts of the NHS, including Foundation Trusts (FTs), must embed a culture of openness and transparency in the way they operate. As demonstrated above, many of the NHS bodies which are leading the way on better complaint handling are FTs.

6.2 High quality data on hospital performance needs to be gathered without creating unnecessary bureaucracy or duplication of effort. There is political consensus around the greater autonomy afforded to FTs. As part of these greater freedoms FTs are not required to submit data on written complaints to the Department of Health, although the vast majority choose to do voluntarily. Discussions with some of the trusts that did not submit data indicates a desire to minimise unnecessary data returns, rather than a disregard for complaints, or a reluctance to learn or be open. Duplication is a particular issue for trusts which provide mental health services

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[21] Parliamentary and Health Service Ombudsman *Listening and Learning: the Ombudsman's review of complaint handling in England 2009–10*

as they also submit returns to the CQC for complaints from patients detained under the Mental Health Act. In most circumstances, information is published in the trust's quality accounts. CQC registration acts as a check that organisations have appropriate complaints processes in place, and the trusts monitor and use complaints to improve services.

6.3 This situation raises a key question about the value of these national level statistics, particularly in a developing environment when all NHS trusts will be expected to be foundation trusts and produce quality accounts. In future, much of this information is likely to be covered by the mandated content of quality accounts.

7. *The Government's plans for future complaint-handling arrangements*

7.1 Current health White Paper proposals have implications for future complaint handling arrangements. In particular, abolition of PCTs will result in the loss of their PALS and there is currently no indication that GP consortia will be required to provide a similar service.

7.2 Proposals to increase patient choice and diversity of NHS providers will heighten the need for greater clarity about where NHS patients treated by the independent sector should address their complaints. Further clarification is also needed about the responsibilities of NHS organisations for complaints made by private patients in NHS hospitals.

7.3 The local HealthWatch is expected to have an important role in relation to monitoring complaints. However, although the likelihood of increased patient choice and a greater diversity of NHS providers is to be welcomed, it will make it difficult for HealthWatch to gather comprehensive information on complaints about the services which local residents use. Without such information, the local HealthWatch is unlikely to be able to exercise effective scrutiny of complaints.

7.4 The NHS Confederation is concerned about the potential loss of specialist advocacy services with the plans to terminate the nationally held Independent Complaints Advocacy Service (ICAS) contracts and pass responsibility for commissioning complaints advocacy to local authorities. We welcome the government's recognition that local authorities should decide who they commission local NHS advocacy services from, but we have reservations that the resources allocated to local authorities for these purposes will not be ring-fenced.

7.5 We welcome proposals to allow the HSO to share information on its investigations and upheld complaints more widely, including with commissioners, the CQC and Monitor. We also feel that it would be particularly beneficial to share the reasons for decisions not to investigate as this could contain useful learning for the NHS. Greater sharing of information by the Ombudsman is likely to help improve services and minimise bureaucracy and duplication.

8. *How data from complaints will feed into the planned new commissioning arrangements*

8.1 Under the planned new NHS commissioning arrangements, the management capacity of commissioners to monitor the quality of services commissioned will be significantly reduced. So while data from complaints will be part of the quality information that commissioners may want to take into account, their capacity for detailed monitoring of such data will be relatively limited. We suggest that the main purpose of complaints should be for providers to monitor the quality of services they deliver and to provide accounts and redress to patients if things go wrong. Ensuring data from complaints feeds in effectively to the planned new commissioning arrangements will be challenging, particularly given the potential impact of increased patient choice and a greater diversity of providers as the market opens up to any willing provider.

8.2 Abolition of PCTs will result in the loss of a central collection point for complaints, particularly for those about primary care providers. Commissioning of these services will be the responsibility of the NHS Commissioning Board, but it is as yet unclear whether people will have the right to complain about primary care providers direct to the Board, and how that might be publicised. This is particularly important given the recognised reluctance of patients to complain directly to their GP.

8.3 Similarly, there are questions about how complaints regarding the refusal to authorise a particular type of treatment should operate under the new system of commissioning. It may be that the new local health and wellbeing boards could have a significant role in monitoring complaints, and ensuring this feeds into commissioning arrangements.

CLINICAL NEGLIGENCE

9. *The cost of litigation against the NHS and the reasons for inflation in recent years*

9.1 Since 2004–05, the value of claims paid under the NHSLA clinical negligence scheme for trusts has increased by 97.6%. The costs of litigation against the NHS are driven by several factors including:

- Continued growth in the number of claims received under the NHSLA clinical and non-clinical schemes (18.6% and 8.2% respectively from 2004–05 to 2009–10).[22]
- The practices of some claims management companies.

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[22] NHSLA op cit

- Continued above inflation increases in the costs of settling claims.
- Disproportionate increases in the legal costs of complainants.
- Changes to the calculation and uplift of periodical payments, which are used as damages settlements where payments are made on a regular basis usually throughout the claimant's life. These will include very high value claims such as for severely neurologically impaired babies.
- Increasing life survival rates and life expectancy particularly of severely neurologically impaired babies.

9.2 For NHS trusts, the costs of their NHS Litigation Authority (NHSLA) fees have increased enormously in recent years to reflect the increasing costs of settling claims. The NHSLA offers discounts to trusts who can achieve the higher levels of NHSLA risk management standards. However, some NHS organisations find the NHSLA requirements onerous and duplicative of other regulatory processes. We have suggested previously that NHSLA should adopt a more outcome based and less process driven approach to assessing NHS trusts and that the results of NHSLA assessments should feed into the process of demonstrating compliance for CQC registration.

