HOUSE OF COMMONS

Public Administration Select Committee

Oral evidence: NHS Complaints and Clinical Failures, HC 886

Tuesday 10 February 2015

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Written evidence from witnesses:

- Katherine Murphy, Chief Executive, Patients Association,
- Katherine Rake, CEO, Healthwatch England,
- Peter Walsh, Chief Executive, Action against Medical Accidents (AvMA).

- Dame Julie Mellor DBE, Parliamentary and Health Service Ombudsman,
- Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission (CQC)

Watch the meeting

Members present: Mr Bernard Jenkin (Chair), Mr Nigel Evans, Paul Flynn, Mrs Cheryl Gillan, Greg Mullholland.

Questions 155-267

Examination of Witness

Witnesses: **Katherine Murphy**, Chief Executive, Patients Association, **Katherine Rake**, CEO, Healthwatch England, and **Peter Walsh**, Chief Executive, Action against Medical Accidents (AvMA), gave evidence.

Q155 Chair: Welcome to this further evidence session on the question of the investigation of clinical incidents in the health service. I am very pleased to welcome three new witnesses. Please could each of you identify yourselves for the record?

Katherine Rake: I am Katherine Rake. I am the Chief Executive of Healthwatch England.

Peter Walsh: I am Peter Walsh. I am Chief Executive of the charity called Action against Medical Accidents.

Katherine Murphy: I am Katherine Murphy, Chief Executive of the Patients Association.

Q156 Chair: Thank you all for being with us. Can I say that today is a particularly good opportunity to hear from representatives of patient groups? We have already heard

informally from people with direct experience of the complaints system in a private seminar. If you want to send us emails, or tweets including our own Twitter name @CommonsPASC, we will pick up your comments. We might not be able to use them today, but they will certainly feed into our understanding.

We are conducting very much an exploratory investigation. If you disagree with each other, please say so, because we want to hear what each of you has to say and we want to get an understanding. We will ask brisk questions. If you can get to the point in your answers as quickly as possible, that is very helpful for us, otherwise I may have to pull you up, because we have limited time. To start with, in summary, how effective does each of you think the NHS is in its current approach to investigating untoward medical incidents?

Katherine Murphy: Thank you for inviting the Patients Association to give evidence. From the Patients Association's point of view, from listening to patients, their relatives and carers on our helpline, when a patient wants to complain, they want to do it for the right reason; they want to make sure that learning happens so that their experience is not experienced by anyone else. Patients and their relatives tell us that the complaints system is too bureaucratic, it is complex, it is confusing and it very often adds to the pain and to the grief that patients are already suffering.

Patients tell us that it is very time-consuming; it is difficult for them to speak to the person who they need to talk to. There is no single access point to make a complaint and, very often when people complain, it takes a very long time for them to get an outcome.

Peter Walsh: I agree with all of that. I will try to add to it rather than duplicate. At AvMA, we get thousands of some of the most serious issues, medical accidents and patient safety incidents. They may be complaints, they may be potential claims or they may be people, as Katherine says, who simply want to stop the same thing happening to someone else. The current system is terribly inconsistent. We see examples of good practice, but we also see examples of very poor incident investigation.

The most common problem that we see is the lack of proper engagement and involvement with the patient or their family from the very beginning. To give you an example, we have seen very comprehensive, in many respects, investigation reports, very thick. Some of them make a number of important recommendations, but we have actually had cases where the patient or, in the case of a death, the patient's family had not even been informed that an investigation was being conducted. Most opinion agrees that to be effective, investigations should involve the patient or the family from the very beginning. They should be involved in setting the very terms of reference of an investigation, and they should have the opportunity to reality-check some of the evidence as it progresses, otherwise investigations can go down completely the wrong track. We have had examples of where NHS trusts have delivered this voluminous report to a family, thinking they are doing them a favour in sharing it with them, and actually when the family looks at it, they see that it is full of error, it is full of assumptions and they have not been rigorously tested all along.

To make that a reality, patients have to be empowered. Even the most well educated and normally confident people, when beset by a tragedy in medical terms, find themselves disempowered. They need specialist advice and independent support through that process. The current system of independent complaints advocacy, we believe, needs radical transformation, consistent standards and ideally to be situated in a local one-stop shop,

ideally the local Healthwatch, so that people can access it easily. Also, there needs to be a more specialist tier of advice, when one bears in mind that the NHS has vast resources at its disposal—clinical, legal and administrative. The patient or the family, in order to engage on anything like an even playing field, needs well informed specialist advice and support. That need was acknowledged by Robert Francis in his inquiry.

Some of the biggest pressures we find are that NHS trusts do not have adequately experienced and qualified staff to actually conduct robust investigations. If you look at the salary grades, even, of complaints staff and other staff who are given the responsibility of carrying out investigations, they are very inconsistent, sometimes on administrative scales. These are people who have to deal with management at the highest level to try to produce an objective investigation and with very senior clinicians in very high-pressure situations, so those are some of the pressure points that we experience on a daily basis.

Chair: That was a very long answer, but it was a very useful one. Thank you very much for that.

Katherine Rake: One of our big concerns is about how low public trust and confidence is in the complaints system and what that means as a result. Our research shows that only 40% of people who have a concern or complaint actually raise that concern or complaint to a member of the health service. That means that we estimate that we lose about 250,000 incidents a year, which equates to a complaint every two minutes that is being lost, because trust and confidence are so low. People fear for the repercussions on their care, which is particularly important where care is quite personal, for instance within GP practices or within a social care setting. People do not get the advice and support that they need to raise a complaint, and people are not confident that their complaints will be taken seriously and that learning will happen as a result. It is not surprising that they are not confident, so again from our research we find that fewer than half of those who do complain ever get an apology. That just cannot be right.

I was speaking last night to somebody who had raised a complaint and was at the end of what she described as a "three-year slog" to get through the complaints system. She said to me it was like she was saying something dirty or wrong, the defensiveness was that high. It was about her mother who had experienced a dislocated and a fractured hip, who subsequently died. It took her a full year to find out that she had had a fall in the care home and another year to find out that she had actually experienced three falls. The case really highlighted to me that this is not just a problem of clinical failure; quite often there is basic administrative failure and a catalogue of errors that people are experiencing across health and social care, which is one of the reasons why we have called for a unified system that brings health and social care complaints together.

However, if we were to get the complaints system right, we know that more people would say what is currently unsaid and would bring their concerns and complaints to the fore, so 84% of us would be more likely to raise a concern or complaint if we knew it would have a positive impact on the services received.

Q157 Chair: You mentioned the need for a single portal for complaints. At the moment, we have quite a number of bodies, agencies and organisations that might investigate a major incident. How good is the understanding of the ordinary member of the public who wants to raise a complaint about where to complain? I am getting head shakes all around.

Katherine Murphy: It is impossible. The vast majority of people have no idea where to go to raise a concern. Most people, when they want to genuinely raise a concern, are met with defensiveness very often, from wards and departments, so they are not encouraged to raise

their concern. The vast majority of people do not want to make a formal complaint; they want to raise a concern, so that nobody else experiences what they have had to experience. Nobody is given information on how to complain or where to complain, so there needs to be much more awareness about complaints and how to make a complaint, and it needs to be made much more simplified in terms of how to raise a concern, both in primary care and in the acute sector.

Peter Walsh: It is a very confusing landscape, and the concept of a single portal has been discussed a number of times over the number of years that I have been working in health policy. In my experience, people have almost always come to the conclusion that, whilst there might be some merit in some kind of easier access to different complaints investigations, far more important is the issue that a couple of us have raised already, which is access to properly well informed, independent advice and support in navigating the system and in actually pursuing some very difficult terrain in terms of complaints procedures. That has not been addressed. If there were properly resourced, easily accessible independent advice and advocacy services, that would be the single most important thing that could be done to help people get to the right place. It is a very grand and ambitious plan to create a single portal, and I think we ought to start at basics, in terms of empowering the patients and families through proper advocacy and advice first.

Katherine Rake: There are in excess of 70 organisations involved in any individual's complaint. No wonder the public finds that bewildering and confusing. Our very experienced researchers took a number of weeks to establish the number, and it is 70. This is not a system that was designed; it is a system that has grown piecemeal over a period of time. From the public's point of view, whatever the question was, 70 cannot be the answer. We need a simple system that is easy to navigate.

We need a bit of both: we need a single portal but we also need "no wrong door" so, wherever somebody flags a concern and complaint, they can be certain that that concern will be listened to properly and resolved as locally as possible, and also that the learning will be taken from it. The health and social care system is at a vast scale, and people need to be able to go wherever they need to go in order to raise a concern or complaint, and have a single named complaints handler. It is up to the complexity of those organisations. Hopefully we will get a simplification—that is one of the things that we are calling for—but in the meantime, it is the duty of those organisations to do the hard work to add together where that complaint needs to be resolved, rather than the individual themselves.

Q158 Chair: Do any of you have any evidence that NHS bodies themselves do not understand where complaints should be held and that people get pushed around from pillar to post?

Katherine Rake: We have certainly had evidence from professionals—from experienced nurses who have had to raise complaints about their own care, for example—who said that this was the first time in their lives that they felt totally on their knees in front of the complaints system. Certainly we have had that evidence, so the confusion is widespread.

Peter Walsh: I also think that what clouds people's minds sometimes is things they have heard or notions they have heard around no-blame culture, non-punitive culture and so on, which are well intentioned but, in the context of investigations and access to different types of investigations, can cloud the issue. For example, where this manifests itself most commonly—we see it quite a lot—is in people's attitudes if the incident under

investigation or under consideration might lead to disciplinary action, professional regulatory action or indeed legal action.

There is a very inconsistent approach taken to this. Last year, we achieved our goal of getting the DH to issue clear guidance to the effect that the NHS complaints procedure should be open to anyone, irrespective of whether they have a potential negligence claim, for example, or even if they are pursuing a complaint, because the complaint is looking at very different issues. Whilst that has been achieved, we have the ludicrous situation whereby the ombudsman is still giving out advice to people to the effect that, if they are taking legal action for criminal negligence or considering doing so, she cannot investigate. That is wrong; it is a misinterpretation of the existing regulations and it is disingenuous. It means that we have this ironic situation where the NHS and the Department of Health are saying that you have an absolute right to an NHS complaints investigation; however, the ombudsman might turn around and say, "Well, actually, go away and sue the people first, and then we will consider whether we are going to allow your complaint to be investigated."

Q159 Chair: This touches on two conflicting strands of thought. One is about complaints and untoward incidents generating investigation without blame, and the other this notion of accountability, which seems to be attached to the idea of blame. Can we have both or are they in conflict?

Peter Walsh: We need to distinguish between the two types of investigations we are talking about. An incident investigation designed primarily around learning should indeed not be starting with seeking to apportion responsibility, accountability and all of those things. It is about establishing root causes and learning to help prevent the same thing happening again. A complaint investigation, however, may well start off on the basis of, "We think someone is to blame, and that is the basis of our complaint", so it has to address those issues.

Q160 Chair: Can I just explore that for a second and bring in the other two? Very often, MPs get a lot of these kinds of complaints, but very much accompanied by "I don't want to blame anybody; I just want to make sure this doesn't happen again." We call that a complaint. We might as well call a spade a spade; it is a complaint, but it is not necessarily seeking blame or even direct redress. What there seems to be a lack of is an ability to establish the facts of an incident quickly and early, on the basis of proper evidence and a proper investigation, even before a complaint is made. You are all nodding.

Katherine Murphy: That is what the public want. They want the facts to be established. They want to know why something happened and how it happened. More importantly, they want to know exactly what is going to prevent the same thing from happening again. They want to have evidence that learning has come out of that.

Chair: You are all agreeing, so I will just move on, unless you have an extra point.

Katherine Rake: It is just to say that there are two things that people want. They do want personal resolution; they want to know what happened in their individual case. If there was a negligent professional, they also want to make sure that that person's practice is changed for the future, so you do need to attribute in order to secure personal resolution for people. I also think that the system learning needs to happen.

One of the things that we know is that it is a very easy sentence for people to write, "We have embedded the learning within our practice." You can see it in all sorts of quality accounts. It is very easy to write. We have a number of Healthwatches now asking to see the evidence, and it turns out that it is much more difficult for those trusts to actually demonstrate how that learning has been taken on board in their local culture. Critically, if an incident has happened in one NHS setting, it is very likely that the learning should be shared right across the NHS, and that part is also absent at the moment. I wonder whether personal resolution—personal, compassionate, swift resolution, a swift establishment of the facts and an apology when something has gone wrong—needs to be kept separate from some of that learning. They are clearly interconnected, but they probably do need to be two separate processes.

