



Health Committee

Oral evidence: [Complaints and Raising Concerns](#),
HC 1080

Tuesday 11 February 2014

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Members present: Mr Stephen Dorrell (Chair); Rosie Cooper; Andrew George; Barbara Keeley; Charlotte Leslie; Grahame M. Morris; Mr Virendra Sharma; Valerie Vaz; Dr Sarah Wollaston

Questions 1-19

Witness: **Rt Hon Ann Clwyd MP**, co-Chair of the Review of the NHS Hospitals Complaints Ssystem, gave evidence.

Q1 Mr Stephen Dorrell (Chair): I do not think you need any introduction to any member of the Committee, Ann, and nor does any member of the Committee need introduction to you, but you are very welcome.

Ann Clwyd: Thank you very much, Chair.

Q2 Chair: If we may, we would like to go straight into it because I know you need to be away by three o'clock.

You have developed some important arguments around people's experiences of things going wrong in the health and care system and issued a report which contained a number of recommendations. The Government have done, I suppose, the easy thing and said, "Yes, we accept them." I guess the question at the heart of the Committee's thoughts this afternoon is: how are we going to notice the difference? What is going to be the result of Government accepting these recommendations and seeing changes in the way the health and care system responds to events that go wrong?

Ann Clwyd: Thank you for the invitation. I am sorry that I have a short time, but I have my own Select Committee which I have to take a part in this afternoon.

I think the short answer to that is: "When the letters stop coming." What has informed me, and us, is the things that people have said in letters. I would like to think that they will stop, but they keep coming. I had one today that asked me if "any action has been implemented following your report? Has the Department of Health kicked it into the long grass, where most recommendations from Select Committees and the like seem to end up?" There is a general sort of cynicism around, about whether yet another report makes

any difference at all. Of course, you have done your reports as well—very good reports; we have had the Francis report; we have had no end of reports. I probably mentioned before that I was on the Royal Commission on the NHS, which was a long time ago now—it reported in 1979—and one of our recommendations was for no further reorganisation in the NHS. Since then there have been 14. Our chairman started off by saying in 1977, when we started, that, unlike other Royal Commission reports, this was not going to gather dust, but of course that is precisely what it did. When I look at some of those recommendations now, I think, “Why on earth weren’t those done when that report came out?”

I have another letter, if I may, that I have just had from a woman who says, “My 94-year-old mother was admitted”—I keep out names of the hospitals—“in December 2013. Her care in this hospital was a disgrace to the NHS. My daughter and I were on our hands and knees wiping the floor round my mother’s bed as it was filthy and smelt of urine. My mother was moved five times to different wards, only one ward showed some caring care. Although they were always short staffed—three qualified staff in a 22-patient high-dependency ward—a patient would want a commode being unable to move because of a stroke. 20 to 25 minutes they would have to wait, by which time it would be too late, their dignity was gone. Meal times were not good; lunch would come, four patients in a ward with none able to feed themselves, food going cold, some even taken away from them without being touched, consequently patients losing weight at a rapid rate. One 99-year-old going down to 5 stone.”

Those letters obviously keep coming, and I am very keen that all our reports should not gather dust, but I don’t think anybody should be in any doubt that the kind of neglect, abuse, insensitivity and the fury experienced, for instance, by the families of Mid Staffs is confined to Mid Staffs, because over and over again we have had the same kind of complaints and the hurt that people feel when they are not heard. The evidence gathered in the course of our review made it abundantly clear that this was not the case by any means. The same things were repeated over and over again—quite simple things to put right, such as a shortage of blankets for people feeling cold, people needing an extra pillow or being dehydrated from not being able to get a drink, reach for a drink or not being encouraged to drink. Then, of course, nursing stations are complained about over and over again in the letters that we had, with people saying, “The nurses were there, but they were gathered round the nursing station and we could not interrupt their conversations.”

As you know, in the course of our review we visited nine hospitals across the country, held seven public engagement events, had eight meetings with individual experts and 20 meetings with leading organisations, but the most telling things were the letters that poured in. By now I have had over 3,000, and they keep coming. As I say, not a day goes by without another letter, e-mail or telephone call from someone. I must say that the staff in my office have been particularly patient. I sometimes come into the room and they are on the phone for 10 minutes listening to somebody pouring their heart out about something that has gone wrong. When it involves another MP’s area, I ask the person if it is okay to pass it on to their MP and the answer is usually yes; so I am also causing some of my other colleagues work as well.

The writers of the letters have talked about a lack of information. “No one spoke to you and no one told you anything. I felt I was intruding. I wanted to know what was happening

to my father.” Then somebody else was saying, “On the main ward it was extremely difficult to speak to a doctor or a senior member of the nursing staff. I tried to be polite but I was always made to feel people were too busy.” Then there are things like an 88-year-old woman who spent seven hours in A and E in a chair, in pain with a broken arm. “During this time I was constantly trying to find staff to ask what was happening. We seemed to be left in a corridor and expected not to ask questions or appear to make any demands.”

Then there is the lack of compassion, which is something I talked about originally when I witnessed it myself. If I may, I will read this letter out: “My 89-year-old terminally ill mother requested assistance for a wash and application of a haemorrhoid cream and was told by the nurses that they hadn’t got time. She requested a change of bedding as a drain had leaked on to the bed sheets but was told, ‘We don’t do that sort of thing. The nurses who come on duty in the morning do that.’ She ended up sleeping in a wet bed all night. She requested help to go to the toilet and was told, ‘Your notes say you are mobile so you can get up yourself.’” Then there are a lot of complaints about meals going cold, with people not being able to reach them. Sometimes they have both arms strapped up and somebody plonks a meal by their side. These things are so obvious that you would not think you would have to say them over and over again.

Q3 Chair: Unfortunately, you receive these stories, I know; we all receive them. I am conscious that you only have half an hour, so the question is: to take your point, how do you stop those letters coming, and how does the system become more responsive to its patients? Too often you heard—and we have all heard—the story that a patient complains and the experience is that they feel the complaints system is just the system gathering round to defend itself. How do you change that? That is the challenge that I think we face.