10. *Impact of conditional fees (no win no fee)*

10.1 The NHSLA believes that the growth of Conditional Fee Arrangements (CFAs—so-called no win-no fee) has directly contributed to the significant increases in claimants' legal costs in recent years, which are often disproportionate to the amount of damages paid, particularly in lower value claims. Growth in the use of CFAs has been stimulated in part by their increasing availability, but also by increasing restrictions on the availability of legal aid for people pursuing clinical negligence cases.

10.2 However, the recent Ministry of Justice review under Lord Justice Jackson of the costs of civil litigation has proposed that in future claimant lawyers' success fees and after the event insurance premiums in matters under a CFA should not be recoverable from the defendant. If this proposal is adopted it should have a significant impact on the level of claimants' legal fees, as well as potentially discouraging some claims.

11. *Implementation of the NHS Redress Act 2006*

11.1 The current tort-based system for settling clinical negligence claims is widely criticised as being slow, costly, complex, and unfair. It is felt to have a negative effect on staff morale and on public confidence, and tends to encourage a culture of secrecy and defensiveness. It is also criticised as failing to deliver patient satisfaction, with a lack of explanations, apologies or reassurances that actions have been taken to prevent the same incident happening again. Clearly a better litigation model is needed which can provide fair access to justice and compensation for patients who have been harmed by negligent treatment in the NHS, at a reasonable cost.

11.2 The NHS Redress Scheme was intended to provide a straightforward, informal way to deal with lower value claims (up to an expected limit of £20,000 at that time), without recourse to the courts. Despite receiving Royal Assent in 2005, the NHS Redress Act has not been implemented in England.

11.3 While such a scheme may seem attractive, particularly by providing access to redress for those who cannot afford to take legal action, there are significant issues in translating this into practice. The costs of implementing the scheme were never properly assessed. This could be significant despite potential savings in legal costs. The NHS Confederation wants to ensure the details of this scheme prove workable for patients and NHS organisations. We are particularly concerned that the scheme should not jeopardise the progress in encouraging NHS staff to report adverse incidents.

11.4 The NHS Redress Scheme would do nothing to address the issues of the small numbers of high value claims, such as for severely neurologically impaired babies, as these would remain outside the scheme. Previous governments have considered ways of developing more workable schemes for these cases, but it is likely that any significant widening of the eligibility for compensation could not be met without a comparable increase in the overall resources available. It is questionable whether the benefits of the scheme would outweigh its costs and the likely impact on the overall resources available for patient care. Whatever the shape of the scheme, individuals will still retain their right to litigation under common law.

12. *The possible benefits of a statutory right to compensation for "treatment injury" from an independent fund, without the need to prove negligence*

12.1 Most so-called no-fault schemes rely on establishing fault and usually put an arbitrary limit on compensation, rather than providing compensation related to needs and extent of the injury. There are also significant questions about the feasibility and affordability of such an approach. We have concerns about how a fund would be financed and administered. We are concerned that in the current climate such a scheme would be funded by diverting resources from existing NHS care.

12.2 Where someone has suffered harm as a result of negligence, it is only right they are compensated. However, "treatment injury" opens up all NHS care to examination irrespective of negligence, and there is likely to be considerable debate about what constitutes a "treatment injury". Opening up cases eligible for compensation without having to prove negligence is likely to increase the number of payments made, but it is also likely to result in measures to limit the overall costs of a scheme. This could lead to a tariff-based system for compensation and lower value settlements for some types of claim, particularly high value claims. Some people who have been harmed due to negligence could therefore be worse-off under such a scheme.

13. Encouraging the use of mediation before litigation is initiated

13.1 In addition to changes associated with the new complaints procedure and the NHSLA's focus on avoiding litigation where possible, the NHS needs to try different approaches and encourage greater use of mediation as part of this. We are supportive of the proposals from Paul Hodgkin (GP and founder of Patient Opinion) to establish a restorative redress scheme, which aims to provide a way of restoring the relationship between complainants and those who have cared for them via non-legal procedures that promote mutual understanding and transparency.

January 2011

Written evidence from Lord Dunboyne (CAL 45)

Lord Dunboyne submits this evidence in a personal capacity to the Health Committee Inquiry into Complaints and Litigation, hoping that it will lead to improvements for all NHS patients, but particularly the mentally-ill. It is based on his experiences since his daughter Genevieve Butler, aged 28, diagnosed bi-polar, was driven to jump to her death in April 2006 whilst she was an in-patient in the Chelsea & Westminster Hospital where she was being treated following an attempt to kill herself by paracetamol poisoning. Five years on, there have been further avoidable deaths, key lessons have manifestly not been learnt and the family is still enmeshed in complaints procedures. Other families are known to be enduring similar harrowing ordeals.

