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# NHS Complaints Procedures in England

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# Summary

This Commons Library briefing paper provides information on NHS complaints procedures in England. The standard two-stage NHS complaints procedure, where complaints are first raised locally and with the option of referral to the Health Service Ombudsman, can be used for most complaints about NHS services. However, other options may also be appropriate in some cases depending on the objective of the complaint, such as obtaining an apology, compensation, disciplinary action, a change in policy, or a clarification of the law.

A section at the end of the briefing paper lists some of the organisations that can provide help and advice to patients who wish to make a complaint about NHS services.

It is important to note that some care services are provided by local authority social services departments. Complaints about these services are outside the scope of this note but further information is available from the Local Government Ombudsman website.

Procedures for NHS staff to raise concerns are covered in a separate Library Standard Note, NHS whistleblowing procedures in England (SN06490).

# 1. Summary of NHS complaints procedures

The standard NHS complaints procedure can be used for most complaints about NHS services. However, other options may also be appropriate depending on the objective of the complaint, such as obtaining an apology, compensation, disciplinary action, a change in policy or clarification of the law.[1]

For example, someone seeking compensation might consider legal action; someone wanting to reform NHS practice and procedures, or simply seeking an apology, might choose the standard NHS complaints route; someone who believed that a specific medical practitioner was at fault might complain to the relevant professional body such as the General Medical Council, which could ultimately prevent a doctor from practising; and for clarification of the law someone might seek judicial review. However, where legal action is being considered professional legal advice should be sought and this is not something the House of Commons Library can provide.

Special procedures apply in certain circumstances, for example to patients raising concerns about treatment under the *Mental Health Act*, in cases where a specific drug or treatment is being refused by the NHS, and regarding eligibility for NHS continuing healthcare.

Where a MP is writing to the NHS on behalf of a patient and states, in writing, that he or she has a patient's consent to access confidential patient information, this should be accepted by the NHS bodies concerned without further resort to the patient.[2]

Over the past decade, written complaints on NHS services have more than doubled, from 95,047 in 2005/06[3] to 198,739 in 2015/16.[4] The 2015/16 figure is the equivalent of 3,822 written complaints a week, or 44 complaints per day, over the year.

1 If a complaint is made using the standard NHS complaints procedure this does not prevent the complainant also using of any of the other types of procedure referred to in this note, including taking legal action.
2 NHS Confidentiality Code of Practice, November 2003, page 43
3 Health and Social Care Information Centre, Data on Written Complaints in the NHS 2005-06, 15 November 2006
4 Health and Social Care Information Centre, Data on Written Complaints in the NHS 2015-16, 15 September 2016

# 2. The standard NHS complaints process

The NHS complaints system is designed to provide explanations of what happened and, where appropriate, apologies and information about action taken to ensure similar incidents do not happen again.

The legislation governing NHS complaints procedure is the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.[5] The 2009 Regulations set out various obligations on NHS bodies, GPs and other primary care providers, and independent providers of NHS care in relation to the handling of complaints. For example, Regulation 14 of the 2009 Regulations imposes a duty on NHS bodies to provide a written response to complaints.[6]

Advice for patients on the two stages of the standard NHS complaints process is set out on the NHS Choices website:

> Ask your hospital or trust for a copy of its complaints procedure, which will explain how to proceed. Your first step will normally be to raise the matter (in writing or by speaking to them) with the practitioner, e.g. the nurse or doctor concerned, or with their organisation, which will have a complaints manager. This is called local resolution, and most cases are resolved at this stage.
>
> If you're still unhappy, you can refer the matter to the Parliamentary and Health Service Ombudsman, who is independent of the NHS and government. Call 0345 015 4033[7]

The two stage complaints system described above was introduced in April 2009. Formerly there was an intermediate stage where the Healthcare Commission would conduct an independent review into the case concerned. The Healthcare Commission was abolished in April 2009 and although some of its functions were taken on by the Care Quality Commission, the new body did not take over the role of reviewing individual cases.[8]

When people have a complaint about an NHS service, they can complain to the provider of that service or to the commissioner of that service. For example, patients who have a comment or complaint about a GP, dentist, pharmacy or optician, which cannot be resolved locally, can contact NHS England, the commissioner of these services. CCGs oversee the commissioning of secondary care such as hospital care and some community services.

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5 Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (SI 2009/309), made in exercise of the powers conferred by sections 113(1), (3) and (4), 114(1), (2) and (5), 115(1), (2), (4) and (5) and 195(1) and (2) of the *Social Care (Community Health and Standards) Act 2003*

6 Further information on patient's rights to complain are provided in The Handbook to the NHS Constitution (27 July 2015).