Ann Clwyd: We made recommendations in four areas. Just to generalise, they were to prevent complaints in the first place. Quite a few complaints can be put right at the bedside at the time instead of escalating, especially by improving the poor communicating skills of many of the NHS staff, and by providing information to people about their stay in hospital and how to provide feedback, good or bad.

Secondly, our recommendation was to improve the way in which complaints are made and dealt with, and, indeed, encouraged as a way of improving the service. Patients, we said, should be better supported and dealt with respectfully and promptly. Boards and chief executives must see the proper oversight of complaints and complaints systems as a high priority and do so publicly. There should be clear standards in all hospitals on complaints handling.

Thirdly, there was a recommendation to introduce more independence into the system. Very often, people felt the NHS was marking itself, and where there is a serious complaint, independent oversight should be offered at the local stage at first, and ICAS should be resourced to obtain independent clinical advice where necessary on behalf of patients or carers who complain. The second appeal stage—the PHSO—I think does not command confidence. That is the evidence we had, and we felt there should be a more localised appeal process with an independent element built in.

Fourthly, the recommendation is to provide more protection for whistleblowers. We just touched on whistleblowers in our report because we didn’t get much outside evidence on whistleblowing, although it was part of our terms of reference. Of course, the Department

of Health was telling us, “We are dealing with whistleblowing and we will be coming forward with proposals.” We are not sure that much has changed in that area.

Many of our recommendations have been made before. They have been made by this Committee and others, and they have been widely supported. Our concern is that they must now result in real change. If I may say so, what we would like the Committee particularly to follow up on is the progress being made by Healthwatch England and the other groups on developing consumer power, because we think consumer power is yet to be properly unleashed. Have they been given the resources to do this strategic work? Is Healthwatch at the local level sufficiently resourced to gather consumer views effectively?

Then we would particularly like to know—and I hope you will ask—what progress Sir Mike Richards, who is the chief inspector, as you know, has been making as our champion for complaints reform. Initially, when we first had a discussion on this, we were thinking of suggesting somebody independent, but actually Sir Mike Richards suggested he might follow up on these things and put complaints reform at the top of his shopping list when he visits hospitals, developing good practice in trusts, changing attitudes towards complaints within hospitals and injecting independence into the process. We have asked for another meeting with Sir Mike in a few months’ time, and certainly at the end of the year, after we made our report, we want a review on a whole pile of things.

Specific issues that maybe the Committee could probe would be the role of the Ombudsman, and how the appeals process could be more local and made more satisfying for people.

Then there are issues around the Independent Complaints Advocacy Service—I am on my last point now. I am trying to get as much out as I possibly can. As to issues on ICAS, we think it should be commonly branded, better resourced and have a wider scope than it does at the moment. There is a strong view, too, that it could be absorbed into Healthwatch at a local level and not separate from Healthwatch as it is at present.

Finally, there is whistleblowing—and I mean whistleblowing really when you meet people retrospectively who have been penalised because they whistleblow. I have had a few whistleblowers myself, Chair, a couple who have said who they are and where they come from. The last one I had was a consultant geriatrician whistleblower, who said, “I can’t give you my name,” but gave me some very interesting facts. I asked, “Why can’t you give me your name?”, and he said, “Because I would be sacked if they knew I had talked to you.” So it is still a big problem, and whistleblowers, I think, have got a lot to put into this process.

Q4 Charlotte Leslie: Ann, thank you for your work on this. I sympathise a bit, as I have had to take on a new intern to deal with all the letters I have been receiving about whistleblowers in particular.

I have two things. I have noticed all this stuff should have happened—and we have said it before—but it has not. One observation that I have made—I wonder what you think of it—is that, particularly in the NHS, what gets measured gets done. In many ways I wonder whether, until handling complaints and handling whistleblowers correctly is more important than meeting targets, managers will always put targets above managing complaints and

whistleblowers. We have seen there are penalties and financial penalties for trusts not meeting targets but no real penalties, particularly on those managers themselves personally, for handling whistleblowing and complaints badly. Do you think that is something that needs to change, particularly the accountability of managers?

Ann Chwyd: I think this is where Sir Mike Richards has a very important role to play. He offered and said that he could do the job to make sure that complaints was at the top of the list of considerations in hospitals, that it would be top of the list in board meetings and that he would attempt to monitor these things. It would be interesting to know what he feels has happened, is happening and should happen before I give you a definitive answer on that, but I think it sounds like a good idea.

Q5 Valerie Vaz: Thank you, Ann, and thank you for your report. You describe two different things, such as not getting a blanket and something very serious like dehydration. Do you think, having gone round to these nine NHS hospitals, that there is a way of triaging those concerns and complaints? Not everyone would want to go down the route of—or even call it—a complaint; they just want a blanket. Is there a way maybe that you have seen in good practice, in some of the good hospitals, that you can compare the way those two things have been dealt with?

Ann Chwyd: Yes. At the back of our report we have listed what we think is good practice. Obviously, there isn't time to go through that, but they are there at the back of the report. At chapter eight we have, "Good Work," "Case study one: The critical friend," for example, "Central Manchester University Hospitals." There we have found the patients or relatives complaining about services "may be pleasantly surprised by the tone of the response. In the most serious cases, they are offered direct personal support from a senior executive," and "a director or deputy director is assigned as a 'critical friend', acting as an independent advocate on behalf" of the patient or their family. There are examples like that dotted throughout the report where we were very impressed.

Q6 Valerie Vaz: There is one last question from me. Do you have a time frame? The Government have accepted many of your recommendations, but have they given you a time frame for when those recommendations will be implemented?

Ann Chwyd: Sadly not. I would like to say today must be the time frame, because a lot of these things can be put right straight away, but we will be pressing the Government and we have said that in the report. There is an agreement that after a year we will go back and find out what has happened. I hope that you in the meantime, in your report, which will come out in the next few months—

Chair: That is why we are here.

Ann Chwyd—will have immediate impact.

Valerie Vaz: Thank you.

