Department of Health

Government response to the House of Commons Health Select Committee Fourth Report of session 2014–15 Complaints and Raising Concerns

Cm 9050

Government response to the House of Commons Health Select Committee Fourth Report of session 2014–15 Complaints and Raising Concerns

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

March 2015

Cm 9050

This publication is available at www.gov.uk/government/publications

Any enquiries regarding this publication should be sent to us at
Department of Health, 79 Whitehall, London SW1A 2NS

Print ISBN 9781474116954
Web ISBN 9781474116961

ID 2903798 03/15 19585

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

Government response to the House of Commons Health Select Committee Fourth Report of session 2014–15 Complaints and Raising Concerns

Introduction

On 21st January 2015, the House of Commons Health Select Committee published the Fourth Report of Session 2014 – 2015 in respect of Complaints and Raising Concerns.

The report followed an inquiry by the Health Select Committee into the current system for handling concerns and complaints about the NHS. The Committee took evidence from the Parliamentary Under-Secretary of State for Health, Dr Daniel Poulter, the Parliamentary and Health Service Ombudsman, the Chief Executives of the Care Quality Commission, General Medical Council and NHS Employers, NHS charities and the Chair of Healthwatch.

This paper sets out the Coalition Government's response to the conclusions and recommendations in the Health Select Committee's Fourth Report of the Session 2014-15.

Overview

Complaints and concerns

Complaints are important and need to be taken seriously. When something has gone wrong it needs to be put right quickly, and organisations need to work closely with people to find the most appropriate resolution to a complaint. Organisations also need to make sure they learn from every aspect of a complaint so that the same thing does not happen again.

One of the most persistent features of complaints and of investigations into failures of care is the need for those who believe they have been let down to be listened to, for what they say to be properly considered, to receive an apology where things have gone wrong, and for lessons to be learned.

An effective organisation will promote a culture of openness, recognise the value of patient comments and complaints and make it easy for patients, their families and carers to give feedback. An effective organisation will also be open about and publish regular information about the complaints it receives and the action it is taking as a result.

Delivery of this culture change will require excellent leadership. This is critical to the delivery of quality care. Patients need the NHS to have appropriately skilled leaders, with the right values, behaviours and competencies at every level of the system.

Those organisations that have done most to meet the challenges of the Francis Inquiries are also those that have gone furthest in listening to patients and carers. Whether it is in the Board room, where patient stories play an increasingly important role in reminding organisations of their core purpose and of what really matters, in the home, the clinic or on the ward. We are driving this movement for change, in part, with improvements to complaints handling to make listening and

acting on complaints part of the common culture of the health and care system.

Complaints often contain hard truths, but they can provide tremendously valuable insight and be the source of ideas for improvements in patient care. A number of NHS organisations have shown how to use complaints effectively as a catalyst for improvement and as a warning light in relation to poor practice.

The Government knows that, whilst ensuring the systems and processes are in place, a key priority is about delivering long lasting cultural change across the health and social care system. This will require effective and joined up leadership at all levels across the system. The Government believes that improving that the way in which the NHS manages and responds to complaints will be critical in shaping a culture that listens to and learns from patients, and ending a culture of defensiveness, or at worst, denial about poor care and harm to patients.

The challenge ahead will be to make listening and responding to patients and staff a natural and highly valued element of the culture of the health and care system everywhere.

Conclusions and recommendations

Developments since the Committee's 2011 report

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

We are pleased the Committee has recognised the value and high importance the Government has placed on improving patient safety and complaints handling. We want to make the NHS the safest healthcare system in the world and we know that listening to patients and staff is absolutely vital to improve care. Whilst we have made significant progress with these aims, the Government is not complacent and recognises that further improvements are necessary.

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

Response:

In December 2013, the Department of Health, and key system partners, put in train a series of individual projects to deliver improvements to the way health and social care complaints are handled. These projects have been overseen by a 'cross-system' Complaints Programme Board. The Board has a single, agreed work programme and a shared ambition to ensure complaints are handled effectively, with learning from them shared and acted upon locally and nationally for the benefit of patients, users of services, the public, their carers and relatives.