Members of the Committee may have come across Genevieve in the course of her work at the Electoral Commission where she was employed till her death; and before that at the Home Office as an executive officer in the unit responsible for the detention of those with personality disorders. In her spare time, she was studying to become a lawyer and had hoped to specialise in the field of mental health. Her mental illness first became apparent in 1998 and had been mainly manageable for some six years. The origins of her suicidal ideation were her horrific experiences whilst detained for eight months to June 2005 in the care of the Central & North West London Mental Health Trust at the Gordon Hospital where she was physically assaulted, sexually assaulted and suffered severe side effects from Semi Sodium Valproate which damaged her hair, skin and reproductive system. No Root Cause Analysis is available and the circumstances are complex, but the trigger-event that immediately preceded her jump from the fourth floor walkway of the Chelsea & Westminster Hospital into the public atrium below can be described as "illegal coercion" by the CNWL Crisis Resolution Team for Genevieve to take prescribed medication on threat of being detained again under the Mental Health Act at the Gordon Hospital. Genevieve was the third mentally-ill patient to have jumped to their death from this walkway.

SUMMARY

A proposal for an Independent NHS Complaints Commission with powers to police, investigate and enforce

1. The Complaints and Litigation procedures are, by design, skewed heavily in favour of the NHS. This was so in 2006, when NHS Trusts were under the control of the then Secretary of State, but the situation is now yet more unacceptable. Foundation Trusts lack even that degree of political oversight: the Inquiries Act is about the only vestigial sanction available to the Secretary of State.

2. The perception is that trust managements are now largely a law unto themselves. It is unrealistic to imagine that a few isolated non-executive directors can maintain good governance: I believe that Andrew Corbett-Nolan could provide the Committee with convincing evidence on this topic.

3. There appear to be no sanctions to take against those in the health industry who lend their names and professional qualifications to documents that are not true, fair and complete.

4. The present Two-Stage NHS Complaints Procedure of "local resolution" followed by referral to the Ombudsman, is even less fit for purpose than the former Three-stage process, in which the Healthcare Commission was the quasi-independent second stage.

5. Chelsea & Westminster Hospital, Central & North West London Mental Health Trust, and NHS London have amply demonstrated to us that self-incrimination is an insuperable impediment to the "local resolution" of the First Stage.

6. The Ombudsman—now the Second Stage—has been involved in our case since 2007. PHSO has amply demonstrated to us that she is unable or unwilling to identify whether the NHS has acted properly and fairly; and unprepared to remedy injustice and put things right.

7. By my analysis, less than one percent of the complaints now being lodged with PHSO are ever investigated in any depth. The process by which cases are selected for further investigation is opaque. Complaints which

were regarded as very serious by the Healthcare Commission are dismissed by PHSO as not "adding value": the Committee will appreciate that each individual complaint is of very great "value" to the complainant. I have compared "assessments" received by a number of fellow-complainants and a selection of rather cynical techniques seem to be regularly employed by PHSO. The focus on "maladministration" is manifestly inappropriate to this first, and only, "non-local" stage in the NHS Complaints Procedure. PHSO has signally failed to adapt appropriately to its new role. To progress complaints of any complexity, complainants are obliged to become experts in the law, NHS procedures and the Ombudsman's procedures. In terms of quality of staff and reaction time, the PHSO seems considerably worse than the Healthcare Commission used to be. Staff turnover appears to be a problem and bureaucratic processes have mushroomed. In short, many believe funds spent on expanding the PHSO to be money wasted.

8. From the outset, we requested independent investigation into Genevieve's death since it was readily apparent (and uncontested) that she was highly vulnerable and that one or more State agents may have contributed to her death by act or omission. To our knowledge, no Root Cause Analysis has been done, let alone an independent investigation.

9. HSG (94) 27 as amended states that "An independent investigation should be undertaken … when it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent".

10. C&W, CNWL, North West London SHA (now defunct), NHS London, Monitor, South Kensington & Chelsea PCT, the Mental Health Act Commission & the Healthcare Commission (now the CQC), the Chief Executive of the NHS, and the Parliamentary Health Service Ombudsman have all at various stages refused independent investigation of Genevieve's death. The Coroner refused to engage Article Two.

11. The Ombudsman has been involved in this case more or less continuously since 2007 when our MP first asked her for an independent investigation. I was particularly disturbed to be told that the then Deputy Ombudsman had been involved, prior to June 2008, in discussions with other bodies to agree a strategy for this case and was said to have been the main obstacle to the Healthcare Commission launching the independent investigation which they had advised me they would do.

12. We have also requested the Secretary of State to fulfil his legal obligations under Article Two of the European Convention on Human Rights (Jordan v. UK) and we continue to wait for him to do so. We further question the conduct of successive Secretaries of State with respect to their duties under the Mental Health Act.

13. I sadly conclude that the Law Courts are the only effective driver for change in the Health Service. As long as this unfortunate situation is allowed to persist, all who rely on the NHS ought to welcome increased litigation. The laudable persistence of the Savage family has probably done more for the welfare of patients than the regulator. However, given the attitude and resources of NHS Litigation, significant civil precedents are, in practice, limited to cases assisted by Legal Aid.

14. CNWL failed to do a Serious Untoward Incident Report and finally produced their Clinical Review Panel Report in 2009. At the instigation of our MP, the Metropolitan Police then reviewed the Coroner's file on Genevieve's death. The official response from the Metropolitan Police was that they were not going to investigate because the coroner had found no evidence of criminal negligence at the inquest in 2007: their unofficial comment was to the effect that there was little appetite to prosecute any individuals for criminal negligence manslaughter when it looked like a case of corporate manslaughter … and their difficulty with that was the burden of proof required.

15. There can be no surprise that such evidence was lacking. The only investigations were carried out by Chelsea & Westminster Hospital and Central & North West London Mental Health Trust, the two trusts at risk of the corporate charge.