Q7 Grahame M. Morris: You have done a tremendous job. You have been very assiduous in analysing the responses you have had, letters, e-mails and so on. In terms of the

recommendations, there are quite a lot; there are 29 of them. Most of them the Government have accepted as being good practice and common sense, but are there any that have not been accepted? You gave an example in the letter that you read out of a ward with 22 patients and only three qualified staff. Are there any particular recommendations—for example, in relation to staffing levels—that you think the Government have not addressed that should be?

Ann Clwyd: Obviously, we commented on staffing levels, and as that letter showed, staffing levels are important; there is no doubt about that. But also, even if you increase staff, you need to make sure that they have the right skills.

Grahame M. Morris: Absolutely, yes.

Ann Clwyd: Unfortunately, too often, even when there appear to be enough staff, the skills are missing. Quite a number of people who wrote to us complained about “degree nurses,” and that especially came from older nurses, who said, “That would never have happened in my day.” We had sort of round-robins from groups of nurses who said, “You should look at what happened when degree nurses came in.” We had quotes like, “Too posh to wash,” and, “I’m a graduate; I don’t do sick.” There were lots of comments like that. If that attitude exists, it is wrong. How you change attitudes, of course, is a challenge for everybody involved in the NHS.

Q8 Grahame M. Morris: I was just trying to identify if any of the recommendations that you have made have been rejected by the Government.

Ann Clwyd: Well, not as far as we know.

Q9 Grahame M. Morris: Right; you are still waiting for a detailed response.

Ann Clwyd: Yes.

Q10 Chair: Have the Government responded formally to your report yet?

Ann Clwyd: I think they have.

Q11 Chair: It is one of the things we might encourage them to do if they have not.

Ann Clwyd: I am not sure how formal the response was. There has been a response but I can’t remember in what context it was. I don’t know if any of you were present on the Floor of the House, but we didn’t actually discuss the report there, so I suppose you would describe it as an informal response.

Q12 Valerie Vaz: We have not discussed the Francis report on the Floor of the House either.

Ann Clwyd: Right. I think they promise to ramp up consumer power, but to do that adequately you have to give consumer groups resources, and I don’t know whether that has happened. Then we had pledges from various regulators. What we tried to hardwire into our system was the promises from the people who could pull the levers. We had pledges from various professional regulators and others to take the relevant steps. For instance, the Nursing and Midwifery Council said it would develop “new protocols” and “improve the experience of patients and other complainants involved in their fitness to practise proceedings,” as well as sharing intelligence and data better with the CQC and other regulators. Whether that has happened I think would be an interesting question for

the regulators, but I know, as to the Nursing and Midwifery Council, that I am going to be asking a question in Welsh Questions tomorrow as to how many are still under investigation on charges of being unfit to practise. Something like 400 are two years old, so that does not seem to be very rapid to me. So are there nurses or midwives or whatever out there—

Chair: This is a subject we have taken up with the NMC in the past.

Q13 Andrew George: Ann, you have been a tremendous harvester of complaints, but I just wonder whether the word “complaint” is the right word. I couldn’t see in your report that you drew a significant distinction between those complainants who were seeking very personal redress—possibly even compensation—and those who were offering feedback because they wanted to make sure that the system improved and that people did not experience what they had experienced. It is certainly my experience in the cases that I take up of those who come to me to complain about the health service that when I ask them, “What is it that you want to achieve?”, nine times out of 10 they say, “I don’t want others to experience what I or my family have experienced.”

Have you reflected on whether the system has created circumstances which are unnecessarily adversarial, where the opportunity to genuinely use the experience of the patients and their families can be used constructively in the health service itself, and whether we are missing an opportunity? It seemed to me that a lot of the language and dynamics in your report were driving what would inevitably be a kind of two-sided adversarial process. Have we missed an opportunity here?

Ann Clwyd: The point that I made at the beginning was that a lot of the concerns, complaints, moans, or whatever you want to call them, can be put right at the bedside. If somebody needs to go to the toilet and can’t get there without help, if they need an extra blanket because they are cold, or if they need a drink, that is something that can be put right, I think, quite quickly, but it is a big mistake to allow things to escalate. I think in the report we have said—it sounds silly—put a piece of paper and a pencil by somebody’s bedside so that they can scribble down what is wrong. A lot of people are afraid to complain. Even when they have something really big to complain about, they are afraid to complain; their relatives are afraid to complain in case somebody takes it out on them in the future or against the person—their relative—who is in the bed. People should not be afraid and it should be made quite clear that if you are voicing a concern, a complaint, or whatever it is you want to call it—we agonised over the use of the words as well—there should be a listening and sympathetic ear. That goes from the top of the NHS right the way down. The responsibility lies right through.

Q14 Barbara Keeley: I just want to ask you to expand on your comments on the role of the Parliamentary and Health Service Ombudsman, if you can, and how that might change. Clearly, it has been accepted that there needs to be better resourcing and some work done on developing a vision and expectations for complaints handling, but what did you feel about the Ombudsman and how that should go forward?

Ann Clwyd: I felt that a large number of complaints go to the Ombudsman but very few are investigated. I think people felt quite angry about that. To take it as far as the Ombudsman requires a lot of effort, and if people find the Ombudsman is only dealing

with a small number, they feel angry and frustrated. The feeling was that the Ombudsman was too far away from the action and that it would be good to have a local-type Ombudsman in a region—not only an Ombudsman based in London, but somebody that people could feel they could relate to more easily. There have been a number of comments about the Ombudsman recently, with people feeling annoyed because they did not have their case—they felt—looked at. I did have a note about the Ombudsman.

Independence from the NHS is something people felt very strongly about, and they did not feel, even though they know the Ombudsman is independent from the NHS, that the system was independent enough. It is quite a big organisation, and it was felt that it should be looking at a larger number of complaints, but also, basically, that it should be closer to the people making the complaints.

Barbara Keeley: Thank you.

Q15 Rosie Cooper: How would you improve the culture in problem areas in the NHS? Obviously, I will talk a little bit about a situation I know quite a lot about. You have talked about patients and families who are frightened to complain, and that is absolutely true and goes to the staff as well. In Liverpool, the CQC have recently done two reports on Liverpool Community Health Trust. In that they measured 10 areas. Liverpool Community Health Trust failed on all 10 and had to have two enforcement notices—actions required. Really good nurses—great staff—are labouring under what was called an oppressive and bullying culture. How do you change that culture? How would you begin to change that culture? What should they do immediately?