7 Information on the standard NHS complaints procedure is available from the NHS Choices website

8 The NHS Complaints Procedure was altered following a consultation, Making Experiences Count, undertaken in 2007. One of the main aims was to align NHS and social services complaints procedures.

A full range of remedies are available through standard complaints procedures including apologies, explanations, remedial action and financial compensation for direct or indirect loss.

## 2.1 The NHS Constitution and patient's rights

The NHS Constitution[9] sets out the following patient's rights concerning complaints and redress:

> You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.
>
> You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.
>
> You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.
>
> You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.
>
> You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.
>
> You have the right to compensation where you have been harmed by negligent treatment.[10]

The NHS Constitution also makes the following pledges which the NHS commits to achieve:

> to ensure that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely affect your future treatment (pledge);
>
> to ensure that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again (pledge); and
>
> to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services (pledge).[11]

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9 NHS Constitution, 27 July 2015. The Constitution was first published in January 2009 following recommendations in Lord Darzi's report High Quality Care for All (2008). Under the *Health Act 2009* all providers and commissioners of NHS care have a statutory duty to have regard to the NHS Constitution in all their decisions and actions.

10 *Ibid.*, pages 9-10

11 *Ibid.*

# 3. Inquiries into complaints procedures

## 3.1 The Francis Inquiries

The first inquiry led by Sir Robert Francis QC into serious failures in care at Mid-Staffordshire NHS Foundation Trust between 2005 and 2008 highlighted widespread and systemic deficiencies in care at the Trust. The report found that contributing factors included ineffective action in response to patient complaints.[12] A second inquiry led by Sir Robert into the events at the Trust, examining the role of the commissioning, supervisory and regulatory bodies, published its report on 6 February 2013. This report made a number of recommendations with regard to the handling of patient complaints.[13]

The Government's initial response to the Francis report, published in March 2013, Patients First and Foremost, noted some changes to the way the Parliamentary and Health Service Ombudsman works:

> The Ombudsman is changing the way it works to start investigations sooner and complete them more quickly. The Ombudsman will publish summaries of all investigations to publicise both good and bad practice, so that the public can make better informed choices about their care. It will focus on identifying systemic issues arising from individual and clusters of complaints and publish more thematic case reports to highlight big or repeated complaints and to build confidence in the value of complaints. It will make it easier for people to complain to them and will work with regulators to drive better information sharing about complaints to gain earlier insight into concerns about quality.[14]

The Government's further response, Hard Truths: the journey to putting patients first, was published in January 2014. It provided a commitment that NHS Trusts will report quarterly on complaints data and lessons learned, and the Ombudsman will significantly increase the number of cases she considers.[15]

In response to the Francis report, the Prime Minister asked Ann Clwyd MP and the Chief Executive of South Tees Hospitals NHS Foundation Trust, Tricia Hart, to advise on how NHS hospitals can handle complaints better in the future.[16] Their report, *Putting Patients Back in the Picture*[17], was published in October 2013. It called for Trusts to provide patients with clear and simple ways of feeding back comments and concerns about their care on the ward.

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12 The Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, chaired by Robert Francis QC, 24 February 2010

13 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 6 February 2013

14 DH, Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (Cm 8576) 26 March 2013, p53

15 Department of Health, Hard Truths: the journey to putting patients first,

16 HC Deb 6 February 2013 cc281–283

17 A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt Hon Ann Clwyd MP and Professor Tricia Hart, 28 October 2013

In February 2015, the Government published *Culture change in the NHS: Applying the lessons of the Francis Inquiries*. The report sets out the progress that has been made in applying the lessons learned from the failings at Mid Staffordshire Trust, including the actions that have been taken to ensure that complaints about care are properly listened to and learned from:

> **Achievements in the past two years**
>
> - The Care Quality Commission is now routinely examining how well organisations handle complaints and those that fall short will have this reflected in their inspection findings.
> - The Department of Health and NHS England have issued a new guide for patients on complaining, and a poster setting out how to make a complaint has been made available to the NHS.
>
> **Next steps**
>
> - The Care Quality Commission's recent *Complaints Matter* report concluded that the quality of complaints handling was variable, and it raised concerns about the timeliness of responses to complaints.
> - The Ombudsman has increased the number of cases she deals with, but more needs to be done to restore and maintain public confidence.
> - A regular and standardised way of surveying people who have made a complaint in both primary and secondary care is required.
> - A review of NHS complaints advocacy services will complete by Spring 2015.[18]