16. Our over-riding impression is that a culture of impunity has been allowed to develop throughout the NHS. Despite changes to procedures and a burgeoning regulatory system, there is today no effective policing, investigation or enforcement within the NHS.

17. All questionable serious incidents should be subjected to immediate transparent independent investigation. This would save time and money in the end. It would also do much to minimise the current confusion of overlapping criminal, civil, and disciplinary issues. Any delay and all internal investigations can only undermine public confidence and increase overall costs.

18. Such investigations might best be done by a specialist unit along the lines of a medical equivalent to the Independent Police Complaints Commission. The Committee should consider creating such an agency with powers of enforcement.

19. To gain an understanding of the difficulties currently faced by the police and any deficiencies in protocols between the police and the NHS, I recommend that the Committee invite evidence from Detective Chief Inspector Trevor Bowles and Detective Inspector Carwyn Hughes of the Sussex Police. They investigated the deaths of five mental patients detained in the care of Sussex Partnership Trust. I believe this to have been the only recent police investigation of its kind.

THE PROPOSED STATUTORY RIGHT TO COMPENSATION

20. A statutory right to compensation for "treatment injury" seems a sensible option to civil litigation providing (i) that, to encourage take-up, it reflects the savings in legal fees by offering more generous terms than would be the likely product of civil litigation and (ii) that transparent systems are in place to ensure that the "negligence leading to the injury" is identified, disciplined and publicised. A blame-free environment is an unrealistically utopian ideal.

21. If families are involved fully in the investigation and if the process and conclusions are transparent, I can see few reasons why such a compensation scheme should not be administered by the same new investigative agency at the front-end of the process. This should result in fewer long-running complaints and much less litigation.

22. Findings and recommendations would need to be disseminated nationally and to carry adequate weight: lessons must be learnt and there must be credible assurances that they have been. Enforcement is essential to credibility.

LITIGATION

23. The Coroners Act, let alone the conduct of individual coroners is presumably beyond the remit of this Committee. However, when a death has occurred, the Coroner's Inquest is often the most important single step in the Complaints and Litigation process. It is the one opportunity that the majority of bereaved families have to establish "what" happened. I was not encouraged when, days after Genevieve's death, a Coroner's Officer remarked to me "It's only the NHS". There are numerous changes which should be made, most notably the active enforcement of Coroner's Recommendations and the monitoring of individual coroners. However, there is one improvement that is well within the present remit. At present, the NHS is not obliged to disclose its evidence to the Coroner: I suggest that NHS practice should, at a minimum, be brought in line with the recommendations on disclosure for the police which were made following the Stephen Lawrence Inquiry.

24. If the official account is to be questioned at the inquest, costly legal representation is essential. The bereaved family is, in effect, cast in the role of public prosecutor. This is neither appropriate nor just. Legal fees are not recoverable unless there is a subsequent legal action.

25. Actions under the Human Rights Act have to be initiated within one year of the incident. Other claims have different statutory time limits: timescales need to be rationalised. Since inquests are often delayed, civil litigation has to be initiated before evidence is heard at the inquest. In an application to strike out our claim, the Directors of Chelsea & Westminster Hospital saw fit to submit to the court that the hospital "did not owe a duty of care to the deceased [their in-patient] as alleged or at all". The cost of civil litigation, relative to the size of most claims, means that it is too few, rather than too many, cases that ever reach the courts. This is exacerbated by the requirement to bear the defendant's costs (ie NHS Litigation) if the case is withdrawn, as we were obliged to by the deliberate escalation of costs.

CREDIBLE ASSURANCES & ENFORCEMENT

26. I purposely emphasise credible assurances and enforcement. We narrowly managed to secure a Narrative Verdict in the face of considerable hostility from the Coroner, Dr Shirley Radcliffe (a medical doctor), because evidence given under oath at Genevieve's inquest by Dr Richard Morgan, Medical Director C&W, directly contradicted certain specific undertakings given to the Coroner prior to the inquest by Chelsea & Westminster Hospital for the express purpose of avoiding the Coroner having to sit with a jury on the grounds of continuing danger to the public. Immediately after the inquest, the Coroner received personal assurances from Heather Lawrence, Chief Executive of Chelsea & Westminster Hospital regarding these undertakings. In August 2010, a fourth patient jumped from the fourth floor in reported circumstances which lead me to believe that the specified undertakings were indeed not implemented. Quite apart from any possible implications on liability for this later incident, the basis of Genevieve's inquest must thus be questionable.

27. Central & North West London eventually sent the family the first (inadequate and subsequently rejected) Report of the Clinical Review Panel on 18 March 2008, some two years after Genevieve's death, six months after the inquest, and one day after the Information Commissioner's Decision Notice FS50132179 17 March 2008 (see also Information Tribunal Appeal Number: EA/2008/0036 CNWL Galloway 20 March 2009). The Committee may wish to look into this and other rulings which appear to conflict with published NHS policies on "being open".

28. Also in March 2008, a further female patient died in blatantly inexcusable circumstances and the Healthcare Commission was finally obliged to intervene in CNWL, identifying Genevieve's death as one of a cluster of three female deaths associated with the CNWL Gordon Hospital, Westminster. To my knowledge, the Mental Health Act Commission had long been aware of the appalling standards in this hospital: it was at last placed on special measures. Having undertaken in writing to undertake an independent investigation into Genevieve's death, the Healthcare Commission suddenly modified its position following discussions with the trusts and the Deputy Ombudsman. To quote a letter to me dated 14 October 2008 from Anna Walker, then Chief Executive of the Healthcare Commission "Our focus has been on systemic issues at the trust rather than

the specific details of any individual case. However, we do take the view that the trust failed fully to investigate the circumstances surrounding the death of your daughter".