Ann Clwyd: I know of other trusts that have had accusations of bullying made against them recently. I don't know enough detail about the bullying accusations—what they consisted of—but I know that in some cases the bullying maybe has occurred because somebody has whistleblown or somebody has wanted to say that they have seen something that should not be happening. Now, we hope that, as a result of all these reports, the chief executive and the board, all the way through, should listen to people who have legitimate concerns about the service.

Q16 Rosie Cooper: You would think the buck stops with the chief executive and the board.

Ann Clwyd: I would, yes.

Q17 Rosie Cooper: In this case I know that the board and the chief executive have known about this for over two years and it just keeps on going. I personally agree with you—we need to find a way to bring trust in and to resolve that, and I am glad you agree.

Ann Clwyd: I would just say that I have done a few health conferences recently. I did one last week where they said, “Bring your overhead slides and give us that kind of PowerPoint presentation.” I said, “No, no, I am not interested in doing that. If you want me to come, I will do my own kind of presentation.” What I did was just read from the letters, as I did in the House of Commons about six times. People are just shocked by what is in the letters, and that, hopefully, provokes them to think, “What am I doing wrong? What is going wrong? How can people write these kinds of letters?” They come from all over the country; it is no particular part of the country. They come from Wales; they come from Scotland; they come from Northern Ireland; and they come from England.

Obviously, the report I was doing was England-based, but it did not stop the letters coming from elsewhere. I think really you make people think, “Can people write these kinds of letters? Are they continuing to write them? What is wrong?”

I think it is up to every trust, and as I said, we have seen some very good practice in some parts of the country and some practice which is not so good. Hopefully, they will all learn from one another.

One of the most interesting things was listening to complaints managers from all over England. I went to their conference. It seemed to me that they did not talk to one another. Several of them had very good ideas and, again, some of them came from areas with good practice, but they did not seem to talk to one another. We hope that that will be put right. If the complaints managers don’t learn from one another, who is going to learn?

Q18 Chair: Virendra wants to catch my eye but I am conscious that we are five minutes beyond the deadline you gave us.

Ann Clwyd: It is fine as long as I get there by half-past three.

Mr Sharma: I will be very quick; I have a very brief question. My apologies for arriving late. You said that the Government have not properly acknowledged your report. What do you expect the Government to do on your report now—what kind of acknowledgment? They asked you to produce this report, you have produced it and now there is no proper debate or acknowledgment on their part.

Ann Clwyd: I think there should be debates on these reports on the Floor of the House of Commons. For instance, I know that on Thursday the report is coming out on the regulation of cosmetic surgery, which is something I have been involved in for about 15 to 20 years because there was so much need for regulation. There is not going to be a statement on the Floor of the House; there is going to be a written ministerial statement. Now, for something which I consider to be important, there should be an opportunity for a proper debate on the Floor of the House.

Q19 Chair: We will take that point on board. Thank you very much indeed for coming and thank you for sparing us a PowerPoint presentation. We are grateful for the work that you do and the evidence you provide both here and elsewhere. Thank you very much.

Ann Clwyd: Thank you very much.

Questions 20-67

Witnesses: **Robert Francis QC**, Honorary President, and **Jenny Treanor**, Project Manager for the Speaking Up project, Patients Association, and **Anna Bradley**, Chair, Healthwatch England, gave evidence.

Q20 Chair: Robert, you are, I think, on your second or maybe even third appearance here. You are very welcome. Could I ask you to introduce your two colleagues as well?

Robert Francis: Yes. There is Jenny Treanor, who is working for the Patients Association and who I hope can assist you with the detail of their work in this field, and Anna Bradley, whom you know well, from Healthwatch England.

Q21 Chair: Thank you very much. I guess we really want to start with the themes that you have just heard being explored in the previous session. In your report on Mid Staffs you said that the system pays “lip service” to listening and to responding to complaints, but we all know there is far too much evidence that patients don’t experience a system that listens to them, and it clearly does not have the capacity to learn from them. The question on the Committee’s mind is how we can make the complaints system more responsive and effective, both in terms of delivering individual redress and from the point of view of other patients, more importantly, ensuring that those signals are heard and learned and the lessons applied. What is your view about how we best do that?

Robert Francis: I have obviously been giving some thought to this. It seems to me that we need to start from a different starting point, and it is partly wound up in what we call this—whether it is “complaints” or something else.

We should start, it seems to me, with what should now be a partnership between patients and the health service rather than a service which does things to patients. If we start from the partnership, partners have—or should do anyway—an entirely open and trusting relationship with each other. They share information with each other; they warn each other when things are going wrong. If one has that as the starting point in one’s culture, you get away from what is currently an assumption that a complaint or a concern is an adversarial thing—as soon as you use the word “adversarial” you immediately bring the doom and gloom of the threat of a lawyer turning up—and you also bring in a concept of flexibility about how you approach these things. At the moment, far too much focus is given to the formality of a complaint—how it should be made and the response times and so on, which are necessary at times—and rather less is given to the substance of what goes into the reaction, if one can put it that way, to a complaint or concern. The whole thing becomes very much paper-driven and so we have to have our complaints reduced to writing—again, perfectly understandably—and the response has to be in writing. If you are lucky, these days, a meeting gets tacked on somewhere into it. What is frequently missed—and I’m afraid that, like so many others, I am still getting the letters from people who have not been served well—is their real frustration that what they wanted to be listened to about, what they wanted to have something done about, has not been responded to at all. They are left with the feeling of being just rejected, in effect, and because of that whatever harm was done to them in the first place is increased. Some people become very damaged indeed and perhaps even more damaged by the rejection in the complaints process than they ever were by what afflicted them in the first place.

From that starting point, it seems to me that, in one sense, it does not matter what legal structure you put behind it. There might be nothing terribly wrong with most of, at least, the complaints rules; it is how individual organisations put them into force. That is a matter of leadership and culture within an organisation. So Mid Staffordshire, which is badly and defensively led and denies anything is going wrong, will have a bad reaction to complaints. A healthy place will have an entirely different attitude to the way it involves patients and staff in the process.