In February 2015 the Government published *Culture Change in the NHS: Applying the Lessons of the Francis Inquiries* and Chapter 2 provided the detail and progress on many of these complaints handling projects. A summary of all the projects is detailed below:

- Issuing clarification that a threat of litigation should not automatically stop a complaint being investigated: A clarification note was published in March 2014;
- Building complaints handling into CQC inspections: The quality of providers' complaints handling has been included in CQC inspections since October 2014;
- A measurable vision for complaint handling across health and social care:

This work was published in November 2014;

- Setting of Standards for Complaints Advocacy: Healthwatch England published these standards in February 2015;
- NHS Constitution Complaints guide: the guide was published in February 2015;
- Move to quarterly publication of hospital complaints data: This project is progressing well, and is on track for the new collection to start from April 2015, with publication of data expected late summer 2015;
- Regular and standard method to survey complainants: A workshop has been held to generate options, and these options have now been narrowed down and are being considered in more detail;
- Review of PALS and evaluation of NHS Complaints Advocacy arrangements: Both projects are underway and we envisage they will be complete by spring 2015.

The complaints system has already been the subject of much scrutiny and was reviewed in 2013 by Ann Clwyd MP and Professor Tricia Hart. The Clwyd/Hart review plus the Francis Inquiries, the Health Select Committee inquiry of 2011, and other contributions to the debate such as HealthWatch England's *Suffering in Silence* report have added much to our knowledge about how effectively the complaints system is working, and where improvements are needed.

The work programme to improve complaints handling outlined in Hard Truths will come to an end in Spring 2015. Decisions about next steps and evaluation of progress will be taken after that.

3. While there have been some improvements there are still too many individual cases which are mishandled, from instances of poor communication to those which end in a complete breakdown in trust between patients, their families and NHS institutions. (Paragraph 16)

We agree that whilst there are many examples of good practice there are still examples of poor practice which cause people to lose confidence in the complaints system. There has to be a culture change from within the NHS that puts patients first. This needs to be reinforced and supported by the use of standards and inspection.

The Care Quality Commission through its Chief Inspector of Hospitals and his team of expert inspectors now apply a rigorously objective and searching approach to assessing the quality of care. This new approach to inspection places a stronger focus on how care is delivered in practice and how it is experienced, rather than just compliance with regulations. In line with this, the Care Quality Commission is now making greater use of the information that it has on complaints.

The current NHS complaints regulations clearly lay out what is expected of all NHS organisations investigating and responding to complaints at local level. Where a complainant is not happy with this response, the complainant can refer the matter to the Parliamentary and Health Service Ombudsman (PHSO). The PHSO investigates complaints that cannot be resolved locally and has taken measures to increase the number of complaints accepted for investigation.

4. We recommend that our successors on the Health Select Committee in the next Parliament continue this work of monitoring improvement in the complaints process. (Paragraph 18)

Response:

We welcome the work that the Health Select Committee has done to review complaints and concerns and hope that this scrutiny continues.

What should good complaint handling look like?

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

Response:

An open culture means that information should be available to patients and the public, their families and carers to enable them to make informed choices about their health and care.

In Hard Truths, the Government gave an undertaking to have complaints data published quarterly for all NHS organisations, and for the data to be put into context, for example, alongside the size of an organisation or the number of patients seen. From April 2015, all NHS secondary care organisations will be required to submit revised quarterly complaints data to the Health and Social Care Information Centre for quarterly publication. It is proposed that Primary Care organisations will start quarterly complaints reporting from April 2016.

NHS organisations are already required, by law, to produce an annual report about the complaints they receive and the lessons learnt. This report must be made available to anyone requesting it. The report contains information on the number of complaints received, the number referred to the Health Service Ombudsman, and a summary of the subject matter of those complaints, any matters arising from them, and any matters where action has been taken (or will be taken) as a result of the complaint. These reports are also sent to the commissioning body.