Peter Walsh: Very quickly, Chairman, there is a great body of evidence now to show that, if investigations are conducted well early on, compassionately and honestly, it reduces the likelihood of complaints or litigation.

I would just like to bring the Committee's attention to a very useful document that goes right to the issue that you are asking about, Mr Chairman, which is the National Patient Safety Agency's incident decision tree. That articulates, in a very straightforward, common-sense manner, that an investigation should, of course, be objective. An incident investigation should not start off with trying to apportion blame; however, it recognises that the facts, as they come to light, may indicate that different things need to happen, such as holding people to account and protecting patients.

Q161 Chair: It is interesting that, in our evidence from the Air Accident Investigation Branch, which we have taken an interest in, we have found that there is a determination not to apportion blame in the investigation, but also a determination to involve relatives of those who have been killed in an air accident or those who have been injured to keep them fully informed of the investigation. How is this compatible with making people accountable for outcomes?

Katherine Murphy: It is very easy to come up with recommendations and actions. As Katherine said, it is much harder to demonstrate that you are carrying out the recommendations and actions. That is where perhaps accountability should lie. I also think that it is really important that family and relatives are kept informed and are involved. Patients and the public deserve an honest and compassionate investigation.

Q162 Chair: Moving on a bit, how do those working in the NHS regard your organisations rampaging over their turf, finding fault with them, and turning over stones and finding things underneath?

Katherine Rake: We have found a genuine desire to learn amongst certain organisations and, amongst others, huge defensiveness. You have the full array there. There is a major issue about consistency, and indeed about the standards of complaints handling that is currently undertaken. We have a duty to seek answers to some of the very simple questions the public ask, which are questions like: is complaints handling nationally better today than it was six months ago or a year ago? Chairman, we simply do not know. There is no national data on the quality and patient satisfaction around complaints handling. There is an enormous gap there. The drive for improvement needs to be set and driven at the national level.

Q163 Chair: Hang on; there is survey data, is there not?

Katherine Rake: It is very limited. It is very limited about patient experience of complaints handling. It is very inconsistent and very limited in true quality—we have some information about the quantity of complaints, but very limited understanding about the quality of the complaints handling and indeed the nature of the complaints underneath it. That is national learning.

Q164 Chair: Who oversees that? Who is responsible for overseeing that?
Katherine Rake: That is also a very good question, to which we continue to seek an answer. I am not sure there is a simple answer.

Q165 Chair: Is that not a job for Healthwatch England?
Katherine Rake: It is not a job within our current statutory remit. It is a job that we would be interested in discussing, but it is not a job within our current statutory remit. Ultimately, there is a responsibility on the Secretary of State, without a doubt, to oversee this, and there is a responsibility in the commissioning cycle to make sure that high-quality standards on complaints are part of the commissioning cycle. There is obviously a responsibility on providers to make sure that they are delivering to standard, and we have gaps at all of those levels.

Q166 Chair: You are saying that there is nobody with overall responsibility for overseeing the quality of complaints.
Katherine Rake: No.

Peter Walsh: Our perception also is that the system has become ever more fragmented, and it has actually been quite illuminating being involved in some of the discussions of the various stakeholders in response to the Clwyd-Hart review of complaints, for example, as well as the Staffordshire one. You will speak to one agency, say NHS England, and say, "We really would like this done about complaints"—for example, national clear guidance on delivering the NHS complaints procedure—and they might say, "Well, that's not us". You go to the CQC, and the CQC will say, "We can inspect and have a look at the quality of complaints handling and how it conforms to our regulations, but it is not our role to actually do the improvement work", and then you have the Department of Health and the other regulators. It is very confusing, and the system would be helped if it was clarified who had direct overall responsibility for holding the ring on investigations.

Q167 Chair: Of course, the National Patient Safety Agency used to have responsibility for this, in some respects, and they were put into NHS England. There is a lot of work going on to develop that capability within NHS England. What do you think about that?
Katherine Murphy: There is work going on, and the Patients Association is working with about 60 or 70 trusts and Clinical Commissioning Groups around the country, using our standards and our survey. There is some work going on, but it is not enough, and it is certainly not quick enough for the public to have any confidence in the system. One of the biggest issues with complaints handling in the NHS is that it is not given the priority that it should be given. Every complaint that comes into the NHS should be seen as a story to tell and should be seen as a learning opportunity, and it is not.

Q168 Chair: You would not trust NHS England to be the ultimate authority to oversee this process anyway.

Katherine Rake: There is an issue about mixing of roles, potentially. One thing to say about NHS England and all the reforms is that they have a responsibility on primary care complaints, so they are resolving some complaints and seeking to resolve some complaints.

Chair: As they should.

Katherine Rake: As they should. Quite how you oversee your own quality—there may be a danger.

Chair: The same applies to CQC.

Katherine Rake: The CQC situation is slightly different but, for NHS England, given that they have some direct complaints resolution, they would effectively be marking their own homework. There is an element of the need for a body that is clearly commissioned to focus on experience, and patient experience as part of that, and to be solely holding on to whether the resolution is working from a patient's point of view. That is the thing that I think is significantly absent at this stage.

Q169 Chair: Is this a role for PHSO, which they should be developing?
Katherine Murphy: I think there was a desperate need, and the public deserve it, for a totally independent body.

Chair: We will come to that later. I am just asking about PHSO.

Peter Walsh: I would say that PHSO has a very legitimate role in giving feedback and advice to the Department of Health and the NHS on its complaints handling. That is different from the role of holding the ring for effective development, delivery and support of good complaints systems. There are complications with NHS England, because of their role in complaints, but on the face of it they would seem to be the most logical agency to actually drive that co-ordinated approach to complaints across the NHS in England, coupled with the role of the CQC, of course, which is more of an inspection, monitoring and quality role. Is the NHS actually doing what it is meant to be doing? Certainly someone has to be responsible.

Q170 Chair: In summary, what do we think about the capability of the CQC and PHSO to investigate clinical incidents?
Peter Walsh: Currently, CQC is not set up to investigate clinical incidents. PHSO is, of course, but only in the context of where a complaint has been made, and we will be discussing later whether there are other sorts of investigations that a central independent agency might be well placed to do. They do struggle. There have been problems. They have increased the volume of the complaints that they are investigating, but with no additional resource. There is a worry that quality has been compromised in this move towards, quite rightly, investigating more complaints.

Katherine Rake: It would be fair to say that the new focus on complaints handling within the CQC inspections regime is to be welcomed. It is work in progress, without a doubt, but that focus is absolutely to be welcomed, not least because, as part of the Keogh review and the inquiry into Mid Staffordshire, the complaints systems in those hospitals that were in trouble have also been in trouble. So complaints and complaints handling are actually

incredibly good indicators of how well or how poorly a hospital is performing generally. That focus is to be welcomed.

The PHSO will only ever deal with a small number of cases, and this refers back to the point I was making at the beginning about the amount of data we lose in the system. The PHSO is currently receiving about 6,000 complaints of the 174,000 that are made overall. Let us not forget those stories that are not currently spoken. There also needs to be access to the concerns and complaints of people who, frankly, are exhausted by their experience and fearful. We do need to do much more. That cannot be the job of either the CQC or the PHSO. We need to do much more to reach out to those people to start to hear those stories in an informal setting.

A final point is that one of the pieces of research we did recently, which actually I found quite shocking, was that there is currently a permission within regulations for anybody to flag a concern and complaint within a hospital setting. We call them citizen whistleblowers or worried bystanders—people who spot something in a hospital that they just know is not right. They are not directly affected, so they are very well placed to raise those concerns. We FOI-ed all of the trusts across England and, of the 164, we only found 30 where we had sufficient evidence that they were properly handling those citizen whistleblower or worried bystander complaints. Where they did take them on, they were a significant number. It accounted for 18% of their overall concerns and complaints. It shows you that, if you send out a signal that you are a listening culture and an open culture, you will get more and more information and very valuable information, from which you can learn. The PHSO only ever deals with the formal end of this. We have to spread our tentacles out much wider.

Q171 Chair: This is my final point. It is a nonsense that, in one case I have had through a constituent, somebody should be told, "Oh well, the patient has not complained. You cannot complain, and so there will be no investigation." That is a nonsense, and it is still happening.

Katherine Rake: That is a nonsense, absolutely. Apparently, 134 trusts are not showing us the evidence that they are fully handling those complaints, which is simply not acceptable.

Peter Walsh: It is a fact, however, that in statutory rights terms you are only guaranteed an investigation if you do make a complaint. I think everyone in this room would probably agree that you should not have to make a complaint in order to get an investigation. Perhaps that is something that could be looked at: an obligation to investigate concerns, as opposed to necessarily making a complaint.

Q172 Mrs Gillan: I have long held the view that when the citizen interfaces with the state, it is usually a pretty unhappy affair, and all you are doing is reinforcing my prejudice, because it seems that we now have a system that is so complex that nobody really knows where to go to or how to have confidence that it is going to be dealt with properly. One of the things that I want to explore with you is how complaints are driving clinical change. I thought I could start off by hearing from all three of you whether you think that the current complaints system is successfully driving any clinical change and where you see the holes are. I do not mind who starts.

Katherine Murphy: I am happy to start. There are a number of trusts that are actually looking much more closely at their complaints. The Patients Association is certainly working with trusts that are undertaking complaints training, that are doing peer reviews and that are working with our complaints standards, so there are many trusts.

Q173 Mrs Gillan: When you say "many trusts", how many? What percentage of the trusts? It is obviously not all of them.

Katherine Murphy: It is a small percentage of trusts, unfortunately, and it is very often driven by an interest from the director of nursing or the director of patient experience. Unless there is a priority and an interest from within the organisation, complaints do fall as a very low priority.

It is driving clinical change, because trusts are telling us that they are looking closer and actually encouraging concerns. You will have nurses going around asking patients if they are okay, if there is anything that they want to talk about or anything that they want to raise a concern about. There are some trusts that are giving out information leaflets that people can complete if there is anything that they were unhappy with before they left the hospital. There are some trusts, but it is too small a number.

Q174 Mrs Gillan: It seems to me that there is no pattern.

Katherine Murphy: There is a huge variability in the service, and it is very difficult. You might have a department within a trust that is trying very hard to improve complaints handling, but the rest of the trust is not interested. It depends also on how interested people are at board level.

Mrs Gillan: Trusts do not actually even have a grip on which areas most of the complaints are coming from, so they are not even doing due diligence on their internal departments and seeing what is going on. There is a huge lacuna there, in other words.

Peter Walsh: We have to start by acknowledging that there is quite a lot of good practice out there as well, in terms of complaints handling. We get a slightly skewed picture in our charity, because it is usually when things are going wrong that people access specialist services like ours. However, even when there is a good complaints investigation, we find that the biggest challenge is that closing of the circle so that there are real clinical improvements to services and patient safety, and that is probably the weakest part of the system. Even when a complaints investigation comes up with very clear recommendations, actually monitoring the implementation of those recommendations and how they are playing out tends to get forgotten. People have done the job; they have responded to the complaint; it goes on to a shelf and sometimes they simply are not followed through.

Q175 Mrs Gillan: Let me just clarify this in my mind. The very thing that our constituents usually come to us to say is, "We don't want any compensation or anything. We don't want this to happen to someone else." You are saying that that very thing is actually what is least likely to happen.

Peter Walsh: I am not saying it is least likely to happen, but it is the most common problem we come across. Even when there has been a good investigation, implementing change is the next challenge for people. People think, "We've done the investigation. We've got the recommendations. Now whose responsibility is it to actually make sure we drive that improvement and change?" We need a more co-ordinated approach to that, a monitoring of that, which perhaps CQC could help do, actually looking at what recommendations have arisen and checking whether they have actually been implemented. It can be very fragmented even within a trust. Who is responsible for those recommendations, and then who is responsible, from outside, for independently assuring that change is actually taking place?

Katherine Rake: The simple answer to your question is not enough and not quickly enough. One of the reasons why they are not being used to drive clinical change in the way that they could is that there is substantial delay in the system, and we hear tale after tale of people failing to get a response, constant chasing and a feeling that the shutters have come down very fast, as well as being confused by where they might seek redress, so they are not quickly enough dealt with. The learning is not necessarily captured.

The other thing to say here is that, quite often when people have a concern and complaint, it does not just apply to one agency. It applies to primary care as well as secondary care, and it is about people's journey through the system, and how those agencies are coming together to learn together about why people's notes did not come through or about why medication was not properly noted. It is some of that very low-level administrative error that drives a lot of people's concerns and complaints, and there is frustration, from the patient's point of view, about why some of these fundamental basic things are not being put right.