29. The specifics details were to be dealt with under NHS Complaints Procedures and the Healthcare Commission undertook to pay counsel to draft the complaint. The trusts refused to forego Stage One and accept an accelerated process. These delaying tactics were successfully employed by the trusts till the Healthcare Commission was disbanded and the case passed to the PHSO.

30. Under the NHS Constitution "The NHS commits when mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively". Our experiences to date would indicate that this commitment is quite simply fraudulent.

Evidence-based Decisions

31. The present process of Complaints and Litigation and the fashionable preoccupation with evidence-based decisions may actually be impeding decision-making for improvements to the NHS: our experience suggests it is an active constraint on the quality and volume of evidence readily available to decision makers. Topics that come to mind include Crisis Resolution Teams and their use as gate-keepers to mental health services; contraventions of the Mental Health Act; and the introduction of Supervised Community Treatment Orders and the de-skilling of the role of Responsible Medical Officer as set out in the Mental Health Act 2007.

32. By way of postscript, I urge the Committee to reconsider the law banning smoking on hospital premises. The ban has potentially fatal consequences. Genevieve jumped to her death whilst being escorted out of the Chelsea & Westminster Hospital for a cigarette before this law was in force. A large percentage of mental patients smoke, finding some degree of relief and consolation in the habit. I understand that those currently detained in the Gordon Hospital, Westminster (and elsewhere) have to get escorted leave under section 17 of the Mental Health Act in order to smoke standing in the street outside. Members of Parliament bear direct responsibility for this dangerous, inhumane and nonsensical situation. Yet more reprehensible is the fact that the law banning smoking in mental health units has created a strong disincentive for numerous patients in the community to seek help voluntarily in a place of safety, thereby increasing risks to the patients and to the general public.

January 2011

Written evidence from Colin Yeo (CAL 47)

1. Rene the Person

2. Rene was 93 years old and lived with her family who were her registered carers with registered Lasting Power of Attorney for Health and Welfare.

3. She had spent her life doing voluntary work of one form or another even in her 90s.

4. Rene went out four and half days a week prior to a fall and fracturing her knee.

5. Rene enjoyed entertaining family and visiting them especially on family anniversaries etc.

6. Rene's Treatment

7. Despite many admissions over recent years Rene was not diagnosed with Bowel, Liver and Lung Cancer until a few weeks before her death.

8. Rene was admitted and was in hospital for four weeks with a fractured knee before it was diagnosed

9. Occupational Therapists tried daily, for four weeks, to get mum to stand on her fractured knee.

10. Occupational Therapists were not aware that mum's toe nails were exceptionally long and cut into her adjacent toes.

11. Nobody in the RD&E Hospital was qualified to cut mum's toe nails.

12. A further eight weeks of hospitalisation and, despite the symptoms of bowel cancer, no diagnoses of her cancers were discovered.

13. Rene's cancer was only discovered on an emergency admission about three weeks after discharge from a twelve week hospital stay.

14. At the fifth attempted discharge a home assessment was done with the hospital matron and occupational therapist doing the assessment. The matron accused a family member that they had abused the staff by having a camera.

15. After the fifth aborted discharge mum was discharged to a residential home where 24 hour care could be provided.

16. The residential home discovered mum had severe painful problems with her bowel which resulted in her going to the toilet with diarrhoea every 40–60 minutes day and night.

17. Rene was re-admitted into hospital with severe abdominal pain from the residential home about three weeks after hospital discharge.

18. Rene was diagnosed with cancer and given only a few weeks to a month to live.

19. Rene was discharged back to the residential home only to be re-admitted a few weeks later when she went in for an X-ray. She was so poorly they had no choice. However the next day a Ward Nurse phoned, unaware of mum's condition, telling us she was being discharged to us. We explained the situation and mum was kept in hospital for a further nine days before being discharged to a nursing home.

20. Mum received the best care in the privately run nursing home which cost only £570 per week. We were told the council residential home cost over £600 and the hospital £700 per day.

21. Rene Schneider passed away a few weeks later.

22. Family Observations

23. During mum's stay she was under the responsibility of about ten different Doctors or Consultants.

24. No one professional member of NHS Staff was responsible for her total stay.

25. Responsibility for her care was passed from one professional to another -like pass the parcel.

26. At one point during her stay no Doctor or Consultant admitted responsibility for her care.

27. The family often found mum dehydrated and being given inappropriate foods for her illnesses.

28. Low or zero fat foods are not available on menus despite this issue being raised eight months previously in which the Director of Nursing promised this would be corrected.

29. Many of the Nursing staff are not aware of the importance of hydration.

30. Many of the Nursing staff are not aware of the fat content of food.

31. Many of the Nursing staff are not aware of the symptoms of dehydration.

32. Many of the Nursing staff are not aware how disease can spread.

32.1 When the nurses have soiled sterilised gloves on, they would pass keys from their pocket to another nurse with clean hands. The result was the first nurse's pocket, keys and the second nurse's hands are all contaminated without either nurse being aware.