What do we do about it? I do believe that these are things that can at least be observed. Whether you can currently measure them is another matter, but I do believe that within the limitations of a regulator—and there are clear limitations to what a regulator can do—an inspection into how well led a trust is, including how it listens to its patients and how it

deals with complaints, will reveal quite rapidly if things are unhealthy and wrong, but I don't think that is enough.

Anticipating the question, because you asked a similar one to Ann Clwyd, I am in the slightly difficult position—but it is welcome—that virtually all my recommendations were accepted, at least in principle; but the ones in this area, where I feel that perhaps there is more reservation than some, which could be looked at again, are what powers of intervention there are at local level in relation to the way a trust is dealing with a complaint. My recommendation was that commissioners should have a more proactive role: not that they should be a place to appeal to, that there should not be a formal appeal or that they should take over the complaint—although I have to say, re-reading the complaints regulations, I reminded myself that they actually have the power to do so—but I do not think that is necessarily the way forward. They, on behalf of those who are paying for a service, it seems to me, have a real role to play, where things have or might have gone wrong, in ensuring that the complaint is dealt with properly, and they have a means locally of making sure that happens, which neither the CQC nor the Ombudsman has. So I would personally like to see that looked at a little more closely than perhaps it has been so far. I am sorry for a very long answer.

Q22 Chair: No; it gives us some food for thought; thank you. Perhaps I can bring in Anna Bradley, as you looked as though you wanted to contribute on these themes.

Anna Bradley: Yes. I don't disagree with what Robert has been saying, but I do think it is very helpful to start thinking about this by reviewing what it is that the users, the patients and their carers are saying about the way the complaints system works. We have heard, in research, in one-on-one conversation nationally and through local Healthwatch, some really revealing things. One in three says that they have had personal experience, or know someone who has had personal experience, of a really quite serious incident, but only half of them have done anything about it. That is quite remarkable really. You have to ask the question: why? This is when it gets particularly interesting. One in four of them says they did not do anything about it because they did not think anyone would be interested. Three in five said they did not know how to do anything about it. One in two said no one would do anything about it anyway and they did not trust that they would get a decent response. As we also know, very many people—Ann Clwyd talked about this too—just feel too vulnerable.

So I think there is something really important in your exploration of these issues about how we help the users of the service to move from the position where, in the words of our annual report, they are grateful patients to being more empowered in this situation and feeling that to want to make a contribution is a reasonable thing for them to do, whether that is a contribution by way of feedback or concern or is something more serious, because on the whole we do not feel that we are empowered to do that.

So there are a couple of very important additions to some of the things that Robert Francis was just talking about around—first, the information that people have available to them. I have the advantage of not being a health and social care person. I have always worked in a variety of different sectors, and in most other sectors you are given this information about how to provide feedback, concerns and complaints at the point at which you have a first interaction with the service provider or the provider of goods. You are handed leaflets, told this is a valuable thing and invited to provide it after you have received the service to

tell them what you think about it. There needs to be information about how to do this generally, but also specifically at the point that you are engaging with the service. We don't do that in health and social care, and it seems to me quite wrong that we don't do it.

Then I come to advocacy. I have to say, of all the things that happened as a result of the Health and Social Care Act, one of the things that became really quite fragmented as a consequence of the changes was the advocacy offer. It was much more of a national service; it isn't any longer. It is commissioned by local authorities—not in itself a bad thing necessarily, but sometimes it is commissioned with local Healthwatch and sometimes not. Of course, they are only talking about national health services—the advocacy in relation to the national health service.

Social care advocacy is a completely different beast. Those people who have mental health service issues have a specialist advocacy service, but if they then move into general health care or social care they need to go a different route. This is a very complicated picture, and yet the one thing that people really need—what we all really need when we are feeling vulnerable and disempowered—is a guide: someone to help them get through this process and make sure that the feedback or the complaint that they have really lands in the system and change is brought about. That is what people want—change to be brought about. I think there is something very important about looking at how we can help people and change the culture in which we all operate in health and social care, as well as looking at the system and what it needs to do to change.

Q23 Chair: Thank you. Do you want to come in, Jenny, or shall we move on to the next question?

Jenny Treanor: The only thing to add really in terms of stopping the adversarial approach is that one of the things that we would advocate would be a more proactive approach to asking people about concerns and complaints before they arise, not even at the end of their episode of care, but for the clinical staff or the departmental staff to be asking people on a regular basis whether they had any concerns—so actually going to them. The onus is not then on the patients or on the complainants.

Q24 Rosie Cooper: If we just responded to the complaints that they already have, would that not be a great place to start—never mind asking them? People would just be enthralled if they dealt with the complaints that people are making. I absolutely agree that that is a great theory, but the message has got to be: “Deal with what you can see and what people are telling you right now.”

Jenny Treanor: I think it is an issue about addressing issues before they get to that point of being a formal complaint, as well, of course, absolutely, as having a proper system for dealing with formal complaints, which we would fully support.

Q25 Andrew George: Mr Francis, the Francis report is, I suppose, going to be seen as a landmark in the development and management of the NHS—at least that is the way it is being referred to—even if the Mid Staffs issue itself is not already a significant landmark. It is almost exactly a year since your report, and I wondered whether either you yourself, or given the advantage of your position as chair of the Patients Association, are in a position to judge what progress there has been over the last year. Has it been lethargic, or are you pleased to see significant change happening in respect of the handling of feedback or complaints?

Robert Francis: Could I just correct you on a point of detail? I am honorary president of the Patients Association rather than its chair, which may have other implications, so any view I give, I hope, is agreed with by the Patients Association; but on the whole, if I may, on this issue I would express my own view.

The general answer to your question is that I have been very encouraged by the reaction to my reports, not only at governmental level, but also within the health service, in that I think there is a genuine determination to try to make the relevant changes to the culture, of which what we are talking about today is clearly a part. There has been some observation, to the point of criticism, about the number of reviews and reports that have, as it were, been produced subsequent to my report. All I would say about that is that, if anyone criticised the length of my reports, if you add together all the pages that have been written since, it perhaps does not look quite as long as it was. The reason for those, however, is that what I did was to look at the problems arising out of the hospital and things needed to be fitted into a wider picture. Also, steps needed to be taken moving towards, at least, the implementation of some of the things that I have suggested.