In short, no, I do not think they are. The huge richness of that data is lost because people are not feeling confident to raise their concerns and complaints, and when they do, it is not clear that that loop is being properly followed or that the learning is fed back into the institution, or indeed that it is dealt with swiftly enough in order for that learning to take place.

Q176 Mrs Gillan: Can I just turn the question on its head? Have all three of you got examples of good practice? Is there one trust, is there one organisation, is there one part of the health service that stands out as providing a really good service from which we could learn?

Katherine Murphy: The Patients Association is working with a number of Clinical Commissioning Groups and trusts that are trying very hard to embark on a journey on complaints handling and are reaching out to those who complain. You will have directors of patient experience, directors of nursing, going out to the homes of people who have complained. There are Derby Clinical Commissioning Group, Somerset Clinical Commissioning Group, Bristol and the Nottingham trust. There are a number of trusts that we are working with, and we see that there is a change and an appetite to learn.

Mrs Gillan: That is encouraging.

Katherine Murphy: It is about sharing that good practice.

Mrs Gillan: That is right. That is why it is helpful to this Committee because, in our report, we can maybe point to those trusts as showing the way for others.

Peter Walsh: I cannot, right at this moment, remember specific names and examples of trusts, but certainly there are examples of good practice and we can send in information, if you like, following the hearing today, about where we have seen that.

Mrs Gillan: I would be grateful, because we need to take something positive from this, as well as all the negatives we have been hearing.

Katherine Rake: I have one example to remind ourselves that complaints are not just about acute trusts, but it is also really important we get this right in primary care. We had Healthwatch in West Sussex, which spoke to practice managers in the area with some

excellent examples of good practice. It is quite difficult in GP surgeries to handle complaints well, because it is very close and very personal, but one practice manager immediately responded "We love complaints. It's the way that we learn." We need to see that consistently across the piece.

Q177 Mrs Gillan: That takes me on to the very difficult question of people feeling empowered to complain. There is a timeliness about complaints, as they often occur after some time and with hindsight as to the patient's journey about which the complaint is being made, but there are also instant complaints whilst treatment is occurring. I understand that there were some stories from Which?, where people making a complaint felt very vulnerable and in fear of victimisation whilst they were still being treated. I think we all know how vulnerable people can feel when they are ill and unable to look after themselves. Do you find that your organisations hear from those people, and how would you recommend that we try to get rid of that feeling, which appears to be a tiny bit of a culture at the moment? That cannot be right. Many of the patient journeys could be improved, and the outcomes could be improved, if their voices were heard at an early stage.

Katherine Rake: There is a very human reality here, which is that, where you have a concern or complaint, you are often ill or you have been recently bereaved. Emotionally and physically, it can be a very difficult thing to do. It can make you feel very fearful and, because people do not have trust and confidence in the system, exactly as you say, they do not trust that their ongoing care will be unaffected. They need to have an independent place to go.

That is why today we have launched a report on the importance of complaints advocacy, by which we mean the independent support that people need in order to lodge a complaint. Everybody needs some support, because the system currently is so complex. It is almost impossible, unless you are an expert, to know where to go, but some people need quite a lot of support, in order to understand where to complain. Critically, what an independent advocate can do is ask them what kind of resolution they want: "What would be a good outcome for you?" By focusing at the beginning on what the patient wants, what the user wants at the end of it, they can help resolve it in a way that feels compassionate and feels supportive.

Currently, we hear too many cases of people being re-traumatised by the way their complaint is being handled, adding layer upon layer—insult to injury, as they say—on top of their original experience. It is really important that they have somebody to stand by their side and to explain to them what the process looks like, what it might deliver and what it might not deliver as well, so that they can be really clear as to what to expect and have somebody to support them through what can be a very long and complicated journey. That case that I was talking about earlier of the three years that that person had to wait in order to get a full resolution is not untypical.

Peter Walsh: So much of this is about culture—culture within organisations—and probably the biggest opportunity we have had for decades to change the culture, in respect of things going wrong in the NHS, is the duty of candour that the Government have brought in. However, to make that a reality and to bring about real cultural and behavioural change, there needs to be a huge investment in training, support and protection, which hopefully we will be hearing about tomorrow from Robert Francis, for staff in doing the right thing. We are not talking about easy territory here for staff, and most of all for patients, but for staff, we need to see a big investment in training to

understand how they should be dealing with concerns, and how they should do so with a sense of confidence that they themselves are not going to be criticised for sharing information with patients and doing the right thing.

Katherine Murphy: We certainly hear from patients who contact our national helpline about the fear of complaining in case their ongoing care will be compromised.

Q178 Mrs Gillan: That is really understandable, is it not? "I'm afraid to complain in case they take it out on me" is the thing. That leads me on, Mr Walsh, to what you were saying. There appears to be in the system, anecdotally—perhaps you can quantify it for me—a reluctance and a deterrent to clinicians reporting incidents, because incidents do not just come from patients and relatives, but they come from within the organisation. Do you think that that is fairly widespread, and how would we overcome that?

Peter Walsh: It is widely acknowledged that there is under-reporting of incidents. The National Reporting and Learning System is not used as much as it should be, although it has been increasing. Perhaps most critical to our consideration is reporting to the patients and the families, and that is the importance of the duty of candour. If that was implemented as it is intended, it would take away the need for so many complaints investigations and would mean the quality of other incident investigations would be so much easier and better directed from the very start. It would reduce the amount of litigation as well, in all likelihood. To make it happen, we have made a start with the regulations. We now need culture change driven by training, support and protection of staff.

Q179 Mrs Gillan: Would you agree with that?

Katherine Murphy: Absolutely. It is about the investment and the support of staff, and the availability of training so that staff feel able and empowered to speak out and to speak up when they are seeing something that they do not like.

Q180 Chair: Can I just chip in there? Who are we expecting to drive this? Who is leading it? Who is accountable for making sure it happens?

Peter Walsh: In terms of the regulatory side of it, it is of course the CQC. However, they would say they are the regulator; they will come down hard, hopefully, on organisations they find not living up to these standards. However, there is a bit of confusion in the system, to say the least, about who actually drives forward initiatives like training, support and real culture change across the NHS. I am meeting with NHS England later today to discuss that very topic. Together with the notion mentioned earlier of responsibility for driving forward complaints, patient safety needs to be more joined up than it currently is. People are looking over their shoulder, left and right, saying, "I'm not sure it is my organisation. It's someone else's."

Chair: In a word, your short answer is, at the moment, nobody.

Peter Walsh: A lot of people are doing small bits.

Katherine Murphy: A lot of people are doing small bits, but nobody is taking overall responsibility.

Q181 Mrs Gillan: The Chairman has made a very valid point. Would I be fair in saying that the complaints system, at the moment, is not driving clinical change either fast

enough or with a great deal of certainty? We are wasting a lot of the information that is coming in, so a lot of efforts that people are putting into making their complaints are not yielding the fruit that they should be. What would be your solution? Is there a one-stop shop that should be driving this?

Katherine Rake: There need to be solutions at a number of levels. Your analysis is spot-on, and unfortunately, the consequence of that is low public confidence, so you get a vicious circle. People do not feel able to raise their concerns or do not feel confident that they are going to be responded to, and you lose more and more evidence. I do think there needs to be a single line of accountability.

Peter is absolutely right that everybody has some responsibility, but it does not appear that anybody has overall responsibility for driving improvement—for capturing the learning and driving the learning across the system. But we also need to make sure that there is change in culture and that feedback is welcomed right the way through the health system. The classic case is that, to complain about your general practice, "Please ask the receptionist". What if your complaint is about the reception staff? That is a pretty big ask. You have to make sure that the culture is open and that you get support and recognise that people find it very difficult to complain. I do not think there is a single solution, but one of the things we need to stop doing is tinkering with the current system. We need to look much more deeply at a much more simplified system, which is one of the reasons we have called for an incoming Government, after the next election, to look at whole-scale reform of the complaints system. I think the time for tinkering has come to an end.

Peter Walsh: Three very short bullet points: independent advice and advocacy for the patients and families; training, support and protection for staff; and thirdly, robust and rigorous regulation, with CQC really forensically looking at how people are carrying out investigations and how they are meeting the standards relating to complaints. That way, you are approaching it from either end—encouragement, support, empowering of the patient and, ultimately, the regulator.

Q182 Paul Flynn: Mr Walsh, thank you for that summary there. Is there a need to reinvent the Community Health Councils in England?

Peter Walsh: Whether we physically reinvent the Community Health Councils is one thing. Getting back to something much more closely resembling Community Health Councils is probably what I would suggest is much more realistic and pragmatic. We have the Healthwatch system. I think Katherine would be the first to say it is not perfect, but it could be built upon and improved to get back to something very closely resembling the local Community Health Council. Independent complaints advocacy, for example, could be brought into the remit of every local Healthwatch, so that it became that local one-stop shop, both monitoring the system and providing advice and support to patients with complaints. That would be a big step forward, in our opinion.

Q183 Paul Flynn: Is there any evidence that the situation is better in those areas that still have Community Health Councils?

Peter Walsh: Wales is the only place that still has Community Health Councils. It is better in terms of people's ease with finding where they get their independent advice and support, and where it is they go to raise concerns or get involved in consultations about their local health service. It is no magic wand. Having a good Healthwatch, having a good

CHC, will not of itself improve the quality of the health service, but it certainly makes it easier for patients to exercise their rights.

Q184 Paul Flynn: Forward to the past is one way out. We have had a number of suggestions and a lot of evidence suggesting that we need a new kind of resource and a new kind of organisation. How would each of you see this? Is this the way forward?

Katherine Rake: Could I first of all take the point about Community Health Councils, and then I will talk about a broader system reform? Just to build on what has been said, the Healthwatch concept is actually, at its base, very similar to the Community Health Council concept, which is about having eyes and ears everywhere across the country, but we have a couple of things that actually create more power within the concept.

One is that we have a national body, and that national body, Healthwatch England, also has statutory advisory powers. We have used those just this morning to advise the Secretary of State on independent complaints advocacy. That did not exist in the previous regime. The other is that Healthwatch at a local level has a statutory seat on the Health and Wellbeing Board, so it is there to look right across the system, health and social care together, to challenge for improvement at a local level.

We have also been working very closely with the inspections, as they have rolled out. One of the things that we have been ensuring happens is that, when the inspectors leave town, Healthwatch is part of those quality summits and they can follow up on the improvement journey that those local trusts need to be part of. These are early days in the Healthwatch concept, but we do have more power than some of our predecessors, and the important thing is to give us all a chance to flex those muscles as we go forward. There are some very good examples, and the richness of the data we have is because of the engagement of many Healthwatches across the country in our work on complaints.

On the question about a new body, there is a risk that we add a 71st body here, and that clearly is not right. We need to look at simplification in the round and begin to take out some of this complexity, rather than add to it.

Katherine Murphy: The most important thing is that patients and the public have confidence in whatever the system is and that the NHS, the CCGs and the trusts use the information that they get to take on board learning from the patient's point of view, and involve and engage the patient at every level.

Peter Walsh: Whether it is a completely independent new body or a function embedded in an existing body, we certainly support the principle that there needs to be a central resource with an expertise in investigations that both could carry out completely independent investigations in some of the most serious cases, but secondly act as a resource for the rest of the system and drive up the quality of local complaints and other incident investigations.

Can I just say one thing in the proposal that was in the article by Vincent and Macrae? It had plenty of great ideas. We would strongly advise against, if such a function or agency was created, the result of its work—the investigations, the facts—being made legally privileged. That would be entirely inconsistent with the duty of candour that the Government has championed, to say, "Well, you can have a thorough investigation. You can have all the facts, but you cannot do anything with them."

Q185 Chair: I do not think that is quite the intention, if I may say so.

Peter Walsh: It would be the effect, if not the intention.

Q186 Chair: When the AAIB takes evidence in just such a way, they can produce a report that would result in a prosecution. All it means is that the actual evidence that it has taken itself is immune. It does not mean that there cannot be a prospect of prosecution arising from the report it produces.

Peter Walsh: With respect, it is a very different context in healthcare. Most of the aviation investigations are into near misses, in any case. In healthcare, you are dealing with well established principles and patients' rights. If you say that this new investigation is going to establish facts, but it is going to be privileged and not easily accessible for people to use in whatever way they see fit, the public will not have full confidence in it. The NPSA incident decision tree is probably the best tool to look at, which says that you can carry out an objective investigation, be just as thorough and as effective as the aviation industry is, but simply recognise that there are some things that might arise from the facts.