The Government considers the quarterly publication of the revised NHS complaints data sets alongside the annual qualitative complaints report will provide patients, their families and members of the public with a more rounded picture of how an organisation handles complaints. This will sit alongside the ratings from CQC inspections which include complaints as a key line of inquiry.

Complaint handling by providers

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

We agree the complaints system should be open, transparent and easy to access, and the Government committed to a substantial programme of work in Hard Truths to help improve complaints handling.

The Government wants to ensure that people wishing to make a complaint are provided with the relevant information to help them do so, for example, how to complain about a hospital, how to seek independent support

and how to refer their complaint to the Ombudsman. A poster template setting out this information was made available to the NHS to download in November 2014.

Lancashire Teaching Hospitals NHS Foundation Trust, for example, is keen to further develop an increasingly positive culture and recognised the importance of high quality information and guidance about the process for providing feedback and raising concerns and complaints. To this end, they have developed a range of resources to inform staff, patients and their families, including:

- A suite of posters, which are widely displayed in in-patient, outpatient and public areas throughout the hospitals;
- Information leaflets that are available in all areas;
- Information on the Trust's websites, both internally and externally facing.

In addition, as part of the Complaints Programme Board work, Healthwatch England commissioned Citizens Advice to expand their health and social care section on *"Adviceguide"* – their consumer-facing information website – to provide consumers with advice on how to navigate the health and social care complaints system, ensuring the public have access to accurate, current and accessible information in one place.

The fundamental objectives of the complaints regulations are to facilitate effective handling of complaints at the local level and to encourage organisational learning leading to service improvements. We recognise that complaints are a valuable source of feedback on service delivery.

We believe that a move away from local resolution to a central complaints 'hub' would take the emphasis away from local resolution and local learning. Local resolution and learning is vital to an open culture where the NHS admits mistakes, deals with complaints effectively, quickly and sensitively, and learns from the experience.

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

Response:

Complaints matter to CQC because they provide information about the quality of care. They tell CQC how responsive a provider is, how safe, effective, caring and well-led they are. CQC can use their powers as a regulator to shine a light on good and bad handling of complaints and encourage organisations to improve.

Complaints and feedback from people who use services is a central part of CQC's *'Intelligent Monitoring'* of health and social care providers. They have made it central to their inspections, and it now includes a Lead Inspector for complaints and staff concerns in large Inspection Teams. The Inspection Teams now evaluate how well health and social care providers handle complaints and will feed this into their regulatory judgements about how responsive they are to people's needs.

Role of Commissioners in complaints, and handling of complaints by Commissioners

8. We recommend that the system for service users to make complaints to commissioners about NHS services should be integrated into a single complaints system. Commissioners need to take a far greater role in holding

providers to account for delivering a well-functioning complaints system. (Paragraph 47)

Response:

A single complaints system already exists governed by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. A complainant can choose whether to complain to the provider of their care or treatment, or the commissioner.

Commissioners have a major role to ensure that services they commission have effective complaints processes in place and are delivered to a high standard. A key element will be the extent to which providers implement change and service improvement in direct response to complaints.

NHS England is currently exploring co-commissioning of primary care with Clinical Commissioning Groups (CCG). As part of that initiative they will be reviewing the approach to complaints management in partnership with a CCG, or a cluster of CCGs with the aim to get them more involved in dealing with complaints. NHS England is also looking to develop, with support from the Ombudsman and other key stakeholders, a toolkit for commissioners that will help support them to hold providers to account for delivering a well-functioning and good quality complaints system.