## 3.2 Health Select Committee reports

The Health Select Committee published a report on the NHS complaints and litigation system in June 2011. It recommended that the Government should undertake a full review of the complaints system and consider the operational and legislative framework within which the Health Service Ombudsman operates. The Committee also called for greater access to advocacy, and procedures for speedy resolution of smaller claims.[19]

In January 2015, the Health Select Committee published a report on Complaints and Raising Concerns. The Committee found that the current system for complaints is variable:

> Too many complaints are mishandled with people encountering poor communication or, at worst, a defensive and complicated

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18 Department of Health, Culture change in the NHS: Applying the lessons of the Francis Inquiries, February 2015, Chapter 2

19 Health Select Committee, Complaints and Litigation, HC 786-I 2010-12, 28 June 2011

> system which results in a complete breakdown in trust and a failure to improve patient safety.[20]

The Committee recommended a single gateway for raising complaints and concerns:

> We agree that the onus should be on the system to help a complainant. People should not be forced to search out the most appropriate way to raise concerns. We recommend that the complaints system be simplified and streamlined by establishing a single 'branded' complaints gateway across all NHS providers. This should be available online, but not exclusively so. There should be adequate resourcing to enable complaints to be examined, identified, and directed speedily to the appropriate channel.[21]

The Committee also stated that there is a strong case for integrating the complaints systems for health and social care, and that this should start with a single ombudsman.[22]

The Government published its response to the Committee's report in March 2015. The response highlights the value and importance that the Government places on improving patient safety and complaints handling. The response sets out the work the Government has undertaken to deliver improvements to the way health and social care complaints are handled:

> In February 2015 the Government published *Culture Change in the NHS: Applying the Lessons of the Francis Inquiries* and Chapter 2 provided the detail and progress on many of these complaints handling projects. A summary of all the projects is detailed below:
>
> - Issuing clarification that a threat of litigation should not automatically stop a complaint being investigated: A clarification note was published in March 2014;
> - Building complaints handling into CQC inspections: The quality of providers' complaints handling has been included in CQC inspections since October 2014;
> - A measurable vision for complaint handling across health and social care: This work was published in November 2014;
> - Setting of Standards for Complaints Advocacy: Healthwatch England published these standards in February 2015;
> - NHS Constitution Complaints guide: the guide was published in February 2015;
> - Move to quarterly publication of hospital complaints data: This project is progressing well, and is on track for the new collection to start from April 2015, with publication of data expected late summer 2015;

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20 Health Select Committee, Complaints and Raising concerns, HC 350 2014-15, 21 January 2015, page 3
21 *Ibid*., page 13
22 *Ibid*., page 19

- Regular and standard method to survey complainants: A workshop has been held to generate options, and these options have now been narrowed down and are being considered in more detail;

- Review of PALS and evaluation of NHS Complaints Advocacy arrangements: Both projects are underway and we envisage they will be complete by spring 2015.[23]

The Government stated that the matter of whether there should be a single health and social care Ombudsman is for Parliament to decide, and is the subject of a consultation by Robert Gordon.[24]

It also set out that from April 2015, all NHS secondary care organisations will be required to submit revised quarterly complaints data to the Health and Social Care Information Centre for quarterly publication. It is proposed that Primary Care organisations will start quarterly complaints reporting from April 2016.[25]

The Government also stated that Healthwatch England Commissioned Citizens Advice to expand their health and social care section on "Adviceguide" to provide individuals with advice on navigating the health and social care complaints system, to make sure the public have access to accurate, current and accessible information in one place.[26]

## 3.3 Public Administration Committee report

In March 2015, the Public Administration Select Committee published its report into Investigating clinical incidents in the NHS. The report called on the Secretary of State for Health after the General Election to establish a national independent patient safety investigation body, funded by the Department of Health.

The Committee found that there were failings in the current NHS complaints procedures:

> the current NHS processes for investigating and learning from untoward clinical incidents are complicated, take far too long and are preoccupied with blame or avoiding financial liability.[27]

The Committee said that there are such serious concerns about the capacity and capability of the Ombudsman service that complete reform is needed:

> Complainants deserve an Ombudsman they can have confidence in. There are serious questions about the capacity and capability of the Ombudsman's office, in particular in relation to complaints involving clinical matters. We are aware of considerable anguish and disquiet where Parliamentary and Health Service Ombudsman [PSHO] investigations fail to uncover the truth, and of pain