Q187 Paul Flynn: Do you think there is a danger of this issue becoming such a major one in the minds of those who are working in the health service that an atmosphere of fear and timidity is created, because they fear litigation? It will be something very similar to what the atmosphere is in America, and clinical decisions are distorted by the need to defend themselves from possible litigation.

Peter Walsh: If I can, I will start on that one. All the evidence, internationally and here, shows that, if there is openness and transparency, people are less likely to turn to litigation. Sometimes they will have to.

Q188 Paul Flynn: Where is that happening?

Peter Walsh: In the United States, for example. Insurers in the United States now try to insist and seek evidence that their clients, the healthcare providers, are proactively telling people when something has gone wrong, because they have, in their own interest, discovered that that will lead to reduced legal costs. That is something that has been borne out across the world. A lot of the thinking has informed the development of the duty of candour.

Q189 Paul Flynn: You do not think that medicine in the United States is more defensive, and that decisions are taken that are not always in the patient's interest, but are in the interests of the practitioners who are guarding themselves against future action.

Peter Walsh: There are rumours of so-called defensive medicine. What is one man's defensive medicine might be safe practice to another person. However, the simple fact that people are open and honest should not be seen by any clinician as something to be afraid of. The evidence shows that it is always the best thing for all parties. That is where we need the education and support for people: to understand that actually it is everyone's best interests to be open and honest.

Q190 Paul Flynn: We are all overwhelmed by the number of bodies involved in this and the complexity of this situation. Do you think all investigations into serious clinical failures have to be led by clinical experts for their outcomes to be respected?

Katherine Rake: I understand the drive to want clinical experts to be part of this, but I also think it needs to stand a common sense test. We need to get beyond this clinicians/public divide and actually make sure that we get a mix of both within all of this. Ultimately, the common-sense explanation of what happened and what is going to be done differently

needs to stand up to public scrutiny and needs to pass the Clapham omnibus test, so I think we need a mix in all of this, actually.

Katherine Murphy: I totally agree. The opinions of clinicians can be brought in when needed, but it certainly does not need to be led by clinicians.

Peter Walsh: I also agree with that. Clearly clinical involvement is absolutely essential, but it does not have to be led by clinicians; it can just as easily be by a layperson. What is absolutely essential is the quality of the clinical expert opinions and, for example, not simply relying on one single expert opinion, with no opportunity for the complainant to challenge or instruct that expert, as is the case to some extent with the ombudsman's investigations at the moment.

Q191 Paul Flynn: NHS England tell us that they are already working on a patient safety investigation branch. Have you all been consulted on this, and do you support it?

Peter Walsh: We were talking about this earlier. Certainly the first I heard about it—and my trustees are involved in various patient safety expert groups of NHS England—was in the context of your evidence last week. It is something that I welcome, because building up that resource and expertise has got to be welcomed, but it would be good if it was taken a stage further. NHS England probably is not the best place for it, and something along the lines that you are considering as part of this inquiry—a centralised expert function or agency—would be the ultimate best place.

Q192 Paul Flynn: Are you suggesting that this is a politically opportunist wheeze by the Government to protect themselves from embarrassment, if you have never heard of it and suddenly it has been plucked out of the air?

Peter Walsh: I could not possibly guess why it has happened in that way—perhaps poor communication.

Q193 Chair: Why is NHS England the wrong place for the patient safety investigation branch?

Katherine Murphy: There is a conflict if it stays with NHS England.

Peter Walsh: NHS England is so closely associated with promoting the NHS and supporting the NHS to be doing the independent investigations. It acknowledges itself, if I am correct, in its evidence, that ultimately it probably is not the right place for it, but something is better than nothing, and it is good to hear that some work is being done about improving the central resource for supporting investigations.

Q194 Paul Flynn: Where is the right place? Katherine Murphy, your organisation had great respect, particularly when Claire Rayner was your president. I do not know what sort of percentage of patients you represent, because I think you would possibly be more accurately titled Aggrieved Patients Association. You see people who have had trouble, rather than the great majority of patients who have no problems at all. Do you think there is a situation of distortion? You represent those who, in most cases, absolutely have a genuine complaint to make, but your whole outlook is based on failure and tragedies.

Katherine Murphy: It is not really. Claire Rayner was our president and Robert Francis is now our president. We are very proud to represent the patients who come to us who actually have nowhere else to go, because there are many organisations that promote the good things that are happening, but there are so many people who, because of the system,

have absolutely nowhere to turn to, and they come to the Patients Association and we support them. The Patients Association does fantastic work in speaking out for the needs of those who are not heard anywhere else in the organisations or in the systems.

Q195 Paul Flynn: You had some harsh things to say about the Parliamentary and Health Service Ombudsman. Do you think they are justified, or do you see solutions that are utopian and obtainable?

Katherine Murphy: The Patients Association speaks out on what we hear on our national helpline. We act as a conduit for patients. Very often, organisations such as the Parliamentary and Health Service Ombudsman probably feel uncomfortable with what we have to say, but it would be wrong of the Patients Association to sit on that very valuable information and not get it to those who need to know. Since we published our report back at the end of November, we have had hundreds more people who have come to us who are absolutely desperate, because they have nowhere else to go.

Q196 Paul Flynn: I am very grateful for your answers. Finally, none of us can see what is going to happen after the election, but if this patient safety investigation branch is taken up by the next Government, is it something you see as a runner, and do you think it will encourage a more collaborative approach to clinical incidents?

Katherine Murphy: My plea would be that patients and the public deserve it. It needs to be absolutely truly independent and accountable to the Secretary of State.

Peter Walsh: We think there is great potential in it. Clearly there are a lot of complex questions to be answered about exactly where it would sit, how it would operate and what the criteria for it conducting investigations should be, because it could not conduct investigations into every serious incident in the NHS unless it was an absolutely enormous organisation. We would not want it, although we see great potential advantages in it, to end up disempowering local investigations. We want to improve the quality of local investigations in trusts and NHS bodies, as well as have a central resource for the more serious cases to drive improvement.

Katherine Rake: There is merit in it for certain, but not as a 71st body, so I do think that this needs to be part of the broader reform and the broader look at the complexity of the system. There are three simple elements that need to come into place, following the design principles that Vincent and Macrae set out about independence and authority. Those design principles are good. We need a proper system of local resolution with local support. We need a decent place to appeal, across health and social care—so an ombudsman for health and social care—and then we need a national body that captures the learning, drives improvement, monitors quality and does those investigations. Actually, if we could go from 70 to three, or three layers at least, that would be a huge step forward from the patient's perspective.

Q197 Greg Mulholland: Following straight on from that, there is broad agreement between the three of you and the Committee on simplifying the landscape. The simple question, then, is this. You in particular, Katherine, have talked about the 70 different layers, etc.; we want to make some concrete suggestions. Which of those layers—what bodies—should be abolished, rolled into one, merged or done away with to end up with this much cleaner, clearer system with lines of accountability?

Katherine Rake: We have on the table, as you know already, a proposal to merge the ombudsmen, so that would be a place to start. The cases that we hear are often a complex

mix across health and social care, so there is a very strong case for having a single ombudsman for health and social care. That is a place where we would start.

Peter Walsh: You could look at the number of regulators. CQC has been born again, and we have great hopes for it continuing its improvement from what was a fairly low base. However, there is real value that is added by Monitor, the NHS Trust Development Authority and a little known organisation aligned to NHS England called the NHS Institute for Innovation and Improvement, but the actual roles and functions of these organisations often overlap. There is scope for modernisation and trimming down, I would have thought.

Greg Mulholland: A bonfire of the health quangos, perhaps.

Peter Walsh: A realignment, a reform, but a reform to a more simplified system, as opposed to adding more and more tiers. What we have to be careful with if there is a new agency, or a new function in another body of investigation, is that if it has its investigations legally privileged—I hope it will not—it will set up a situation where any independent adviser of a complainant, a family or a patient who had had a problem would have to advise them, "Don't rely on that route, because you cannot do anything with the information it is going to look at". You would be forcing people down the complaints route, which would be a missed opportunity, because an investigation, well done, timely, open and honest, can greatly reduce the number of complaints that end up at the ombudsman's door or end up as civil claims.

Q198 Greg Mulholland: Can I ask—obviously the general election is just a few weeks away now—why no one, either on the political side or in the health sector side, seems to be getting a grip on this complexity and the frustrations that it seems just about everyone feels?

Katherine Murphy: I am sure every MP will have constituents coming to them talking about complaints within the primary and the acute sector, possibly because nobody is actually paying any attention to the whole complaints system. It is such a low priority.

Katherine Rake: I do not doubt the intent of many people to get this right. I think that there is a big gap between intent and reality here, not least because of local interpretation of the rules, hence the case I brought up earlier about a citizen whistleblower. The intent is set out in regulation to receive concerns and complaints from third parties. It is just not being delivered at a local level.

The system is currently mind-boggling. People are a bit lost and do not know where to start. It has been put in the "too difficult" box for a very long time. We need some root-and-branch here; we need to really simplify. To do that is going to take some time, and that journey needs to start with an incoming Government after the next election. The intent is good. People have recognised the value, but people are overwhelmed by the current complexity and struggling to find a way through it. That is where I think works like yours will be incredibly helpful.

Q199 Greg Mulholland: This is the final question from me. The first thing is that I hope you realise that this Committee takes this seriously and certainly wants to do what we can to address this, but we also believe that the ombudsman system should have a major

overhaul, moving to a citizens' ombudsman service that becomes the first line for complaints for citizens with any complaints about any public sector.

Part of that reform could easily involve the central citizens' ombudsman service working with other qualified expert bodies to look at clinical complaints and to use those where appropriate, where the complaint clearly needs it—it does not in all cases. Do you think that that could be a way of simplifying the landscape? It would also ensure—this was the point that you made, Peter—that we do not forget that we need to have good independent local complaints as well, due to the sheer number of complaints in the NHS. That could easily be done by having regional ombudsmen responsible for that in counties.

Peter Walsh: Speaking for my own organisation, we certainly agree on the need for reform of the ombudsman. If it is to be one citizens' ombudsman, we would strongly argue that there needs to be a very specialist branch of it for health and social care. In terms of its relationship to the potential new body, there is a difficult tension there, in that the ombudsman is looking at different issues and carrying out different types of investigations—complaints on clinical incidents, which is what we understood would be the main remit of this other agency. We have to have that distinction between the types of investigations. However, as we said in our submission, we think that one of the benefits of a new agency would be the creation of a bank of clinical expertise, which could be called upon, for example by the ombudsman in her investigations, because, as we have already discussed, good-quality clinical input is absolutely essential to any of these complex clinical investigations.

Q200 Chair: I have two very brief last questions, unless you want to add something very briefly. The first one is, Katherine Murphy, you said it is important that any new body should be directly answerable to the Secretary of State, rather than at arm's length. Why is that?

Katherine Murphy: The public will need confidence that, from an accountability point of view, somebody is ultimately accountable for what happens. That is from a reassurance point of view for the public.

Q201 Chair: Do the other two agree with that?

Peter Walsh: I am not absolutely sure. I agree with the principle of accountability but, on whether a body might be more independent if it is at arm's length rather than reporting directly to the Secretary of State, you might say that there is a difficulty with a direct relationship to the Secretary of State. These are difficult issues. We do not have any one answer for it.

Katherine Rake: If you were to get the kind of whole-scale reform that we are talking about that would be subject to a Green Paper or White Paper, I would suggest, actually, that we ask the public where they would get most reassurance from and take our lead directly from them. Propose different models within the consultation and ask for public views on that.

Q202 Chair: The second point I just wanted to ask about is that Peter Walsh is obviously very clear that he does not want any kind of immunity for clinicians or whistleblowers, or for anybody who is going to a body of that nature, in the way that, for example, independent accident investigation operates in maritime, air and rail. Do the other panellists agree with that?

Katherine Murphy: Openness and transparency are very important.

Chair: Is that a yes or a no or a not sure? It is a dilemma.

Katherine Murphy: It is a dilemma.

Katherine Rake: The need for individual resolution needs to take primacy. That would be my view.

Chair: What does that mean?

Katherine Rake: We need to have a body that delivers resolution for the individual, including a full disclosure of information on what happened in that individual case. That takes primacy.

Q203 Chair: There is no question that full disclosure about the investigation would be made. It would just enable the body to conduct the gathering of evidence in a privileged space. Would that be a problem for you?