Complaints handling in primary care

9. The Committee is concerned about the effects of centralising complaint handling in primary care by NHS England. We do not believe that primary care complaints should be investigated in a different region. This has led to fragmentation and disconnection from local knowledge and impaired the ability to deliver a timely response and learn from complaints

We recommend NHS England reports on progress on providing a primary care complaints system that is responsive to patients in a timely manner and which results in local learning and improvement. (Paragraph 52)

Response:

Currently around 80% of complaints are made directly to providers. Those relating to primary care services (such as GPs and Dentists) are handled locally and without involvement from NHS England. Of those made direct to NHS England, the majority are investigated locally by engaging with the relevant provider or Sub-Region.

As the Committee has identified, NHS England has centralised the processing of complaints in some areas. In some parts of the country complaints made direct to NHS England are handled directly by Regions. In other parts of the country complaints are handled by Commissioning Support Units (CSU) and signed off by the relevant Director within the relevant region. NHS England has found some advantages to the more centralised approach including the flexibility to scale resources to meet demand and this model also delivers good value for money.

NHS England's overall aim for any chosen model is to achieve a quality service, with local insight, which is cost effective and delivers good outcomes for the complainant. NHS England will be monitoring arrangements on an ongoing basis to ensure it delivers on these aims.

Complaint handling in Social Care

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

Response:

Currently there is a single legislative framework covering NHS complaints and adult social care complaints. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 lays out what all NHS organisations must do when investigating and responding to complaints.

These regulations require organisations to allocate a complaints manager to handle the complaint, offering the complainant the option of a face to face meeting to discuss how they wish their case to be dealt with and the timescale for investigating and responding to the complaint.

Normally this timescale should be no longer than 6 months from the date of the complaint; if longer the complaint manager must inform the complainant in writing advising them of the delay and the reason why. This process applies across the whole of the NHS and adult social care system.

The regulations provide a clear, robust framework for handling complaints effectively. This must go hand in hand with culture change. Effective organisations will promote a culture of openness, recognise the value of patient comments and complaints, and make it easy for patients, their families and carers to give feedback.

The matter of whether there should be a single health and social care Ombudsman is for Parliament to decide, and is the subject of a consultation by Robert Gordon.

Complaint advocacy services

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

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

Response:

The Department set up a workshop comprising a selection of current NHS advocacy providers, the Local Government Association and Local Authority Commissioners to explore the feasibility of introducing a single brand for NHS advocacy services and issues around the effective delivery of this service.

The Government has recently awarded a contract, following a competitive tender, to a charity who are undertaking a high level review of the commissioning arrangements for independent advocacy services. We expect a report in the Spring to allow recommendations to be prepared for consideration later in the year.

The Department's Complaints Programme Board has also initiated a review of PALS. A workshop has been arranged with key stakeholders to produce initial ideas in some key areas including the scope of the service, funding, statutory basis and effectiveness. The aim of the PALS review is to produce an initial report identifying the key issues to inform a wider review of the service at a later date.

13. We recommend that the Government provide a progress report on the functioning, funding and budgets of

local Healthwatch organisations, in order that the information be available to our successor Committee. (Paragraph 72)

Response:

The Government agrees that it is important there is transparency about how local Healthwatch are fulfilling their remit and the impact that they are having. Each local Healthwatch is required to publish an annual report setting out how it is delivering its statutory activities – an important way of ensuring this information is available to local communities and to other interested parties. In terms of a national overview, Healthwatch England provides an overall picture of the local Healthwatch network in its annual reports and the Department of Health has also commissioned the Kings Fund to review progress.

Local authorities are responsible for commissioning local Healthwatch providers, and the funding provided by central government is not ring-fenced; the Government believes it is for local authorities to decide how best to resource their local Healthwatch, in line with specific local needs and circumstances. To enable transparency over funding decisions, local Healthwatch are required to include funding information in their annual reports and Healthwatch England has collated and published information on funding for all local Healthwatch.

Local Healthwatch do not have a statutory responsibility to deliver complaints advocacy services, although in some cases local authorities have chosen local Healthwatch to provide this as an additional service. Similarly, there is no requirement on local Healthwatch to improve complaints handling processes but the Government agrees that – where local Healthwatch have decided this is a local priority – they can play an important role here. The Government also agrees that complaints data, along with other sources of feedback, have the potential to provide important information to local Healthwatch, and believes that Trusts should provide this data when requested.