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23 Department of Health, Government response to the House of Commons Health Select Committee Fourth Report of session 2014–15 Complaints and Raising Concerns, page 3-4
24 *Ibid.*, page 8
25 *Ibid.*, page 5
26 *Ibid.*, page 6
27 Public Administration Select Committee, New independent investigator of clinical accidents needed, say Committee, 27 March 2015

> inflicted by the Ombudsman's defensiveness and reluctance to admit mistakes. This underlines the need for improved competence and culture change throughout the system, including in the PHSO. PHSO leadership is aware of the need for this change, but it is proving more challenging than expected. We welcome the PHSO's aim to improve the quality and accessibility of its services. However, the Ombudsman's office is under considerable strain. Fundamental reform of the Ombudsman system is needed.[28]

The Committee have also stated that reform of the complaints process would mean more complaints are resolved at an earlier stage, leading to less subsequent referrals to the ombudsman:

> We pursue this topic in the hope of achieving quicker and more effective resolution of incidents of clinical failure locally, leading to faster learning and more positive change, without the need for a complaint, and therefore a substantial reduction in the number of people whose cases reach as far as the Ombudsman.[29]

The Chair of the Committee, Bernard Jenkin, reported that the Secretary of State for Health appears to support their proposals:

> We are very pleased that the Secretary of State for Health has already appeared to have accepted the principle of our main recommendation. His engagement with this inquiry has been exceptional. The Shadow Health Secretary has also made a commitment to review all hospital deaths.[30]

The Government responded to this report in July 2015 in part of their published document, Learning not blaming. On the Committee's recommendations on the Health Service Ombudsman, it stated:

> We would like to see improvements in the pace and responsiveness of the Parliamentary and Health Service Ombudsman, and – crucially – much greater patient and public confidence in its work. We agree with the Committee that fundamental reform of the Ombudsman system is needed. The Government have signalled their intention to simplify and modernise the existing Ombudsman structures, as outlined in the draft Public Service Ombudsman Bill announced in the Queen's Speech on 27 May.[31]

More generally, about complaint handling in the NHS, the Government response said:

> We are working to put in place a more open and transparent culture in which all forms of feedback – comments, concerns, compliments and complaints – are welcomed and acted upon.
>
> […]
>
> Over the last two years action has been taken in a number of areas. We have increased transparency by improving the quality and frequency of national complaints data in secondary care. The

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28 Public Administration Committee, Investigating clinical incidents in the NHS, 27 March 2015, HC886 2014-15, para 75

29 *Ibid*., para 9

30 Public Administration Select Committee, New independent investigator of clinical accidents needed, say Committee, 27 March 2015

31 Department of Health, Learning not blaming: The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation, Jul 2015, pages 41-2. See also pages 46-7.

> first quarterly data returns will be published in the summer and for the first time there will be more granular detail on the issues being complained about. We have sought to build an enduring national partnership of organisations committed to working together to improve complaints handling, and looking at complaints within a wider context.
>
> […]
>
> We continue to believe it is important that improvement in the handling of complaints is linked to wider issues around hearing the patient voice, learning lessons and focussing on providing safe, high quality services. Delivering this requires the whole care system to play its part. As steward of the system the Department will convene a new national partnership of organisations which looks at complaints improvement within a wider context, building on the work done to deliver commitments set out in "Hard Truths", and considering how to improve the culture around patient feedback, including complaints.[32]

[32] *Ibid.*, pages 43-5.

# 4. The Health Service Ombudsman

The office of the Health Service Ombudsman was created by the *NHS Reorganisation Act 1973* following pressure for an effective resolution of grievances, given the exclusion of the NHS from the 1967 *Parliamentary Commissioner Act*, as outside the direct responsibility of what was then the Minister of Health. The office was subsequently modified by the *Parliamentary and Health Service Commissioners Act 1987, the Health Service Commissioners Act 1993* and the *Health Service Commissioner (Amendment) Act 1996.* This last Act considerably broadened the scope of the investigations by enabling the Health Service Commissioner to investigate all aspects of NHS care and treatment, including clinical judgement. It was designed to place the Ombudsman at the top of a unified NHS complaints procedure. Complainants can refer their case directly to the Health Service Ombudsman and do not have to go through their MP (and cases can continue to be referred to the Ombudsman during a pre-election dissolution period).