32.2 When a nurse sneezes into her hands she continues working without washing her hands. She could be passing meals or just doing normal nursing work.

33. NHS Staff and Social Services Management/ Staff spent vast amounts of time trying to save money by playing pass the responsibility between each other. The NHS discharge when patients are ill and social services delay accepting responsibility. The result is increased cost to tax payers and severe suffering to patients and their families.

34. Nursing staff were observed using expensive bed protection sheets to wipe up a spilt drink. When asked we were told it was quicker than getting out the mop.

35. Nursing staff pull electronic equipment around by its mains lead. As an electrical engineer this can cause intermittent operation of the equipment leading to medical misdiagnosis and making the equipment difficult to repair.

36. NHS Staff will not write down what they tell the patient verbally. They will not allow you to record what they say concerning your condition or treatment. They will not let you take photographs or videos. They will not let you access to the patient's medical condition or records. This applies to both the patient and the patient's representatives. This makes it impossible to bring the bad staff to account.

37. Complaints Handling

38. The family had Rene's verbal/ written consent and Registered Lasting Power of Attorney (LPA) for Health and Welfare but all details of her current medical condition and treatments were withheld.

39. The family were told that the medical records could only be viewed using the Freedom of Information Act which could cost up to £50 and take up to 40 days.

40. The family tried to collect evidence to prove Rene was medically unfit for discharge. This involved taking photos of Rene in her single room with no staff present.

41. The senior staff said the use of a camera in hospital was illegal.

42. The senior staff refused to confirm this in writing.

43. The NHS Devon Information Governance Officer said this was not true, photos could be taken, provided no third party was involved.

44. The Matron said the LPA could not be used unless the patient had been declared mentally incapacitated. Research proved we could decide mum was mentally incapacitated.

45. To avoid argument mum gave us her written consent.

46. A meeting with the Matron and Complaints Manager was organised to raise our concerns.

47. At the meeting we presented mum's written consent and the Matron then said mum didn't have mental capacity to sign the form.

48. The Matron and Complaints Manager took a copy of our registered LPA and promised this would be put on record so that we would not need to present it again.

49. The Matron and Complaints Manager re-iterated that the LPA could only be used through the Freedom of Information Act.

50. They both decided that problems with mum's medical care at the RD&E hospital were not their responsibility. NHS Devon buy the services from the RD&E unit.

51. Many actions were verbally promised at the meeting but were not done. No minutes were taken by the Matron or Complaints Manager.

52. We wrote a letter to the Information Governance Officer asking her to confirm the situation regarding access to mum's medical records. This letter was both posted and sent by email (the address we had used successfully before). This letter has never been replied to.

53. Rene was diagnosed with cancer at the same time as the family received a letter accusing them of abusing staff. This was done by falsely accusing the family of taking photos of NHS staff.

54. A letter of complaint to the Chair of NHS Devon asking for a proper investigation into the staff abuse and mum's medical care was answered by the same Complaints Manager who previously failed to do her job.

55. The Complaints Manager refused to investigate because she denied the family had Lasting Power of Attorney which she had previously taken a copy of.

56. Subsequent attempts to contact the Chief Executive via her personal assistant were redirected to the Complaints Manager.

57. The ICAS advocate wrote a letter to the Chair of NHS Devon expressing concerns about the independence of the investigation by the Complaints manager. They were contacted by the Complaints Manager who said there was no conflict.

58. A Parliamentary and Health Ombudsman Advisor, who agreed with our concerns, tried to contact the Chief Executive of NHS Devon but was redirected to the Complaints Manager who again said there was no conflict of interest.

59. Our MP, Ann- Marie Morris, contacted the Chief Executive and asked for an investigation.

60. The investigation for our MP said no investigation was possible because they only had a copy of our application for Lasting Power of Attorney.

61. The ICAS advocate's communications could prove that this was not true so we requested a copy of all communication between the ICAS advocate and NHS Devon.

62. ICAS initially told us it would take a few days. It took about six weeks to arrive.

63. The Patients Association who were working with the Daily Mail to investigate NHS care for the elderly asked the NHS Devon for a copy of the application.

64. The Chief Executive of NHS Devon apologised for previously stating we had not supplied the correct Lasting Power of Attorney. She admitted that a mistake had been made.

65. The Chief Executive promised an independent review into mum's health care and the complaints handling procedure.

66. The Chief Executive has sent the family a terms of reference for the independent investigation.

67. The NHS Devon terms of reference want to check if NHS procedures have been followed. The family want to know what went wrong. This could include whether the staff had failed to do their job and/or whether their procedures are wrong.

68. We think it has the potential for another cover up.

69. The Reason for Recent Sharp Rise in NHS Complaints

70. We believe the reason for NHS complaints increasing is the complaints procedure does not lead to a correction of faults occurring in the system.

71. The staff (or the NHS system) involved in mistakes are not corrected by improved procedures, retraining or dismissal.

72. Since nothing is learnt from mistakes these mistakes become acceptable practice and result in further complaints occurring. No systems are changed, no one is retrained and no staff, who are incompetent, are dismissed.

73. The Effectiveness of The Constituent Parts of The Complaints System: Local Resolution (Supported By ICAS) And Referral To The Ombudsman

74. The PALs unit are not effective because their main brief appears to advise, liaise and prevent litigation.

75. Our experience of the PALs unit showed that these people do not tell the truth. Local resolution was never reached because they refused to allow us to record the local resolution meeting. This was probably to prevent litigation.