The second stage: the Health Service Ombudsman

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

Response:

We agree that the work recently published by the Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England ["My Expectations for Raising Concerns and Complaints"] clearly defines universal expectations for what good complaints handling should be like. It has made clear what is required of organisations in respect of complaints handling, and now informs CQC's inspections.

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

Response:

The Parliamentary and Health Service Ombudsman will be responding separately to these issues.

Professional regulators and complaints

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

17. We welcome the willingness of the GMC to review its practices and investigations to ensure that they adequately support registrants who genuinely raise patient safety concerns in the public interest, and protect them from retaliatory action. Such a review must have as its primary purpose the establishment of an open reporting culture. (Paragraph 103)

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

19. Linking together professional regulation, system regulation and the complaints system is essential. Progress towards this goal is another issue that our successor Committee will need to monitor in the next Parliament. (Paragraph 105)

Treatment of staff raising concerns

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

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

Response:

On the 11th February 2015, the Secretary of State for Health accepted in principle all the recommendations set out by Sir Robert Francis QC following the *Freedom to Speak Up Review*. In his report, Sir Robert confirmed the need for further change in the NHS after hearing shocking stories of people's lives being destroyed because they tried to do the right thing for patients, people losing their jobs, being financially ruined, brought to the brink of suicide and family lives being shattered.

However, we know that many staff do feel supported to raise concerns about patient care with many dedicated managers going out of their way to address those concerns.

The only way we will build an NHS with the highest standards is if staff who raise concerns about patient care always feel listened to if they speak out. The message must be that bullying, intimidation and victimisation have no place in our NHS. On the 11th February, the Secretary of State for Health wrote to all Chairs of NHS

Trusts in England, asking them to work with Government to eradicate the bullying and intimidation and victimisation that Sir Robert has described in his report and outlining the importance of a culture where staff feel able to speak up about concerns without fear of repercussions.

Sir Robert's recommendations set out 20 principles and a programme of action to help foster a culture in the NHS where people feel free to speak up about unsafe care. The report calls for local accountability for changing culture, backed by the national role of the system regulators to offer oversight and guidance. These 20 principles that providers of NHS services and regulators are asked to focus on are grouped into five themes:

- Culture Change;
- Better handling of cases;
- Measures to support good practice;
- Particular measures for vulnerable groups;
- Enhancing the legal protection.

The Government has already taken steps to protect NHS staff, for example by enshrining the right to speak up in staff contracts, and amending the NHS Constitution to highlight and make clear the rights and responsibilities of NHS staff and their employers in respect of whistleblowing. We support staff in the NHS and Social Care via a free, confidential and independent helpline which has recently published refreshed NHS and Social Care Whistleblowing guidance. It is clear, though, from the Freedom to Speak Up report that there is more to do.

Sir Robert Francis QC has listened carefully to the testimonies of many whistleblowers with both good and bad experiences. The recommendations in his report set out measures to ensure support is available for staff, so that those who do raise concerns in the future can do so without detriment or suffering and their contributions to improving patient care can be valued and celebrated.

As the Freedom to Speak Up report indicates, the issues faced by historic whistleblowers can often be complex. Many cases have already been considered by the courts and the Government's view is that there can be no general basis for reopening cases that have been through a legal process. However, Sir Robert does make recommendations on the specific matter of support to find alternative employment in the NHS. He sets out the principle that where an NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.

More specifically, he proposes a support scheme for NHS workers and former NHS workers whose performance is sound and who can demonstrate that they are having difficulty finding employment as a result of having made protected disclosures. The Government is currently consulting on the implementation of the principles and actions set out in the Freedom to Speak Up. Furthermore, the Government has brought forward legislation to protect whistleblowers who are applying for NHS jobs from discrimination by prospective employers.

ISBN 978-1-4741-1695-4