The Parliamentary and Health Service Ombudsman's 2013/14 Annual Report states that the service received 27,566 customer enquiries – an increase of 2.2% on the previous year. Of these, 17, 964 enquiries related to health services and 1,778 health investigations were completed.[33]

The current remit of the Health Service Ombudsman is set out in the *Health Service Commissioners Act 1993* (as amended), which gives the Ombudsman power to investigate in certain circumstances, including:

on a complaint duly made to [the Commissioner] by or on behalf of a person that he has sustained injustice or hardship in consequence of

- a failure in a service provided by a health service body,
- a failure of such a body to provide a service which it was a function of the body to provide, or
- maladministration connected with any other action taken by or on behalf of such a body,

Any failure or maladministration mentioned in subsection (1) may arise from action of

- the health service body,
- a person employed by that body,
- a person acting on behalf of that body, or
- a person to whom that body has delegated any functions.

A complaint under the 1993 Act may be made by an individual or a body of persons, whether incorporated or not, other than a public authority.

In November 2014, the Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch published a

[33] Parliamentary and Health Service Ombudsman, Annual reports and accounts 2013-14, page 14

'vision' for what good complaints handling should be like. My expectations for raising concerns and complaints sets out five key user-led principles for raising complaints and concerns:

- I felt confident to speak up
- I felt that making my complaint was simple
- I felt listened to and understood
- I felt that my complaint made a difference
- I would feel confident making a complaint in the future[34]

The CQC will use the framework in its new inspection regime, and NHS England will also use it as a performance management tool as part of the NHS Outcomes Framework.

On December 2016, the Government published a draft Public Service Ombudsman Bill. This would create a Public Service Ombudsman (PSO) for UK reserved maters and for public services delivered solely in England. The PSO would absorb the existing remits and responsibilities, and supersede the positions of, the Health Service Ombudsman, as well as the Parliamentary Ombudsman and the Local Government Ombudsman.

For more information on this, see the Commons Library Briefing, Draft Public Service Ombudsman Bill CBP 7864.

## 4.1 Health Service Commissioner for England (Complaint Handling) Act 2015

On 2 July 2014, David Davis presented the *Health Service Commissioner for England (Complaint Handling) Bill*, having come 19th in the Private Members' Bill ballot. The Bill received Royal Assent and became an Act of Parliament on 26 March, coming into force on 26 May 2015.

The Act has two distinct objectives that together seek to improve the handling of complaints by the Health Service Commissioner for England [known as the Health Service Ombudsman]. The Act amends Section 14 of the *Health Service Commissioners Act 1993* as follows:

> Where the Commissioner has not concluded an investigation before the end of the 12 month period beginning with the date the complaint was received, the Commissioners must send a statement explaining the reason for the delay to the person who made the complaint
>
> The Commission must lay before Parliament an annual report which contains the following information:
>
> - How long investigations that were concluded in the year to which the report relates took to be concluded

[34] Local Government Ombudsman, Healthwatch, Parliamentary and Health Service Ombudsman, My expectations for raising concerns and complaints, November 2014, page 8-9

- How many of the investigations took more than 12 months to be concluded; and
- The action being taken with a view to all investigations being concluded within 12 months.

The Government supported the Bill and the Department of Health drafted Explanatory Notes, with the consent of David Davis, the sponsoring Member. The Explanatory Notes provided the following summary of the Bill:

> The Health Service Commissioner for England (Complaint Handling) Bill seeks to increase the effectiveness of the Commissioner (known as the Health Service Ombudsman), who is the final tier of the NHS complaints system. It does so primarily by requiring the Health Service Ombudsman to take action with a view to concluding investigations of complaints within 12 months, and by requiring her to inform the complainant, in any case where this timescale is not met, of the reason why not.[35]

Further information is provided in the Commons Library briefing, Health Service Commissioner for England (Complaint Handling) Act 2015 [Chapter 29], CBP 07170.

[35] Explanatory Notes, Health Service Commissioner for England (Complaint Handling) Bill, para 3

# 5. Medical negligence

In cases where someone has been harmed as a result of negligence by an NHS organisation or healthcare professional, an individual might consider taking legal action against the NHS or member of staff concerned. The aim of taking legal action is usually to try and obtain compensation. Compensation payments can be made following a successful claim of medical negligence and settlements are sometimes made out of court following the initiation of legal action.

Taking legal action against an NHS body or any local authority can be long, costly and complex. It is therefore advisable to seek professional legal advice.