Katherine Rake: I am not sure I know enough about the proposed design. If there was full disclosure and then an ability for the individual to act to seek the resolution that they then wanted on the back of that evidence, then I would be comfortable with that.

Chair: I can see there is a public confidence issue from all three of you—a doubt.

Q204 Mrs Gillan: I was pleased to hear that patient satisfaction with the NHS has risen from 60% to 65%, in a recent survey. I want to try to get a grip on the size of this problem. Of the people who are treated in the NHS, what percentage of those people end up either in the complaints procedure or wanting to complain and not knowing how to?

Katherine Murphy: Very few people who actually have a genuine complaint end up complaining, because it is so complex and it is so bureaucratic. We only hear from a tiny percentage.

Q205 Mrs Gillan: What is your best estimate, from your experience?

Katherine Murphy: I think we probably hear from one in every 25.

Peter Walsh: It is less than 1%.

Katherine Rake: There are 174,000 formal complaints, and our estimates are we are missing about 250,000 incidents, through failure to report. That is our best estimate, so that is a complaint every two minutes that we lose.

Q206 Mrs Gillan: What percentage is that of all the people who are treated within the NHS? Is it 1%?

Peter Walsh: It is absolutely tiny. There are two statements. One is that it is tiny, and it is mostly tiny because most of the care in the NHS is good, I am glad to say.

Mrs Gillan: I was trying to elicit a positive.

Peter Walsh: It is a tiny percentage, but I absolutely agree with both Katherines that there is a black hole, a whole group of people, who we are not even seeing, because it is too difficult; it is too scary. There are even those who get worn down by the system, who get in the system and perhaps get as far as asking the ombudsman, but are worn down.

Mrs Gillan: You think that is about 250,000 people.

Katherine Rake: They are the people we are losing, yes. The one thing I would say is that satisfaction levels are not a very good measure overall of people's experience. We have done some work around satisfaction and asked a series of follow-on questions about whether people have experienced poor care and how involved they felt. While we also found high levels of satisfaction when you ask that question, if you ask about experience of poor care, we were polling about one in three saying that they had had some experience of poor care within the NHS.

Q207 Mr Evans: I get a sense that the vast majority of my constituents who get healthcare in Lancashire are very pleased with the care that they get, but, for the relatively small number of people who do complain, it is a personal tragedy, particularly when it ends up in death or indeed immobility or serious ill health afterwards. With the investigations that take place at the different levels and the confusion that exists, even articulate people find it difficult, never mind an elderly frail person who wants to make a complaint. How many at the end of the process do you get a sense think there has just been a cover-up and that the default is stonewalling—wearing down, I think you said, Peter, which I think is a perfect example—and of course the trauma of going through reliving the misery that their relatives and loved ones went through? Cover-up, stonewall.

Katherine Murphy: We certainly hear from patients and the public who have had that very experience and have described it just like you have done. They have been worn down by the process. These are very often people who have been bereaved and traumatised, and that whole episode has compounded the grief.

Peter Walsh: We have come across some pretty horrendous cover-ups and they do happen still. Hopefully the duty of candour will address them, but I would say far more commonly, people's experience is that they have been the victims of incompetent, poor-quality investigations. They have not been listened to, they have not been empowered to inform that investigation, and they end up being the victims of that, with all the feelings of frustration and anger that that leaves them with.

Katherine Rake: I certainly think, when people make a formal complaint, their sense is that bureaucracy takes over and they get forgotten as part of it. We have certainly heard from people who were not natural conspiracy theorists who ended up being so. Often, as Peter says, it is the result of poor administration rather than active cover-up, so keeping a really close focus on compassionate and swift resolution, rather than process taking over, is where we need to go.

Chair: Thank you all very much indeed. You have been on the witness stand for quite a long time and given us an awful lot to think about. Thank you very much indeed. Could we have our next two witnesses, please?

Examination of Witnesses

Witnesses: **Dame Julie Mellor DBE**, Parliamentary and Health Service Ombudsman, and **Professor Sir Mike Richards**, Chief Inspector of Hospitals, Care Quality Commission (CQC), gave evidence.

Q208 Chair: Welcome to our two new witnesses. Can I ask each of you to identify yourselves for the record, please?

Dame Julie Mellor: Julie Mellor, the Parliamentary and Health Service Ombudsman.

Professor Sir Mike Richards: Sir Mike Richards, Chief Inspector of Hospitals at the Care Quality Commission.

Q209 Chair: Thank you both very much for joining us. You have both been the subject of a certain amount of discussion already this morning. Is there anything either of you particularly want to say, or will you deal with it as we go through our questions?

Professor Sir Mike Richards: I am happy either way, Chair.

Chair: We will just carry on then. Paul Flynn.

Q210 Paul Flynn: Katherine Rake just described this situation as mind-bogglingly complicated. Dame Julie, could you un-boggle it for us and explain what powers of investigation your office has and when you started to look into clinical investigations?

Dame Julie Mellor: I can indeed. I would just say that I very much supported what Peter Walsh was saying about the need to disentangle the three elements that we are looking at here. One is the support and advocacy for individuals. The second is the complaints system, of which we are the final stage. The third is the investigation of serious incidents in order to learn and improve patient safety. We need to try to disentangle those, in order to have a sound debate.

Our role, as the independent ombudsman service, is to investigate impartially and adjudicate on the complaints of individuals and their families when they are not happy with the resolution offered by the service provider. Our remit in relation to this inquiry is that many of the complaints that we receive are about avoidable harm or avoidable death, and that has given us, as we have increased the number of investigations we have done, a database to mine to look at the quality of those local NHS investigations, including where they are supposed to be looking at patient safety.

Q211 Paul Flynn: What are the limitations in your structure that limit your effectiveness?

Dame Julie Mellor: There has been plenty already that I agree with; it would be so much better if there was one public ombudsman service. As you know, I am thrilled that this Committee proposed that last April. I think you asked me, Mr Flynn, about when we were able to investigate clinical cases. The health part of our remit was established in 1973, and we were given the powers to investigate the clinical aspect of complaints in 1996. Actually, that was the result of an intervention by this Committee, because it was quite clear that there was a major gap in redress for people. While administration happens in the NHS, it is a supportive role to actually looking after people and therefore involving clinicians, so there was a huge element of redress that people were seeking that could not be remedied unless we had the ability to look at the clinical aspects of complaints.

Most of the complaints we receive would be a mix. For example, there was a case recently that we laid before Parliament of someone who was not diagnosed with breast cancer and it was now terminal, and it probably would not have been. In that case, there were flaws in the clinical aspects of the diagnostic tests that were done at a certain stage, but there were also flaws in the administration, in the recall system, to make sure that this woman was recalled in time to get further diagnostic tests. Most complaints are a mix.

Q212 Paul Flynn: You enlivened our weekend with your press statements. Were you trying to get your retaliation in first?

Dame Julie Mellor: My understanding is that one of the reasons that this Committee wanted to look at this is that we had been talking to people about our concerns about the variable quality of the clinical incident investigations in the NHS, so that is the information that I wanted to share with this Committee today.

Q213 Paul Flynn: Can I ask both of you about the current system for investigating serious clinical incidents? What has worked best?

Professor Sir Mike Richards: Maybe I could start by setting out what the CQC does in this regard and then come on to how it might be in the future. Clearly, we monitor, we inspect and we regulate all providers of health and adult social care, so it is about 40,000 different organisations that we regulate. We have been going through a period of very radical change in the last 18 months, as I am sure you are aware, with three Chief Inspectors, of whom I am one, for hospitals, mental health services and community health services. I also have a colleague who does primary medical services and another one for adult social care.

We have radically changed the way we inspect, based on large teams gathering much more data before we go in, talking to staff when we are on site, and going into clinical areas. Clearly as part of that, we do look at what things go wrong, and they are a very important part of our inspection process. Those clinical incidents contribute to our key question about whether care is safe. They are complaints, which we think of under our key question of whether a service is responsive to the needs of patients. We also look at staff concerns, often called whistleblowing. All three of those also contribute to our fifth key question, which is: is a service well led? The openness and transparency of a service really will dictate, in many ways, whether those are well done.

Our role in the system, as far as incidents and complaints are concerned, is to oversee the quality of handling of those by individual trusts. On every inspection we do, we will look into how well incidents are being managed and how well complaints are being managed. We are still learning as we go, and I am not saying that we are doing it as well as we should or could in the future, but we are doing it a great deal better than we were a year ago, and we are seeing variability. I think that came through from the previous witnesses.

Within the health service, it is hugely variable. There are some trusts that really encourage reporting of incidents, and so a high number of incidents being reported by a trust is often a good thing, particularly if they are high number of incidents with low harm or no harm. That is true not just in this country; it is true if you go to Virginia Mason in the United States, which is the place that prides itself in being one of the safest hospitals in the world. It has probably the highest number of incidents being reported. They are thrilled that their number of incidents being reported is going on going up, but they can also demonstrate that their number of insurance claims is going down at the same rate. It is a culture, and we see it in some hospitals in this country, of saying, "Please report, and we will learn from that".

Equally, at the other end of the spectrum, for example when we are holding focus groups of junior doctors, we always ask them about incidents and whether they report incidents. All too often what they tell us is, "Oh, well, I did report one or two, but I did not get any feedback, so I actually stopped. It was not that easy to do it. It took up time," so it was not made easy for them. In the best hospitals that is not the case. They really are encouraging it; they learn from it; they feed back and it is a completely different culture.

Paul Flynn: I appreciate that not everything can be simplified, but that answer was one of labyrinthine complexity.

Professor Sir Mike Richards: I will try to separate the different bits.

Paul Flynn: I will try to study it later with a towel wrapped around my head.

Q214 Paul Flynn: Dame Julie, what works best?

Dame Julie Mellor: What works best in what sense?

Paul Flynn: In the complaints and incidents structure, what is happening? Where is there a need for improvement?

Dame Julie Mellor: In relation to this inquiry looking at safety incidents, before looking at what works best, I would like to share what we have found in our analysis of these incidents. As we have taken on more cases—over the last 21 months, we have taken on about 4,500 health complaints—about 550 of those have been about avoidable deaths, so they are a significant proportion of our work. We have looked at a sample of 150 that were either avoidable death or serious avoidable harm, and looked at the quality of investigations locally and what they achieved.

I have to say the results were shocking. We found that 40% of the local investigations of serious incidents were not good enough to identify if something had gone wrong. If you cannot identify if something has gone wrong, you cannot move on to why, and to the learning and therefore improvement.

On the other point, which again reinforces something that Peter Walsh says, it is a small number; it is a sample, but it is indicative of something. Of the 150, 28 were ones where we thought the incidents were so serious that they should have been formally reported as serious untoward incidents. Only eight of them were. That suggests that there is an under-reporting of incidents and therefore an under-investigating of incidents, and therefore continuing risk to patient safety and the learning not happening. That was what we had found in our data.

Q215 Paul Flynn: One can understand how patients who are aggrieved are baffled by the complexity of the organisations and the multiplicity of bodies that are there. Are you concerned that patients will be disheartened and dispirited by this and abandon their complaints, because of the likelihood that their complaints will be passed through a number of bodies without in fact getting anywhere in the end and reaching any sensible conclusion?

Dame Julie Mellor: Absolutely. As you will know from earlier discussions with the Committee, when I took on this role, we commissioned some research so that we could have an evidence-based strategy. One of the things we found—Katherine Rake was saying the same thing earlier—is that of those who have something to complain about in health, a very significant proportion, probably around half, do not because they fear it will not make a difference. That is one of the reasons why, following the Francis report, following the Government's "Hard Truths" and following the Clwyd-Hart review, we worked with Healthwatch England and with the Local Government Ombudsman to describe, from the patient and public perspective, what great complaint handling would look like, so that provider organisations could assess themselves against that and actually look at where they were doing well, where they were not and what they needed to do to improve.

I am pleased to say that the Care Quality Commission is now using the "My Expectations" report, as we call it, as part of the way in which they look at complaint handling in their hospital inspections. Also, NHS England has committed to work with us on developing the measurement tools and making sure that commissioning decisions will consider the performance against "My Expectations". This is an example of trying to get the whole system aligned on what good would look and feel like for the public and actually measure progress against that.

Q216 Paul Flynn: The work of the ombudsman has been severely criticised by the Patients Association, among others. Are you confident that the ombudsman service has the capacity and the capability to investigate these incidents?