76. The ICAS unit is run by staff working part time, who have no authority, are poorly trained and were reluctant to push the NHS Trust to fulfil their legal and moral responsibilities.

77. We found it very difficult to contact our advocate because she worked part time (she never told us), was often away on training courses, was on holiday or sick. She helped to compose a letter to the NHS Trust Chair saying he had a statutory obligation to reply to our letter. This was done but he never replied to this or any letters we sent. Our complaint was passed to the person we were complaining about to handle it. The Advocate thought this unfair but said she said she was powerless to change it.

78. It was felt that care must be taken when dealing with ICAS. They appear very reluctant to challenge NHS Devon. They will ignore letters and emails. Everything takes a long time to be done.

79. The Ombudsman has no authority.

80. An Ombudsman advisor agreed with us that the person we were complaining about should not be handling the complaint. Although officially she was not involved she did phone the NHS Trust to change this but failed.

81. Our complaint must have cost hundreds, if not thousands of pounds, in money wasted on NHS personnel who handle complaints. Nothing was achieved. It should have involved just one person with the result of large savings in future NHS costs.

82. The Role of Patient Advice and Liaison Services as a Gateway to the Complaints System

83. The complaints system is part of the PALs unit and is a gateway to the complaints system brick wall.

84. The whole system which includes the PAL service, ICAS and the Health Ombudsman is designed to take a long time, to frustrate, extend the suffering and wear you down. They are very effective at achieving this.

85. PAL service, ICAS and the Health Ombudsman are obsessed with procedures even when things are clearly wrong.

86. The complaints procedures are not available to anyone who does not have the patient’s authority (ie a hospital visitor who observes a patient being badly treated has no right to complain).

87. The Patient Advice and Liaison Services assume that the patient or loved one who reports a fault needs advice or a liaison service. They assume that there has been a misunderstanding. This can be useful but when there is a complaint the issue is referred to the complaints department within the PALs unit.

88. To minimise the number of complaints received they make it impossible for most people to complain by saying that only the patient or the Executor of their Will can complain. A person with Lasting Power of Attorney can complain but in practice every obstacle possible is used to prevent this occurring.

89. The Complaints department work very closely with the legal department to minimise litigation but this has the effect of allowing mistakes to be continually repeated.

90. There appears to be no department with the task to improve quality of healthcare in the hospital.

91. Our complaint should have led to a couple of extra X-rays being taken to save three months of hospitalisation.

92. The Failure of some Foundation Trust to Report Complaints

93. Our experiences of systemic lying within the NHS service, to quite high management levels, make this statement very likely.

94. There is no procedure to handle complaints against the PALs unit which includes the Complaints department. We could not get these people to be made accountable for lying even though we had the proof and involved Ann-Marie Morris our Member of Parliament.

95. The Cost of Litigation against the NHS

96. Generally the cost of litigation is inversely proportional to how much effort the NHS has put into preventing the problem from occurring (ie problems are continually being repeated which the complaints system should have stopped a lot earlier).

97. The cost of litigation will be proportional to the number of complaints made in a fair system (ie reducing the number of complaints through reducing NHS mistakes will reduce litigation costs). Currently the complaints system reduces the number of complaints by making it very difficult to complain.

98. Damages are large when the NHS continues to make mistakes when they know the mistakes have a long history.

99. The cost of litigation is a lot lower than it probably should be because the suffering and loss of life for the elderly is of a lower value than the young (ie a mistake on a 25 year old mother would have higher litigation costs than a 65 year old grandmother).

100. The cost of litigation is a small proportion of the problem. Our mother was misdiagnosed with a fractured knee with the result of a three month hospital stay which should have been only a week. At £700 per day this adds up to approx. £60,000.

101. How to Improve the NHS Complaints Procedure

102. To improve the complaints procedure you need to reduce the number of complaints.

103. NHS staff and the systems they work with must be made accountable. This means accepting that either: operating systems may need changing; staff may need retraining; staff may need to be dismissed.

104. To make it easier to validate complaints, patients and their representatives should be allowed to request to record interviews on their healthcare. This can then be used as evidence should a complaint arise.

December 2010

Written evidence from Charlotte Radford (CAL 48)

My Personal Experiences

1. In response to your request for evidence for the above Inquiry, I submit the following information, which I confirm to be my own experiences of the process whilst pursuing a complaint about the treatment, care and death of my mother at Macclesfield District General Hospital on 13 March 2007. The complaint is at present under Investigation by the Health Service Ombudsman.

2. In summary—my elderly mother suffered appalling treatment and care whilst an inpatient for just 10 days at the above hospital. When admitted she was elderly and frail, but she was not dying. Within seven days however, she was in a very weakened state both physically and mentally. This was undoubtedly due to negligent care, failure to provide solids or adequate fluids or correct an error in medication, which caused her to suffer from increasing levels of pain until her death. Her pain levels were intensified after an undocumented abusive hoisting, which was initiated by the staff nurse in charge of her care, in my opinion because my mother had complained of constipation discomfort and had refused her medication. She was left hanging high above her bed calling for help for an undetermined period of time until I found her.

3. My mother pleaded to be taken home and after this fearing for her safety. While trying to secure her discharge home for Comfort Care, the medical team proceeded to delay her discharge overnight. In this time they covertly terminated and withdrew her supplemental oxygen under false pretences, withdrew all her nursing care and observations and after prescribing Opioids late that night, left her to die without interventions, any assistance or attempts to intervene to help her deteriorating breathing.