The NHS Litigation Authority (NHSLA) handles negligence claims made against the NHS and works to improve risk management practices in the NHS. When a claim of negligence is made, the NHSLA is responsible for acting on behalf of the NHS body involved and as a result does not offer advice to individual patients. However, the NHSLA website explains how negligence claims are handled:

> **Information for patients**
>
> The NHS Litigation Authority (NHSLA) handles negligence claims and works to improve risk management practices in the NHS.
>
> **Negligence claims**
>
> Under English law, an individual may be entitled to compensation if they have been injured as a result of the negligence of another person. In order for a patient to obtain financial compensation when something goes wrong in the NHS, the following criteria must be met:
>
> The doctor (or other health professional caring for the patient) must have acted in a way which fell short of acceptable professional standards. The test is whether the actions of the health professional in question could be supported by a "responsible body of clinical opinion". It will not be enough to show that other health professionals might have done something differently if a "responsible body" of health professionals would support the action taken.
>
> The harm suffered by the patient must be shown, on the balance of probabilities, to be directly linked with the failure of the health professional to meet appropriate standards. If, for example, there was a good chance that the patient would have suffered the harm even if the health professional had acted differently, then the claim is unlikely to succeed.
>
> If you believe that these two criteria have been met and you wish to seek financial compensation you should seek legal advice. The organisation Action against Medical Accidents (AvMA) can help you to consider the options that may be open to you after suffering a medical accident and can, if you wish, put you in contact with a specialist solicitor. AvMA also offers support to patients in coming to terms with the effect that a medical

> accident may have had on them, whether or not clinical negligence is potentially involved.[36]

In January 2017, the Government announced its intention to impose a new fixed cap of £25,000 on the amount of costs that legal firms can recover on all clinical negligence cases. There is currently no limit on legal costs that can be recouped and the Government expects the new cap will help in saving the NHS up to £45 million a year in litigation costs.

On this announcement, Jeremy Hunt said:

> It's important that when significant mistakes happen in the NHS, patients are able to have an open dialogue with a trust about what went wrong, receive reassurance of what is being learnt, and can discuss what form of recompense or redress may be appropriate. Legal action should only be one part of this process. Unfortunately, what we often see in lower cost claims is a deeply unfair system where unscrupulous law firms cream off excessive legal costs that dwarf the actual damages recovered. We believe this creates an adversarial culture of litigation, which is inflating insurance premiums and drawing away resource from the NHS at a crucial time.

On 1 April 2017, the NHS Litigation Authority's name and remit was changed. It became the NHS Resolution, a body newly focused on reducing the number of clinical negligence cases as well as improving learning and developing new interventions to reduce mistakes. It will aim to resolve concerns and disputes more quickly, as well as making more use of mediation and dispute resolution, in order to reduce the number of course cases. It is also expected to put more resources into intervening in maternity related cases earlier. This change is part of the Government's drive to halve the rates of stillbirth, neonatal and maternity deaths, and brain injuries suffered at birth by 2030. Jeremy Hunt commented that the changes would ensure 'an enhanced focus on learning and prevention, not just litigation.'[37]

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[36] NHSLA website; Action against Medical Accidents have a helpline: 0845 123 2352 (open Monday to Friday, 10am to 5pm)

[37] 'Jeremy Hunt announces major overhaul of NHS quango', Health Service Journal, 21 March 2017

# 6. Judicial review

A judicial review is a procedure that enables someone to challenge a decision of a public body, such as an NHS organisation or the Secretary of State for Health, on the basis that the decision is unlawful.

A decision might be unlawful if:

- the decision-maker does not have power to make the decision, or is using their power improperly,
- the decision is irrational,
- the procedure followed by the decision-maker was unfair or biased,
- the decision was in breach of the Human Rights Act, or
- the decision breaches European Community (EC) law.

Judicial review is not a form of appeal. The judge will look at how decisions are made, rather than judging the decision itself. To be entitled to make a claim for judicial review, someone must have a direct, personal interest in the action or decision being challenged. Further guidance on applying for judicial review can be found on Her Majesty's Courts Service website.[38]

The right to make a claim for judicial review is derived from administrative law. As noted elsewhere, if someone is considering taking legal action they should get professional legal advice.

[38] Further information is available from the NHS Choices website and the 'Introduction to Judicial Review', by the Public Law Project.

# 7. Complaints about individual medical practitioners: professional regulation

If someone believes that the behaviour of a medical practitioner, or other healthcare professional, might call into question his or her fitness to practise, then a complaint can be made to the relevant professional body. For example, in the case of a doctor, this would be the General Medical Council (GMC) or in the case of a nurse, the Nursing and Midwifery Council (NMC).

A list of the bodies that currently regulate healthcare professionals in England is provided below, together with details of the professions they regulate:

General Chiropractic Council (GCC): the GCC regulates chiropractors.

General Dental Council (GDC): the GDC regulates dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists.

General Medical Council (GMC): the GMC regulates doctors.

General Optical Council (GOC): the GOC regulates opticians.