Dame Julie Mellor: I am. Let me say that, as you know from our annual scrutiny hearings, I would be the first to say that there is lots to improve about our service, particularly about the way we communicate with customers and the transparency of our methods, and we need to address things like the "why" question, training all our staff who do our most serious investigations in root-cause analysis and human factors science.

Our decision making is sound, and that is what we are here for: to make those decisions. As we have moved from hundreds to thousands of decisions, more members of the public are benefiting. Again, the earlier witnesses were talking about what people want out of complaining. So when we adjudicate, people are getting an acknowledgement, when we uphold, of the impact on their lives. We are putting things right where that is possible and, where the complainant wants it, making sure that the provider is taking action to improve the service.

Q217 Paul Flynn: From your previous answer, Professor Richards, I gleaned that the policy might be that it is difficult to hit a moving target, and a process of continual change will stop any complaints from really striking home. There have been recent improvements to the regulatory system. What has this approach resulted in, in the way that the NHS is monitored? Has there been a change recently?

Professor Sir Mike Richards: I am not sure if I will answer the first part of your question, but I will certainly answer the second part, which is whether there has been a change. It is in evolution, but we can certainly point to individual trusts where they are taking complaints handling much more seriously. They are doing it better. I can think of one, for example, where about 18 months ago we issued a warning notice specifically about their complaints handling. We went back and re-inspected. I actually spoke to the manager responsible for complaints. It was not perfect by then, but it had improved enormously. There was clearly a focus on complaints and making use of the information from complaints. I specifically asked questions about whether he could point to changes that had been made as a result of complaints, and the answer was yes.

Q218 Paul Flynn: The health service was established in 1947, and it is still evolving into a complaints service that we can be proud of.

Professor Sir Mike Richards: I would agree with the implication behind your question that it has taken us a very long time. I think that openness and transparency are relatively recent developments, and they are still in progress within the NHS. In the best hospitals, it is very clear to me that the will to learn from complaints and therefore to encourage complaints is there, and in the less good hospitals it is not yet there.

Q219 Paul Flynn: What factors do you think should affect an investigation and decide whether it is handled independently or handled locally? Who would decide that? Are there improvements to be made there?

Professor Sir Mike Richards: That is an absolutely critical question in the whole business of deciding whether there should be an independent organisation to do this. With the sheer volume of incidents—1.5 million a year being reported on the National Reporting and Learning System—that amounts to several hundred a week at an individual trust level. If you even look just at those that are related to severe harm and death, there are 10,000 a year in the country, which is 200 a week. I cannot see any central organisation managing that, so my priority would be to make sure that the individual trusts, the providers, do this job well, because they are undoubtedly the people who are doing the majority of this workload.

On top of that, there may be a case for saying that there are some specific themes coming through that we want to probe further. That is something that the CQC can do. We can decide if we really want to look at a particular area, and we can then do it in a sample of trusts. We can learn from that and then embody that into our main inspection programme for all trusts. The priority should be to get it right locally. There may be a case for some national investigations where there are particular themes that need to be investigated more fully.

Q220 Paul Flynn: Should all these investigations be carried out by medically qualified people, who, as we know, in many investigations tend to close ranks within their profession?

Professor Sir Mike Richards: You need medical advice, input and expertise in these investigations. Coming up to 13 years ago, I was quite close to the investigation that was led by the witness you saw last week, Brian Toft, into a particular incident that had happened in Nottingham, intrathecal chemotherapy in Wayne Jowett, which some of you may remember. That was led by Professor Toft, as an individual who was experienced in leading investigations. He was supported by two cancer doctors. I thought that was an extremely illuminating investigation then. There were many years of work that I was responsible for in trying to get the health service to implement the recommendations that came out of Professor Toft's report. I believe we have done that—touch wood. That is the scale of the challenge. I do not think it always needs to be led by doctors, but you will always need doctors, and indeed nurses and other health professionals, engaged in the investigations.

Q221 Paul Flynn: Do you think we need to look at the National Patient Safety Agency reviving the Community Health Councils? Are there solutions in the past that we can try again?

Professor Sir Mike Richards: As Katherine Rake said and as Dame Julie has said, I do think there is a huge role for advocacy. That could be provided through Healthwatch, but it needs to be done better than it is at the moment. I would strongly support that, but the actual investigation of both incidents and complaints needs to be a primary responsibility of the provider organisation. They may well need to go externally to get the independence that they need, but they should be doing that and we should be checking up on them to make sure they are.

Q222 Paul Flynn: We have recently seen an upheaval in the health service. To some people, it is a reorganisation; other people see it as the start of privatisation. Have any of these changes produced improvements in the way that patient complaints are handled?

Professor Sir Mike Richards: It is difficult to know which bits have led to which improvements, but we are seeing slow improvement. It is not as fast as any of us would like, but we can point to individual organisations where that improvement is happening. The very fact that all the trusts in the country know that we look both at incident handling and complaints handling is a change in itself. The fact is, we have given that a priority, and I have made it very clear that that is something that we will look at in all our inspections.

Q223 Paul Flynn: Has there been an improvement, Dame Julie, in fewer incidents and an understanding of pooling the wisdom of the investigations into national improvements?

Dame Julie Mellor: In terms of overall numbers, no. We see a steady increase in the number of complaints coming to us. The number of complaints in the NHS is around 150,000 a year. It is gradually going up, but not exponentially. I would agree with Mike Richards that there are things people are doing in their different roles that can lead to improvement. For example, just as the CQC has improved its inspection regime, we have changed the way that we work with the CQC and are making much more intelligence from our complaints available to them.

For example, the CQC does—I do not know what you would call it—a series of investigations, a block of investigations, and we get told the hospitals that are going to be investigated and we provide intelligence based specifically on the topics of complaints, the proportion upheld and so on for each trust, as part of the intelligence for that inspection regime. We are doing summaries of our cases that are searchable by trust or by issue on our website, so that that is available for people to use to look at what needs to improve. We also published this year information by trust on the number of complaints per episode of treatment— the number of complaints that came to us and the number of complaints we investigated and upheld—so that you can get some comparator of how well individual trusts are doing at complaint handling, which again is a kind of transparency that can be used to drive improvement.

When we see big and repeated mistakes, we make sure that the system deals with those. For example, as you know from the hearings you have held on sepsis and midwifery, they are two areas where we have now said there is work to be done and people have made commitments. On end-of-life care, we are feeding in intelligence, because of the number of cases we get, to the Care Quality Commission; actually, both organisations are doing work on the subject of this inquiry, on the quality of local safety investigations. There are mechanisms that are feeding in intelligence that enable people to act on the outcomes.

Q224 Paul Flynn: When the new Prime Minister is elected, if you had 10 minutes with him, what would you tell him to do?

Professor Sir Mike Richards: I would certainly tell him that good assessment of quality of care, including the quality of handling of incidents and complaints, is a vital part of driving quality improvement. I would be saying to him that, on every aspect of quality of care that we look at, we are seeing far too wide a variation within the NHS. Frankly, that is unacceptable for a National Health Service that, as you indicated, has been in existence for

over 60 years. That variability is something that we need to tackle, but the first step in tackling it is to turn a spotlight on it. That is what we can do. It is not predominantly for the trusts themselves to put things right. Where they need support—and you will be aware of things like special measures where they really are struggling—then we need extra support. That is where we are working with Monitor and the Trust Development Authority on that. This business of buddying between high-performing trusts and ones that are struggling is something that is really quite new in the NHS.

Chair: You are going slightly off the point.

Professor Sir Mike Richards: I think it was in response to—

Chair: Can we move on?

Q225 Paul Flynn: What would you say, Dame Julie, to the same question?

Dame Julie Mellor: I would say the same to any new Government as I would say to this Committee today, which is that our evidence shows that, all too often, the quality of local investigations into serious incidents and avoidable harm is not good enough or is not happening. That needs addressing. It should always be that every NHS local provider should be investigating not to apportion blame, but to find out what and why, which leads to improvement. In looking at the solutions, rather than rushing to structural changes, first understand the levers, which is what some of your questions are getting at, across the complex health system, to look at what are the levers that are really going to make a difference. In our evidence, we have suggested some principles that might be considered in considering what levers.

One is expertise, which is what has already been referred to—not just clinical expertise, but expertise in investigations, expertise in root-cause analysis and human factors science, and accreditation of that expertise, so that all the clinicians and the public are confident about that expertise. Another is independence, and what I gather is called a just culture, creating a safe space locally, because I would agree with everyone that, actually, it is locally that you are going to get the biggest improvement, where there is a safe space to investigate these cases.

Q226 Mr Evans: I was interested to hear what you had to say about this hospital in America that is rather pleased about the number of complaints going up, so that they can improve the level of service.

Professor Sir Mike Richards: Can I just clarify? It was not the number of complaints; it was the number of incidents reported by staff that had gone up. There is a risk of confusion between those two. The number of incidents being reported is demonstrating a willingness and openness to say things are going wrong that we can learn from.

Q227 Mr Evans: It seems in my mind somewhat perverted that, to be honest, in the UK, as you know from the league tables, organisations will be judged on complaints, whether internally or externally. Of course the *Daily Mail* will emblazon, quite rightly, the headline that says this trust or organisation is failing because of the incredible increase in the number of complaints. Can you not therefore see that most of these organisations would see any complaint, internally or externally, as a slight against the delivery of service?

Professor Sir Mike Richards: That is why we are very clear in what we tell trusts: that we are not judging them simply on the numbers.

Mr Evans: The *Daily Mail* will.

Professor Sir Mike Richards: The *Daily Mail* may, I agree, but we will not, and that will not then be reflected in their ratings. Some of the best hospitals in this country actually have high levels of reporting of incidents, particularly incidents with no harm or low harm. We talk to them about that. As I said earlier, we go and talk to the junior doctors, the senior doctors, the junior nurses and senior nurses. We ask about the incident reporting. We ask the senior management about how they respond to that and, actually, high levels of reporting can be a good thing and that will not count against them in our rating.

Q228 Mr Evans: To go on the personal level, Dame Julie, you talked about this lady with misdiagnosed breast cancer. Can you just give a little colour? This is a statistic on the one hand—people look at statistics and make judgments—but at the personal level, this sounds as if it was avoidable as well, which is a huge tragedy. Can you just tell us exactly what happened and then what the implications of you intervening were on this case?

Dame Julie Mellor: It was a failure to diagnose rather than a misdiagnosis. As I said, this woman is now terminally ill. We laid it before Parliament and we distributed it widely. Actually, the feedback from the cancer experts in the system and from individual providers was much greater than we have had for a lot of our reports, because it struck a chord for people that there was a mixture of clinical diagnostic weaknesses and administrative weaknesses around recalls for appointments and stressing the importance of coming back for appointments, when a serious diagnosis had not been eliminated. My sense is that, in that one case, there will be a number of providers that are now reviewing. Indeed, the specific provider in that specific instance has reviewed and changed its appointments system and its recall system for appointments.

Q229 Mr Evans: That is the important point, prevention. Sadly in this particular lady's case, her life will end sooner than it otherwise would, but the lessons from that mistake must be rolled out everywhere so that, even though you may have some best practice operating in some other areas, it is important that they all learn that, "This is what went wrong here; can you please check your procedures in your own organisations to make sure that it cannot possibly happen in yours?" Is this happening?

Dame Julie Mellor: That is why, when we see either very big or repeated mistakes, we do pull together the analysis and then work with the system players to get agreement to change, as we did on sepsis. That is exactly why. We now have commitment from top to bottom in the NHS to take action to improve the diagnosis and rapid treatment of sepsis, as a result of our insight from complaints.

Professor Sir Mike Richards: I have read the breast cancer report with interest. I used to be a breast cancer specialist, and I can absolutely see how that case could happen and how it can be prevented. It is very important that those lessons are learned.

To go back to the example of the patient in Nottingham who was given intrathecal chemotherapy in the wrong way, and died as a result of it, the report by Professor Toft was absolutely first class, but that in itself would not lead to change. After that, I oversaw the development of national guidelines. We then got trusts to say whether they were complying with the guidelines. We even got the chief executives to sign off that they were. We feared that they were not, so we then instituted a national round of going round the hospitals peer-reviewing and, sure enough, they were not but, actually, when we went back a second time, they all were.

Driving change is not just about the report; it is about a lot more too. That is where we as the CQC can do that on a scale. Going back to Dame Julie's example of sepsis, we are always looking at how conditions like sepsis and including sepsis are managed within a hospital. What are the processes they have to recognise that somebody is rapidly deteriorating? How do they escalate that so that more senior doctors and clinicians are involved? How quickly do they get antibiotics to the patient, for example? That is part of our inspection process. The combination of a good report and then a process to make sure it happens is how we can work together.