In relation to complaints and feedback, I am encouraged by the move that is being made in the direction of not only requiring a duty of candour, openness and transparency, but actually putting in place steps that mean that is more likely to happen, and also, if I can put it bluntly, some behaviour among leaders which shows they themselves are embracing candour, sometimes to the point of criticising themselves for doing so. That, I think, is encouraging. Of course one could quibble with some of the detail, but it is time to stop talking about how things are done and get on and do them, quite frankly, and I hope we are now in that business.

If I have concerns in the area we are talking about, like Anna, I am concerned at what is or is not happening with advocacy services and the support network. It does seem to be more fragmented even than it was at the time I looked at it. I am concerned about how that is funded and what is happening with the money around that, but most importantly I think it is becoming more difficult than it was for people to find what is the advocacy service. I recently had an experience where a letter arrived and I thought the answer to it would be to put the individual in touch with the advocacy service appropriate for the particular hospital that the complaint was about. I am afraid I spent 20 minutes on the internet and was none the wiser. If I could not find it, then I don't know how a member of the public was expected to, so I think there is work to be done there.

If I may say so, one of the things I am slightly concerned about with you opening this inquiry—but it is not a criticism of you doing so—is whether, yet again, another inquiry is used as an excuse: “Well, we had better wait to see what they say.” One of the things—if I can just plug it—to which the Patients Association has been making an enormous contribution is in encouraging trusts, through its standards and toolkits, to take up the means of improving the complaints procedures that they have. I would hope that that sort of thing would spread, so that, rather than talking about the theory, trust executives actually get on, look at their systems and seek to improve them, partly through peer review and partly through patient feedback. Those are the things, and it is a bit of a mishmash of an answer to what could have been a very long answer indeed.

Andrew George: That is right. I think the Health Select Committee would feel honoured if we thought that people outside were actually waiting with bated breath for our reports to come out before they acted.

Chair: If I can just say, it would be a defence for a trust to say that it is in the process of implementing some changes. To say that it is waiting for our report would not be regarded as a defence.

Q26 Andrew George: No, quite, but I just wanted to follow this up in the sense that your opening remarks implied that a self-confident trust sees complaints or feedback as a treasure trove of potentially constructive feedback from which they can learn lessons and improve their service, and a less self-confident trust probably sees complaints as very unwelcome irritants to the process. Taking that theme forward, do you think that that kind of balance is properly understood among the acute sector, which I think primarily is the sector that we are looking at—you heard my question earlier about the distinction between them—or whether the default position of the adversarial kind of route is one which is adopted too often?

Robert Francis: The Nuffield Trust, as you may know, published a report last week which was a survey of trusts and their reaction to the recommendations in the report. One of the notable features that came out of the responses was, first, a welcoming of the ability to exercise more candour, and part of that—many trusts seem to think—was looking at their complaints procedures, improving those and involving patients more in that and other processes. If that was reflective of the generality, then I think we should be encouraged, but of course all these things can just dissolve very quickly under other pressures and the chief executives being required to focus on other things, so you do need incentives, I think, to ensure that this progress is maintained.

Q27 Andrew George: I wonder whether, Ms Bradley, you within Healthwatch are in an advantageous position to take an overview as to how things have progressed or not over the last year in this respect.

Anna Bradley: In this respect, it is probably fair to say that it is too early to tell. You might find that frustrating because you have been talking about this for longer, but Healthwatch have only been in this—well, in existence, actually—thinking about this agenda for the last nine months. We, like others, have work to do in the context of both the Ann Clwyd report and the Robert Francis report, and it really is only just beginning.

In “Hard Truths,” which is the Government’s response to all these reports taken together, which is part of the answer to the question that you asked Ann Clwyd, that they did not respond to her report but to all the reports together—rightly or not, I don’t know, but that is what they did—there is quite a programme of work around complaints in which many people in the system have got a role to play, including Healthwatch but also NHS England, the CQC and many others. I would certainly encourage you to take a look at the extent to which that work is progressing and whether it is doing so at the rate at which it should. That would be a very important thing that you can do.

I would also want to encourage you very much not just to focus on the acute sector, because the reports that we have received have moved that agenda—at least the thinking about that agenda—forward significantly. Actually, local Healthwatch are finding that if the problems in the acute sector in relation to complaints are difficult, let’s look at the

primary care sector and the situation, for instance, in relation to GPs. I have reports from several local Healthwatch who have been doing things like mystery shopping of GP practices to see whether they can garner information about how to complain or give feedback in GP practices. The short answer is that it is extremely difficult. The staff can provide the answer, but they usually have to go away and find it from someone else. There are rarely written information leaflets. There is certainly no collection or collation of any complaints or concerns that are made in a way which would enable everyone to improve service.

Social care, again, is another story. A more expansive look at this across the whole sector is going to be really important and also the only way that you can really respond to the experience of the individual user, because the fact is we don't use services in packages which are defined by institutions. Most of us, if we are involved in using health and social care services, find ourselves using several of them, and the issues or concerns we have usually run across several of those different services. It is really important for us, therefore, that the way our concerns are dealt with is joined up by all those players and dealt with as a package, not us having to complain or feed back in three different places using three different systems. It is far too complicated.

Andrew George: That is helpful.

Q28 Charlotte Leslie: Very quickly—and I hope you will forgive some of my frustration—we talk a lot about culture change, and sometimes it feels with all this that we all know what should happen and keep saying it should happen, as if saying it more means that somehow magically it will happen, but we haven't really talked about not only how you change a culture, but how you create a culture. Surely one of the things that creates a culture is, at the soft end, its incentive and disincentive system, and, at the hard end, its rewards and penalties system. Certainly one thing many people looking at this objectively find very puzzling is how people can be surprised that we are not seeing the kind of changes that we would like to see—I am still getting the letters and I guess most people are—when you still have people in place who have been responsible largely for systems that have not been good or have failed. I am certainly working on cases now where there are individuals at the top of the tree in managerial positions who have made, at best, very questionable decisions, when those who have raised concerns and complained are currently either still out of a job, because they have whistleblown and never had a job again, or are frightened about speaking out because, very reasonably, they will be in fear of losing their job. It strikes me that once you have those rewards and penalties systems the wrong way round, it is going to be very difficult, just by tackling symptoms, to get a culture change if we have not tackled the cause. From that, I have two questions to Robert Francis.