General Osteopathic Council (GOsC): the GOsC regulates osteopaths.

Health and Care Professions Council (HCPC) (formerly the Health Professions Council): the HCPC currently regulates arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, social workers in England and speech and language therapists.

Nursing and Midwifery Council (NMC): the NMC regulates nurses, midwives and specialist community public health nurses.

The General Pharmaceutical Council (GPhC): the GPhC regulates pharmacists, pharmacy technicians and pharmacy premises.

The Professional Standards Authority for Health and Social Care (PSA) (formerly the Commission for Healthcare Regulatory Excellence): the PSA aims to protect the public, promote best practice and encourage excellence among the regulators of healthcare professionals listed above.[39]

Measures to ensure the professional regulators protect and promote patient safety were contained in the Health and Social Care (Safety and Quality) Act 2015. The Act give the regulators of health and social care professionals an overarching objective of public protection. This includes

[39] The Department of Health Liberating the NHS: Report of the arms-length bodies review published in July 2010 considered the role of the CHRE. The review noted that it continued to fulfil an ongoing need but proposed to make it self-funding and extend its remit to social care.

objectives to protect, promote and maintain the health, safety and wellbeing of the public, and to promote and maintain public confidence in the professions regulated by the regulatory bodies. Further information is contained in the Library note on the Health and Social Care (Safety and Quality) Bill [Bill 17 of 2014-15].

In April 2014, the Law Commission published its proposals for major reform of the professional regulators in a draft Bill and an accompanying report, *Regulation of Health and Social Care Professionals*. The Law Commission proposed a series of changes to ensure regulation becomes more effective and robust, and set a new single framework for the regulation of all health and social care professionals. The Government published its response to the Law Commission in January 2015. It accepted the large majority of the Law Commissions' recommendations in full and others in part, and accepted the large majority of the Law Commissions' recommendations in full, and others in part accepted the large majority of the Law Commissions' recommendations in full, and others in part committed to legislate on the Commission's proposals in due course.[40]

No legislation subsequently was introduced on the Law Commissions' recommendations. However, in answer to a written question on 13 December 2016, the Government stated that it remained committed to reform, and that it intended to consult shortly on its reform priorities "taking account of, and moving beyond, the Law Commission's work".[41]

Lord Hunt of Kings Heath introduced his own Regulation of Health and Social Care Professions Bill, a private member's bill, to the House of Lords on 26 May 2016. It received a second reading on 3 February and will go into its Committee stage on a date yet to be announced. It is based heavily on the Law Commissions proposals. For more information, see the House of Lords 'In Focus' note, Regulation of Health and Social Care Professions Etc Bill [HL] (HL Bill 24 of 2016–17).

40 HC Deb 29 January 2015 HCWS235
41 PQ 56253 [Health Professions and Social Workers], 13 December 2016

# 8. Complaints in particular situations

Special procedures apply in certain circumstances, for example to patients raising concerns about treatment under the *Mental Health Act 1983*, in cases where a specific drug or treatment is being refused by the NHS, and regarding eligibility for NHS continuing healthcare.

## People detained under the Mental Health Act 1983: the CQC

The Care Quality Commission (CQC) has powers under the *Mental Health Act 1983*,[42] to make sure that health services are correctly applying and interpreting the Act. In particular, the CQC can keep the use of the Mental Health Act under review and check that the Act is being used properly where the Act is used to restrict a person's rights. A person's rights can be restricted under the powers of the 1983 Act in the following ways:

- **Detention under the Mental Health Act:** People who are suffering from severe mental disorder may be detained in hospital for assessment and/or treatment, where this is necessary for their own health or safety, or for the safety of others.
- **Treatment being received under a Community Treatment Order:** Patients who are detained in hospital may be given a Community Treatment Order upon discharge from detention. They are then subject to supervised community treatment, where they must meet certain conditions to remain in the community. The conditions usually include compliance with treatment and living at a named address.
- **Treatment or care being received under Guardianship:** Guardianship is designed to be a framework of minimum constraint to enable mentally disordered people to receive care outside of hospital. People subject to Guardianship may or may not be receiving specialist mental health treatment, but can be required to live at a certain place and attend other places for treatment, work, training or education.[43]

The CQC cannot formally investigate all aspects of an individual's care and treatment but it can provide advice and assistance to those making a complaint against a health service. The full procedures are not covered in this note but the CQC website provides further information.

Since April 2009, patients subject to certain aspects of the *Mental Health Act 1983* have had statutory access to an Independent Mental Health Advocate (IMHA).[44] IMHAs are intended to help and support patients to understand and exercise their legal rights. IMHAs will be

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42 Prior to the creation of the CQC in April 2009 these powers were exercised by the Mental Health Act Commission.