4. My sister and I were called into the hospital urgently during the night, but my mother was already in a coma and sadly died within half an hour of our arrival.

5. The Trust had shown little respect for human life, had failed to consult with my mother or myself as her full-time carer in their decision making. They were only intent on preventing her discharge home for fear of legal action being taken for the damage and physical state she was in. In spite of all the evidence I have provided and the recordings which support my criticisms of care, the Trust have continued to deny any wrong doing and any failings in care. They have made no recommendation for improvements or taken any responsibility for their actions.

6. The expert reports which I subsequently commissioned and financed, have however, highlighted numerous failings. The nursing report cites no less than 25 criticisms and many incidents of sub-standard care. The

Clinical Report is also critical and additionally highlights the Trust's failure to provide my mother with the correct Coronary Care medication and tests as per Nice Guidance 2003. See below:-

7. SUMMARY OF NICE GUIDANCE ON TREATMENT OF CHRONIC HEART FAILURE (2003)

Key recommendations

The following recommendations have been identified as priorities for implementation.

Diagnosis

1. The basis for historical diagnoses of heart failure should be reviewed, and only patients whose diagnosis is confirmed should be managed in accordance with this guideline.

2. Doppler 2D echocardiographic examination should be performed to exclude important valve disease, assess the systolic (and diastolic) function of the (left) ventricle and detect intracardiac shunts.

Treatment

3. All patients with heart failure due to left ventricular systolic dysfunction should be considered for treatment with an ACE inhibitor.

4. All patients with chronic heart failure require monitoring. This monitoring should include:

- a clinical assessment of functional capacity, fluid status, cardiac rhythm, and cognitive and nutritional status;
- a review of medication, including need for changes and possible side effects; and
- serum urea, electrolytes and creatinine.

8. If the Guidance had been followed it would likely have enhanced and extended my mother's life by several months.

9. The process of Local Resolution was innately floored and showed total systemic cover-up, deceit and dishonesty by all staff concerned. As the Chief Executive and Deputy Chief Executive were both aware of the details of my complaint, I would have to conclude that in signing responses they were both complicit in the systemic process of cover-up and the corrupt handling of the case. It would seem conclusive from my and other complainants experiences, that that the investigation by Trust Complaint Departments and manager's of their own employees, is open to abuse and is far from transparent, open or honest, as is the present requirement. Until there is Accountability in Healthcare and a Legal Duty of Candour, there will be no improvement and patients will remain to be dangerously at risk.

10. I can only conclude that in my particular complaint case, that the Trust have been intent on preserving reputation and preventing Litigation rather than securing patient care, welfare and safety.

11. The Local Resolution process has proved to be a daunting, demoralising and distressing experience in which I have been blamed, discredited and my integrity questioned. The overall outcome for the complainant is that they will be permanently damaged by the process, which would be more aptly described as a "battle" for Justice.

12. HEALTH SERVICE OMBUDSMAN

My complaint has been with the Health Service Ombudsman since March 2009. The case was passed onto them for review by the Health Care Commission when they disbanded in April 2009.

13. Stage Two of my complaint has involved a total of four case managers, one investigating manager and two closures to date. As a result of the expert medical report and the new Coronary Care issue, I have been informed that a new complaint will have to be submitted to review this matter. Even when there may be evidence of major failings within Investigation, it would seem that unless the complainant has cited an issue for review, it will be ignored during the process.

14. The Ombudsman's discretionary powers also allow them to choose which cases to review or investigate and what issues to include. Their decision is final and may exclude matters of national importance and concern. The particular issue I refer in my case which was excluded from Investigation, portrays a national failure of the NHS to audit or scrutinise the care and treatment provided to patients issued with DNR Orders, who are on their death automatically categorised as "Expected" to die. This "Expected" death category is used in Trust figures and in national statistics. The issue of DNR Orders and the "Expected" death category is, in my opinion, a means for Trusts to cover-up deaths, which have resulted through error or intention or plain sub-standard healthcare. It is my opinion that the vulnerable and elderly are significantly at risk from this and that many suspicious deaths, including those at Mid-Staffordshire hospital were not investigated because of this.

15. To date I have experienced two other serious problems during the HSO's handling of my mother's case:

- After informing them that I was considering taking legal action and was taking advice on this possibility, I was informed by the HSO case investigator that, in spite of the changes made to the Complaints Procedures in April 2009, I could not pursue both concurrently. I was then given an ultimatum to choose between the two. I reluctantly chose to withdraw Legal proceedings in preference to achieving better healthcare and outcomes for other patients. It has subsequently been made clear to me by AvMA, that the Ombudsman's office gave me inaccurate and misleading information and that I should have been able to pursue both concurrently.
- The second unacceptable issue it that the HSO Investigation Report, which is nearly completed, will be sent to the Trust alone for comment, response and possible amendment, before I am allowed sight of it. As the Complainant, I would site this as a prime example of bias towards the NHS during a supposedly Independent bodies investigation.

16. My confidence in the NHS is sadly destroyed, my experiences of the Complaints process and the shocking realisation that a supposedly honourable, trustworthy and caring national organisation has been shown to be corrupt and dishonest and that there is additionally, during the Complaint process and Litigation, a bias towards the NHS by the Independent Investigating bodies. The system truly lets us down and the NHS continues to be allowed to betray us all.

December 2010

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