Q230 Mr Evans: My final question is related to my questions right at the very end of the session with the previous witnesses. You were both nodding about the recognition of people not complaining. I know Australians call us whinging poms, but clearly we are not as effective complainers as we should be. How do you correct that?

Secondly, there is the culture of stonewalling—apparently not cover-up, but none the less the bureaucracy is still such that you could probably get an eight-page report to somebody in medicalese, which most people would not understand, which says, "Not our fault". In the end, it just wears them down, or indeed the elderly people are frail themselves and may not be as articulate as they otherwise would want to be in progressing a particular complaint. How do you address all of that?

Dame Julie Mellor: That is the million-dollar question. The phrase that Katherine coined last year, which you have identified the two parts of, was "the toxic cocktail", which we have then used to describe the problem with the complaints system. It is about the lack of confidence to complain in the first place and then, when people do, the defensive response that means the complaint is not resolved properly.

On the lack of confidence to complain, that is one of the reasons we worked with Healthwatch England and the Local Government Ombudsman, and now with the CQC and NHS England, to get the public's description of good complaint handling. The first one is: "I felt confident to speak up". If every provider in the country actually measured what the public said about whether they felt confident to speak up, the ones that had an environment that was stonewalling, that was pushing back, that was not encouraging the complaints, would show that people did not feel confident, and that was what they needed to address. That information would be available to the CQC as part of its inspection regime; it would be available to their commissioners as part of the commissioning data they would use. It is about putting the spotlight on it and using the levers of commissioning and inspection, where that is happening, to get the change through.

Professor Sir Mike Richards: On the non-complaining culture, the first step in that is, at a local level, to raise awareness of how it can be done. We always ask about that: what steps the trust is taking to make people aware of how to complain. I mentioned a trust earlier where we had seen very good improvement in general. The one bit that they had not yet improved was making people aware. They knew that and they had plans in place for that, but that was something they had not done. Awareness, combined with the advocacy that the other witnesses have talked about, which is very important, would make it clear to people it is okay to tell us that things have gone wrong, because we want to learn.

We are a learning organisation. If they can do that and if they really are that, actually, we can also look at the quality of the investigations and the quality of letters that they write back. Are they in medicalese? Can somebody understand them? Are they addressing the

questions that people really wanted answered? Again, with some of the best trusts, when they get a complaint in, it is read very carefully by a senior person, but they will then often phone the patient, offer them a face-to-face interview if they want one, and say, "Can I just go through your letter to make sure we are picking up on the points?" They do that before they do the investigation, rather than doing it afterwards and finding that they have missed the point. That is just an example that can be done.

Q231 Mrs Gillan: Can I just dig a tiny bit more into the qualitative nature of the build-up to the end process, when you are gathering and disseminating the information from these complaints? For example, the CQC said that investigations into serious incidents should be carried out as soon as the incident is identified. The Royal College of Physicians agreed entirely with that, but went further by saying that one of the problems was that there is not only a blame culture, which can inhibit reporting and learning, but also a real ongoing problem with record keeping in the NHS. Apparently there is a large number of cases where medical records are inaccurate or missing. Would you say that that is correct, and how do we actually go about making sure that the gathering of the information in the course of a complaint is good enough?

Professor Sir Mike Richards: There are two issues about record keeping: that there is genuine record keeping within the hospital system; how good are the records? The second is how good the records are about investigating complaints or incidents. We always look at record keeping. In general, when we go into every hospital that we inspect, it is one of the key questions we ask in our safety questions, and we will always report on it, so you will always see in our reports a heading on medical records. For example, we have come across trusts where, in 25% of out-patient attendances, the medical records are simply not available. If that is the case, how can that be safe? The clinician seeing the patient will not know what was going on and will not have access to that. It delays everything, but more than that, it is actually unsafe. We have come down hard on those trusts. Fortunately those are only a very small number, but they exist.

The second part is the record of investigating a complaint. What we are just starting now is that, when we go in to look at hospitals, both about complaints and about incidents, we will look at a sample of the files on those complaints and incidents, and we will choose which ones we look at—we will not just let the hospital choose for us—so that we can see whether they have conducted the investigation properly and whether the documentation is there.

Q232 Mrs Gillan: Do you find, Dame Julie, that there are incidents that come to you where you find, for example, that records are not complete? I am using that as an example. Do you then feed that back to the CQC as well? Is there live interaction between the two of you on the learning process?

Dame Julie Mellor: Yes, we do find it all too often. Specifically in the work that we have done partly to help the Committee with this inquiry, where we have looked at the quality of local investigations, we have found that, of those 40% where the investigations were not adequate, one of the things that was often missing was the decent original medical records. Yes, we do provide that information, as I was indicating earlier. We make sure that we respond to the CQC's requests for each batch of inspections that they are going to do with information about the topics of complaints and the findings in those complaints. I am sure we will get it even better over time, but we absolutely have a rigorous way now of doing that.

Q233 Chair: On this question of records, how do either of you know that the records being kept are in fact objective, particularly when it comes to medical records?

Dame Julie Mellor: Do you mean factual?

Chair: I will start with Sir Mike. How do you inspect the quality of medical records?

Professor Sir Mike Richards: The first step is to say, "Can we find our way through the medical records?" If a locum doctor was coming into that hospital, how quickly would they be able to work out how to read a medical record? That happens day in, day out, and it is important. We would look to see if there were days when there were no medical records written.

Q234 Chair: Supposing there is a medical record of an incident, how would you know that that medical record is an accurate medical record?

Professor Sir Mike Richards: We cannot always know that.

Q235 Chair: How would you assess the generality of the quality of medical records, in respect of their accuracy and objectivity?

Professor Sir Mike Richards: We will look at the original complaint that may have come in or the documentation of the incident. We will look to see if the right people have been questioned about it and whether the right statements are there.

Q236 Chair: You do not look at individual complaints.

Professor Sir Mike Richards: We can look at a sample of complaints and a sample of investigations, and we will read the initial investigation or the letter of complaint, let's say. We will then see whether that seems to have been addressed properly. Then, of course, the other thing that we are particularly interested to know from a trust is whether they actually survey their own complainants to know how satisfied they are. Again, the best trusts in the country undertake surveys of the people who have complained to find out how satisfied they are with the process. We look at all of that process and, if something has been falsified, no, we may not pick that up, but we would pick up the generality.

Q237 Chair: The interaction with the people who raised the issue in the first place is a very important part of the assessment. Dame Julie, very often—or not very often but, we have heard, on occasion, in very powerful cases—your organisation tends to accept the medical record as evidence. How do you assess the quality of that evidence when you are at the long-stop end of a complaint, which might have happened a year or more before? Are you in a position to?

Dame Julie Mellor: Yes. The first thing to say is that one of the key things about an ombudsman service is that it is a lay decision-making service, exactly because it is independent. We have clinical advice, but our decisions are made by independent investigators. The second is that we recognise that, however good our clinical advice, where people are not satisfied with our decision, where they are disappointed that we have not upheld it, it will make them question or criticise our methods, and so we put particular focus on making sure that we are providing high-quality advice and can demonstrate that.

For example, when people start as a clinical adviser to us, every single piece of advice they give will be peer-reviewed until the senior clinicians involved are satisfied that they have reached a level of competence in providing the kind of advice that we need. We set standards for that advice based on principles, professional standards, the speciality

guidance, the NICE guidance, etc. We have a process of one-to-one reviews, where the supervisor will select reviews to supervise.

Q238 Chair: By the time you see the medical records, it is quite hard for you to find out whether they are accurate, because very often the relative of the deceased will be saying, "That is not what happened; I was there."

Dame Julie Mellor: One of the things that would be helped in our investigating of complaints, if there were better-quality local investigations, would be, first, that there would probably be fewer complaints that would arise, because people would get the explanations they need in order to move on without necessarily complaining. The second is that, where complaints come through to us, if there is a decent local investigation, we can investigate more quickly and therefore provide a faster adjudication and have a sound evidence base to use in doing that.

Q239 Mrs Gillan: Just to finish up on this business of disseminating information, I was very impressed with the sepsis report and the midwifery report, which is obviously the endgame that then puts it out there in the public domain. What I am interested in is how you check that the information and the lessons learned actually reach the front line of the NHS or the health organisation concerned. How do you carry out an audit to make sure that that has actually been effective in reaching the parts that maybe other instructions cannot reach?

Professor Sir Mike Richards: Very often, we are the audit branch to Dame Julie's initial investigation. Going back to the example of sepsis, absolutely we are looking at how well that is managed as we go round the trusts in this country, and that will then contribute to our assessment of the safety in that service or in that hospital. We are doing multiple audits, in a way. It is a very large-scale peer-reviewed programme that we are running, looking at different aspects of quality.

Q240 Mrs Gillan: In your large-scale audit, would you say, on a scale of 1 to 10, that those lessons are reaching the front line?

Professor Sir Mike Richards: I would say it is variable. I am afraid I do sound like a stuck record on this one, but we see very good practice and rapid implementation of new guidance in some places and much slower implementation in other places.

Q241 Mrs Gillan: Do you have stars? Can you name names of those organisations that are really good at it?

Professor Sir Mike Richards: As you may know, we rate every trust that we are now going into "outstanding", "good", "requires improvement" or "inadequate"—the same rating scale as Ofsted—but we do more than that. We rate individual services, so we will rate the maternity service within a hospital, as well as the A&E, the medical service and surgery, etc. This is all transparent and is all in our report.

Q242 Mrs Gillan: You would say that the maternity services report from the ombudsman is reaching the parts it needs to reach and being taken on board.

Professor Sir Mike Richards: Do I say that all maternity services are functioning fantastically well? No. In broad terms, they are doing pretty well, but they could be better. We will inspect all of them to make sure that is the case.

Q243 Mrs Gillan: It would be a success story for the PHSO.

Professor Sir Mike Richards: Either maternity or sepsis, yes, if we see that those have been fully implemented everywhere we go. It is not the case yet, but, yes, that would be.

Mrs Gillan: There is no better way of doing it.

Dame Julie Mellor: Can I just add though, on midwifery, that everyone is agreed now on what needs to change? What we now need is a Government that will change the regulation for midwifery. That is the final stage that will deliver on our recommendations.

Q244 Chair: Who is responsible for making sure, for example, there is comprehensive root-cause analysis of an incident?

Professor Sir Mike Richards: Again, that is part of our responsibility. When we are looking at incidents and the investigation of incidents in a trust, we will look to make sure not only that they are being recorded properly, but that they are being investigated properly and reported on properly. We are about to do something we call a thematic investigation, where we will look across a whole range of hospitals at precisely that point.

Q245 Chair: That would go for human factors analysis as well.

Professor Sir Mike Richards: Yes, indeed.

Q246 Chair: We have established that the ombudsman is quite far away in history terms from most incidents that you investigate, and we have also established that you can inspect the quality of investigations, Sir Mike, in their generic form, but you cannot supervise or oversee individual investigations at the time when they are needed. The objective we have set ourselves in this is that there should be a ready way of establishing the facts of an incident early and objectively. Are we in agreement that there is very patchy coverage of this capacity across the health service generally at the moment?

Professor Sir Mike Richards: I think in every answer I have given I have said there is variation. There is variation in this too.

Q247 Chair: Who is responsible for whole-systems analysis of incidents? Sir Mike, with the greatest of respect, you do not have the objectivity to investigate yourself or the effects that your inspections might have had on the safety of a particular medical procedure or a particular hospital? You cannot do that.

Professor Sir Mike Richards: First of all, I report to the CQC board and we meet in public. You probably know all of that.

Q248 Chair: Of course, but it was decided that the Health and Safety Executive could no longer investigate rail crashes, because the Health and Safety Executive had approved the track layout and the signal layout at the Paddington rail crash, so they set up a new body, the Rail Accident Investigation Branch, which would be able to take a whole-systems approach to safety management, safety investigations and incident investigation. Do we accept that this gap exists in the health service? It is not a criticism of you personally.

Professor Sir Mike Richards: First of all, we hope CQC is transparent, and of course we report to Parliament.

Chair: I am not contesting that.

Professor Sir Mike Richards: We are under scrutiny. Laying that to one side, I come back to the point that the largest need is to make sure it is done well locally. To my mind that is the thing that we should be concentrating on, then I do think there needs to be advice and expertise available to support trusts to do that well, and possibly training as well. That

would help to make sure that local investigation was done well, and then CQC can make sure that that local investigation has been done well when we go round inspecting.