43 The mental health charity MIND also provides an outline guide to the Mental Health Act 1983.

44 The *Mental Health Act 2007* amended the 1983 Act to include provisions for an advocacy service for patients. Section 30 of the 2007 Act introduces new sections 130A-D in the *Mental Health Act 1983.*

available to most detained patients as well as patients under supervised community treatment or guardianship.[45]

## People refused treatment or medicines: exceptional cases funding requests

In March 2010, the then Secretary of State issued Directions to primary care trusts (PCTs) on the funding of treatments and medicines recommended for use in National Institute for Health and Clinical Excellence (NICE) technology appraisals. The Directions required PCTs to apply funding so as to ensure that a treatment recommended for use by an appraisal is normally available within three months after the date of publication of the appraisal.[46] The subsequent *Health and Social Care Act 2012* contains a number of provisions to enable the continuation of the duty for commissioners of health services (including clinical commissioning groups, NHS England and local authorities) to fund NICE approved drugs, following the abolition of PCTs from 1 April 2013.

For drugs and treatments not covered by NICE technology appraisals the NHS Constitution explains that patients have the right to expect the local NHS decisions on funding to be made rationally following a proper consideration of the evidence, and for the NHS to explain its decisions to patients.[47]

The Handbook to the NHS Constitution explains that while NHS commissioners can have a policy not to fund a particular treatment, they must consider requests for funding in exceptional individual cases:

> Administrative law requires that the decisions of NHS bodies and local authorities are rational, procedurally fair and within their powers.
>
> In addition, decisions by the courts have made it clear that, although an NHS commissioner (which will include a local authority commissioning public health services from 1 April 2013) can have a policy not to fund a particular treatment (unless recommended in a NICE technology appraisal recommendation), it cannot have a blanket policy; i.e. it must consider exceptional individual cases where funding should be provided.[48]

## People refused NHS continuing healthcare

The Library standard note NHS continuing healthcare in England[49] sets out the eligibility criteria, assessment process and dispute resolution procedures for NHS continuing healthcare.

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45 The Department of Health website provides further information on IMHAs.
46 PCTs had a legal obligation to comply with these Directions, which are made under section 8 of the *NHS Act 2006*.
47 NHS, NHS Constitution, 27 July 2015, page 7
48 NHS, The Handbook to the NHS Constitution, 27 July 2015, page 50
49 House of Commons Library standard note NHS continuing healthcare in England (SN/SP/6128)

# 9. Organisations that can help

There are a number of organisations that can provide help and advice to individuals who want to complain about NHS services, including:

- Healthwatch: The *Health and Social Care Act 2012* included measures intended to strengthen the voice of patients from April 2013, including the creation of local HealthWatch organisations and "HealthWatch England", a new independent consumer body within the Care Quality Commission. The Government has said that where a local HealthWatch becomes aware of poor complaints handling within an organisation, such as a provider or commissioner of local care services, it would be able to submit views to that organisation, in the form of reports and recommendations. There will be a statutory duty on that organisation to have regard to those views.
- Action against Medical Accidents (AvMA): AVMA is an independent UK wide charity. It can help patients to consider the options that may be open to them after suffering a medical accident, including providing contacts for specialist solicitors. AVMA have a helpline: 0845 123 2352 (open Monday to Friday, 10am to 5pm).
- The Care Quality Commission (CQC) is the independent regulator of health and social care in England. The CQC does not have a role in handling individual complaints but it does have powers to ensure registered service providers are handling complaints properly. It will also use feedback from users of NHS services to spot patterns of incidents indicating that there could be a problem.
- Citizens Advice Bureau: CABx can advise on NHS complaints.
- The Independent Complaints Advocacy Service (ICAS): ICAS is a free, confidential and independent service which can help patients make a formal complaint about NHS services.
- Independent Mental Health Advocates (IMHAs): From April 2009, patients subject to certain aspects of the *Mental Health Act 1983* have statutory access to an Independent Mental Health Advocate (IMHA).[50] IMHAs can help and support patients to understand and exercise their legal rights.
- The Patient Advice and Liaison Services (PALS): There is a PALS in every NHS trust and they can provide further information and discuss options about how complaints can be resolved. Some complaints can be taken up by PALS on patients behalf, while other complaints may require an investigation to be carried out, subject to the nature of the complaint. You can find your local PALS through PALS Online or by visiting the NHS Choices website.

[50] Under the Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008 (SI 2008/3166)

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