First, the only way in which managers historically have been held accountable is if they also have a medical qualification, such as Barbara Hakin, through the GMC. How is your recommendation going on a kind of accountability structure for managers, and, also, I think care home managers and owners would be included in this, taking your point? Secondly, how do we incentivise and reward people for blowing the whistle, for example—and this is a very crude suggestion? If someone is found to be a vindicated whistleblower—i.e., they have gone outside the complaints procedure to raise a point and it is found to be

vindicated—is there any way they can be put on the opposite of a black list, like a white list, and have a flag by their name? Then, if they apply to another trust or organisation, which should—any good organisation will—welcome whistleblowers because they are going to point out complaints, it is going to be a symbol that they have that correct culture. If that organisation does not take on someone who is proven to be a vindicated whistleblower, is there any way that they have to provide an account for that decision? To me, the first flag that an organisation is a bad one is if it does not snap up a whistleblower. I just wondered if you had any thoughts—end of speech.

Robert Francis: I presume that question is directed at me. Just in terms of accountability, I will deal with what I see as the picture rather than my own accountability. The first point is that the culture change will take place with the right leader in place in the particular organisation, in my view. It is quite simple. To take your example, a trust which is led by a chief executive who personally welcomes and celebrates a whistleblower or, hopefully, before even that, the raising of concerns, and at the same time comes down like a ton of bricks on anyone who has been seen to try and prevent that, will change the culture pretty rapidly, I think, in their institution. But your question is more about the leaders who are not doing that for all sorts of different reasons. We need—and I have made recommendations about—accountability. The way in which that is being implemented, as I understand it, is by a fit and proper person test and, as it were, Monitor’s guidance. There is, I think, a discussion to be had about whether it applies to a sufficient range of people within NHS organisations, but at least it is a step forward from where we are at the moment. Whether that works or not needs to be kept under review, but because it is a step forward it would be better to let that get going, I think, and see what we do and what happens with it.

In so far as whistleblowers are concerned, I am afraid my answer is very blunt about that. We now have unanimity among those who are leaders of the Government and everywhere else that suppressing whistleblowers is absolutely wrong. It seems to me that any chief executive, any board, that is found to be guilty of that should be sacked. I put that absolutely bluntly. There can be no excuse any longer. If you want culture change, if a step or two like that could be taken—and it is far from me to comment, but it may be there are some opportunities out there—then I would suggest that that ought to be done.

Q29 Chair: “Pour encourager les autres.”

Robert Francis: Yes.

Q30 Dr Wollaston: Can I return to the point about raising complaints about primary care? I wondered, Anna, whether you share a concern I have—and perhaps you could say how widespread this practice is—of complaints now being handled out of the area. When you complain about a GP practice, it is no longer being handled within the local area but sometimes sent several counties away to be handled. It seems to me that it has been made more difficult to complain. How widespread is that, do you find?

Anna Bradley: I think you are referring, Sarah, to the fact that if you don’t complain to the GP practice itself, the next port of call is NHS England, and in particular the regional office of NHS England, because GP services are commissioned by the NHSE rather than by the clinical commissioning group. I have to say that, from the consumer point of view, here you are dealing with your local GP, and the idea that you go to something which

seems really very remote from your immediate experience is doubtless counterintuitive at best. Whether or not there needs to be another layer, I don't know—I hesitate to suggest other layers in the system.

We have produced a kind of atlas of all the organisations that are involved in handling health and social care complaints. We have 70 organisations on it so far, some with more peripheral interests than others and many with a very important role to play. But it is already terribly complicated, and anything that could be done to simplify and streamline it would be a good thing rather than anything else, so I wonder whether the answer to the problem you raise is, again, advocacy, because who it is who does these things does not matter so much if you have a guide through the system. If you know that you can go to a local advocacy service and you can find it—as Robert Francis says—then they can make sure that your complaint or concern is dealt with in an appropriate fashion; they can help you do that. But it is an important question and I don't know how the organisations might need to be refined.

I would encourage you to take a look at that map and the responsibilities that exist and wonder whether there are not some ways in which this could be simplified. There are two answers to this very complex process, are there not? One is to simplify the structures a little, and the other is to make it easier for people to find their way through it by giving them a guide and making sure it is more joined up. We need to do both, I think.

Q31 Chair: We would be interested to see the list of 70.

Anna Bradley: We will share them with you with pleasure.

Chair: It would work out the map.

Q32 Grahame M. Morris: I was very interested in one of your replies earlier to my colleague Andrew George, when you said, “It is time to stop talking and start doing.” I wondered about the practicalities of how we might do that, because you also mentioned a number of reports and the tendency among some organisations to wait and see what the outcome and the recommendations are, and there is always a risk of paralysis by analysis, is there not, rather than getting on and putting the problems right? In your report, you recommended that methods of registering a comment or complaint must be readily understood. Why do you think it is that patients currently find it hard to make complaints and raise concerns? In practical terms, what can we do about that? Should we put a pen and paper or a suggestion box maybe by every bedside to make it as easy as possible? You did say, in terms of a toolkit, that it is a case of spreading best practice and learning from the patient experience. What are your thoughts on the practicalities of it?

Robert Francis: I don't think that is a bad idea, but it never ceases to amaze me when I go and visit somebody in hospital that they have available at the bedside no information whatsoever about the services, their expectations and who is in charge of their care, let alone anything about complaints. It seems to me that every time a patient goes into hospital, there ought to be a sort of induction process where these sorts of things are discussed. If it gets down to the level of being warned where the fire escape is, then it becomes meaningless, but if a nurse says to the patient, in welcoming them into the ward,

“Now, if you have any problems, talk to me about it, or, if you don’t think I can deal with it, here is the means of doing it,”—on a personal basis, so that people are given authority, as it were, the freedom to raise things that worry them, which I suspect they are probably not at the moment—that would be a start. If that involves a piece of paper and a pencil, fine.