Dame Julie Mellor: I am not sure there is anyone in the system who you could say is free of having an impact on the system. In that sense, we all have to think whole-system, but I do not think there is anyone—whether it is the Department in setting policy, the inspection regime, the impact of our recommendations for remedy and so on—who you could say is actually so outside the system that they can be an organisation—

Q249 Chair: Is that not what is needed: an ultimate authority that is completely outside the system and yet accountable?

Dame Julie Mellor: That is why we end up with public inquiries for things, because it is only by someone who is outside of Government and outside of delivery—

Q250 Chair: There has not been a public inquiry into an air accident since 1972, which suggests there is a very high degree of public confidence in a body that both provides legal immunity for witnesses and is not part of the aviation regulatory culture or operational culture. It is completely outside it.

Dame Julie Mellor: I would endorse what Mike Richards has just said about focusing on improving things locally. If there is one thing that this Committee might start to open up and impact upon, it is the issue of a safety culture locally, so that people do feel confident to speak up, whether it is a complainant, a member of staff or clinicians who are involved and recognise that they have made a mistake. That safe space locally, with the right expertise and advice, as Mike Richards has been saying, bringing in independent clinical review where needed, depending on the seriousness and so on—if those three things could come out of this inquiry, as the focus that will improve the quality of investigations locally, it would be a great outcome.

Q251 Chair: What are the potential benefits of having some independent incident investigative body in the Department of Health, as opposed to part of the health system, or what are the drawbacks?

Professor Sir Mike Richards: The drawbacks are creating yet one more organisation, even if it is a subset of the Department of Health. We have heard that there were 70 organisations. I do not particularly recognise that figure, but I could well believe it, so we would be creating a 71st, when actually what we need to be doing is concentrating on the organisations that already have statutory duties, which they are not performing as well as they should.

Q252 Chair: Some of those bodies are too far away from the incident, like Dame Julie's, or in a regulatory capacity rather than investigative capacity, like your own, or in a commissioning capacity, like NHS England. Is it not odd that the patient safety domain has been moved into NHS England, which is itself a commissioner and to some extent unconsciously a regulator?

Professor Sir Mike Richards: There will be people within NHS England who might agree with you on that, but I welcome the fact that the emphasis on safety is somewhere.

Q253 Chair: We all welcome that, but I am wondering whether there is a missing element that would help drive all the things that you want, like much more comprehensive local investigations, safe places for people to go and speak and tell the truth. We were told that an airline of 10,000 employees would have 800 people investigating the record keeping

on safety, so clearly AAIB has promoted that safety culture, albeit from on high, investigating relatively fewer incidents.

Professor Sir Mike Richards: I completely recognise the analogy with the airline industry, but we have to recognise the scale. The number of incidents even being reported now is 1.5 million per annum in the NHS, and we know that it probably should be a lot higher.

Q254 Chair: How would you prevent a body like this being swamped?

Professor Sir Mike Richards: That is the crux of it. It is trying to work out which incidents it would look at. I have not yet come up with an answer to that. Presumably it would be a subset of those at the severe harm or death end of the spectrum but, as I said, there are 10,000 of those a year, so even that would be impossible to do at a national level. We would have to find a way of saying which particular incidents. Do we think this is maybe an incident that may reflect things that are happening elsewhere? It may be something that has not been fully investigated elsewhere, so that would therefore be a reason to refer it to this new organisation, should it exist.

Dame Julie Mellor: How you prevent it being swamped is first, as we have said, by improving the quality of local investigations. In terms of what it might do, I would agree that if activity were to take place nationally on this, then it has to be about identifying the big or potentially repeated mistakes from all the data sources—from our own, from the regulator, from the NHS Litigation Authority, from the national records process and so on—so that you have all the sources of data to analyse what the big and repeated mistakes are and if those are the ones that this body needs to focus on, in order to drive patient safety where it will have a huge impact, because it is repeated.

Q255 Chair: Can I also ask about what I asked the previous panel about—this conflict between investigating to establish facts without blame and investigating in order to provide redress, punishment or what one might call accountability, in its negative sense? Sir Mike, you talk about the need for the "separation of the function of investigation for learning purposes from the function of investigation for regulation and enforcement". Is that the same conundrum?

Professor Sir Mike Richards: It is the same dilemma that you have been probing. We all want organisations to be learning organisations, and a lot of that can be done by looking at the near misses, the no-harm and low-harm incidents, because there may be a lot of learning from those. Where there has been severe harm or death, I would agree with the previous witnesses that, ultimately, for the benefit of patients and relatives, we need to say, if there is blame, where that lies.

Q256 Chair: In terms of investigation for regulation and enforcement, that is your job.

Professor Sir Mike Richards: Our job is to regulate the provider organisations and take enforcement action.

Q257 Chair: You cannot also do investigation for learning. You cannot do that; somebody else has to do that.

Professor Sir Mike Richards: We are not trying to do that.

Q258 Chair: Who does that?

Professor Sir Mike Richards: The individual organisations.

Q259 Chair: Obviously, but who oversees and empowers them in that function?

Professor Sir Mike Richards: We oversee them.

Chair: You do regulation and enforcement. You do not do investigation for learning purposes. You have said they have to be separated.

Professor Sir Mike Richards: We do not do the investigations per se. We look to see whether they are a learning organisation.

Q260 Chair: I understand but, in terms of separating the function, that is not your function; it has to be somebody else's function. Whose function is it, apart from just relying on the individual trusts to do it, which we all agree is very patchy?

Professor Sir Mike Richards: It is partly through our ratings process that, if we rate a trust as either requiring improvement or as being inadequate, that in itself puts pressure on the trust.

Q261 Chair: First of all, your regulation is not itself safety-assessed independently. Its impact on incidents is not itself independently assessed. Secondly, we all know there are limitations on the degree of regulation to achieve things. There are limitations. Regulation does not necessarily promote learning. It changes behaviour, but it does not necessarily promote learning.

Professor Sir Mike Richards: It does not necessarily promote learning. I personally believe the new approach that we have introduced is much more likely to do that, and we have seen examples. I can think of trusts that we have been to, when we came out with fairly harsh reports just over a year ago, where we have been back in and they have made huge changes. They would be the ones who would say, "Actually, this was a wake-up call", so good inspection can be the trigger to learning and improvement.

Q262 Chair: Inspection and regulation are inherently threatening. They are inherently adversarial. We know that from every kind of regulation we have ever seen. What we need is a no-blame culture. You cannot do the no-blame culture because, I tell you, my local hospital has just been criticised by CQC and they felt very blamed. That is what regulation does.

Professor Sir Mike Richards: To which my answer would be that I hope that leads them to improve, because they need improvement. I know which hospital it is, and they need improvement and they need it big-time.

Q263 Chair: We are also looking to create a no-blame culture. You are part of the regulatory system; you cannot do the no-blame culture. That is not what you do.

Professor Sir Mike Richards: We can see whether there is a no-blame culture within the individual organisations. The organisation to which you refer, I would say, has not been a model on that regard.

Dame Julie Mellor: I do not have an answer. It is something that the system has to consider. What are the levers around that enable them to separate as much as possible the learning from the accountability that is a consequence of recognition of a mistake? For example, where I have seen it work well is where you get a good-quality local investigation of a serious incident that says, "We have made a mistake. Now we need to take responsibility for addressing the consequences of that," and that could include saying to the family concerned, "We made a mistake, and we recognise the impact that it has had

on the individual and their family." If they can, they put it right or they apologise, and they show what they are going to do to make sure it does not happen to anyone else. There is a separation. Let us find out what happened safely, in a safe space, and then say we have to take responsibility for the consequences.

Q264 Chair: You describe that the relationship between the PHSO and any new body needs to be "symbiotic". What do you mean by that?

Dame Julie Mellor: As I said, we would hope, if there were better-quality investigations happening, that there would be fewer complaints that would come to us. For those that do come to us, we would have better information from an early-stage investigation to use to adjudicate. The other way round, we can again feed the insight from our casework back into whoever is doing the investigating at a local or national level, as part of their intelligence for them to use to improve.

Chair: Thank you both very much indeed for your evidence. We have had a very interesting morning. Greg, I am sorry—do ask your question.

Q265 Greg Mulholland: I just have one final question to Dame Julie, if I may. This follows up some of the conversations that you have collectively had with the Committee before and the support, I think it is fair to say, that you have given for our recommendations of reform, which sadly so far have fallen on entirely deaf ears, it seems, when it comes to Ministers, which is very disappointing. You must yourself be very frustrated, indeed distressed, by the very strong criticism made of your ombudsman service by those who feel very strongly that they have been let down by the service, including on health matters. Really, this is not something just for you, but this is something that Parliament—it still being the Parliamentary Ombudsman—has to take seriously and has to seek to deal with, because it is undermining confidence in the ombudsman system.

Can I just ask you briefly how you think that needs to happen and what potentially needs to happen here in terms of legislation to do that? It is perhaps having a different system, which then involves having a relationship with other expert bodies or clinical experts, locally and nationally, to deal with things, so that there is more confidence in the system. How do you think we can finally get to grips with this? It is in your interests, it is in Parliament's interests and clearly it is in the interests of all those who do not have confidence in the system at the moment.

Dame Julie Mellor: Are you talking specifically about reform of the ombudsmen landscape?

Greg Mulholland: Yes, but particularly with regard to health investigations.

Dame Julie Mellor: We have heard from the previous witnesses and we have argued to you, and you have supported what we have said, which is that actually there should be one public ombudsman service. In relation to health, where that becomes most crucial is because of the number of incidents that probably do not get investigated as serious clinical incidents, but actually the consequences for individuals are as severe when people fall between health and social care. There are a number of cases of unsafe discharge, for example, where they are unsafe because the right social care has not been set up in the community when someone is discharged.

We would say there should be one public ombudsman service. As you know, we do joint investigations with the Local Government Ombudsman, but they are clunky because we are two organisations. We are doing as much as we can to make that as smooth as possible, and we have just set up one team that does that. One public ombudsman service with the right powers, so the powers to do investigations on our own initiative, where we can see prima facie evidence of significant service failure, or that is brought to us by MPs from your casework, we think could make a profound difference. It would be much easier for the public to know where to go, so in that sense it would be simplifying the landscape. It would be much easier for the ombudsman service to provide a decent service to the public, because it is in one place, and it would be better for Parliament, because it would have data from across the piece, from one organisation, supporting you in holding Government to account for service failures.

Greg Mulholland: Just if I may, Chair, a final plea as we approach the general election: for all those with an interest in that, which is the Committee, the ombudsman service and many other bodies and many members of the public, to help put pressure on so that we do get a real move forward in the House.

Q266 Chair: Thank you both very much. A penny has dropped in my mind about one thing, and I am just going to share it with you to see if you get a reaction from it. It is very much based on your comment, Sir Mike, about the separation of the function of investigation for learning and for regulation and enforcement. Learning and improvement come in an atmosphere of high trust and openness, where there is no blame. Therefore, the objective investigation to establish facts needs to be done insulated from any possible redress or enforcement. That does not mean that redress and enforcement are not extremely important, but it is the lack of that space for learning and improvement, and admission without blame, that we are all struggling to promote in the health service, one way or another. I just wonder whether the paper that provoked this investigation has not stumbled on something that will help us promote this more effectively than we have had before.

Professor Sir Mike Richards: We see trusts that do openly investigate incidents and are learning organisations, and what we then do is to say they are good or even outstanding. We can then complement what they are doing by reflecting that in our ratings and hopefully others can then learn from that and say, "What it is that Hospital X or Hospital Y is doing?" They can read our report to find out.

Q267 Chair: I agree with every word of that. If it sounded as though I was disagreeing with you, that was not what I was seeking to do. I was seeking to distinguish between what you do very effectively and what might be done in addition to what you do, not to replace or to countermand, and indeed to give you more evidence to draw upon, which you would then help enforce and regulate. That is where we are.

Dame Julie Mellor: I would endorse what you said completely, Chair. I think it is a real key, and if this inquiry can focus on how you create that safe space—the consequences have to be addressed afterwards, but if you create that safe space to get at the facts of what happened and why, that is how we will get a learning culture.

Chair: That has to be at a local level, as much as anywhere else. On that happy note of agreement, thank you very much indeed for giving us so much of your time. Can you convey this Committee's thanks, both to everyone in your organisation, Dame Julie, and everyone in CQC, for the very important work they carry out? We know that both your

organisations are going through difficult change programmes and have been subject to a lot of criticism. That is hard for them and hard for people who depend upon your services as well. We are looking for that improvement and depending upon you for it. Thank you.