I think there ought to be a standard requirement in any hospital that people are welcomed in that way, but that is not enough because, as has been said, with regard to how you complain after you have left, which is when most serious complaints will happen, people do need guidance through the system and I do think we need perhaps a better, more simplified way available to do it, while at the same time understanding that you must not just have one way of doing it. What I mean by that is that there ought to be an easy way, but if someone chooses to do it a different way you should not reject them from the system. There should be some sort of common gateway or portal where you did not have to worry about whether it was a social care complaint, an NHS complaint or about your GP, because actually it could be about all of them, and someone else should sort that out for you—not you. That is what I would like to see happen.

The next thing I would like to see happen is that, quite early in the process, someone is offered a meeting to understand more what it is they want out of the process, because what they want out of the process might not be readily apparent, frankly, from what they have originally written. They may not understand what is available to them and I think they need to be taken to that. Those would be my initial steps to make it easier and to get the message out there that, “We actually want to hear from you,” not, “We really don’t want to hear from you.”

Q33 Grahame M. Morris: Arising out of that, in 2011 this Committee had an inquiry and published a report in which we recommended that the Ombudsman’s remit should be changed to provide a means of independent appeal for more complainants. Do you have a view about the need for independent review when it is impossible to get local resolution—where it has not been possible to resolve the issue locally? Do you think it should be the Ombudsman or some other body—at the risk of further paralysis by analysis—that the matter is referred to? Perhaps Anna might give us some thoughts on that as well.

Anna Bradley: Perhaps I can start by saying that Robert Francis mentioned information by the bedside. That reminds me that we heard from one local Healthwatch where we were delighted to find that in one hospital there was information by the bedside exactly of that sort—one hospital—and we also heard from another local Healthwatch where in a GP practice, when they went in to mystery shop, the receptionist said, “Fantastic,”—literally, these were her words—“we love complaints. It helps us to fix things before they go wrong.” There are far too few people who respond in that way, and there is far too little information to help people. These are very easy fixes if we can get them right.

My understanding of the system is that if things don’t get resolved at the local level, then you do have that appeal to the Ombudsman. One of the very good news stories from the consumer and user perspective is that the Ombudsman is very clearly committed to investigating a much larger number of complaints that come their way, and that is very helpful. Although we have an Ombudsman for health care and an Ombudsman for social care—the PHSO and the LGO—they are working increasingly closely together, which is something that we must welcome because of the issues I raised about complaints crossing

between different services. That bit of the system looks like it is changing quite a lot already.

Robert Francis: I agree that it is changing, and it is very welcome that the Ombudsman is undertaking more cases. It is also welcome, and this is more impressionistic than from data, but my impression is that there is less effort put into finding reasons not to investigate the complaint when it comes to the Ombudsman. That is very important, because if they are not investigated, whatever the Ombudsman says in nice words towards the complainant, they will feel that their appeal, if you like, has been rejected. I am certainly not in favour of inserting another level of appeal in the system, because we have tried that and it was a disaster. What worries me about the Ombudsman is that, however much she tries, she will only ever be able to deal with a tiny proportion of the cases where people are dissatisfied with the outcome. If you look at the surveys that exist now about people's reaction to complaint, it is a significant percentage who are dissatisfied but who don't appeal. I think that will always be the case. I am afraid I see the only way round that is not by having another appeal, which in itself sounds adversarial and brings all the problems into play, but to look again at the ability of someone locally—it could be commissioners, local Healthwatch or an oversight and scrutiny committee—to intervene in some way just to ask the responsible trust, not take its responsibilities away, to have another look at something. It could decide not to, but the pressure there must change things and people would not feel so alone.

Q34 Chair: Is there a way of reconciling that? I think the Committee, when we looked at this previously, would certainly agree with you that the last thing we want is to reintroduce the three-tier process, but that leaves open the question of whether the Ombudsman is the right destination for the upper tier of a two-tier process or whether a more local system, possibly of the kind you describe, might get us to a more valued process and indeed quicker outcomes.

Robert Francis: It might well be worth looking at. I was writing my report—and I suppose I am still speaking to you now—in times of financial stringency, and therefore the chances of setting up any new organisation seem to me practically quite remote at the moment.

Q35 Chair: We are not short of organisations. It is just a question of—

Robert Francis: No, that is true.

Q36 Valerie Vaz: Just to pick up on that point, actually it costs the NHS quite a lot of money to go down the litigation route, and when people feel they do not have local redress then they will do that. You mentioned that the Ombudsman is going to take on more cases, and we all know that, but is it not the remit, which you mentioned, of what the Ombudsman is going to look at? So people are still going to be dissatisfied, aren't they?

Robert Francis: I think there is an issue about the Ombudsman's remit—inevitably so, given the nature of the beast—and it is too narrow, because if it requires there to be maladministration as well, you are making it more akin to a judicial review process rather than an appeal by way of rehearing, if you are looking at it in lawyers' terms.

Q37 Valerie Vaz: I think I mentioned it with Ann Clwyd, but it is really how you define what is a complaint and what is a concern, I suppose at a local level, before it even gets to the Ombudsman stage.

Robert Francis: I suppose my point about the Ombudsman was that what is the Ombudsman's remit depends quite a lot on the discretion of the Ombudsman, and that depends, to a large extent, on the resource available to do the work. Whether it is the right way—it may well be worth looking at a system, but you have to remember that there are vast numbers of complaints, and if there was a local level of appeal I suspect there would be a lot of appeals—and whether that would improve the complaints process, I think, would need to be looked at.

Anna Bradley: There is a kind of phrase often used in other sectors, which is that in relation to complaints and concerns the object of the exercise is to get it right first time. That sounds much easier than I know it is in health and social care, but, on the other hand, that has to be our ambition, it seems to me, rather than to put in more layers—to focus on getting it right at the initial handling of the concern and the complaint. I am sure that Robert is right when he says that part of the answer to that has to be bringing people together so that you can really find out what it is that is of concern and see if there is a way to address it right there and then. More investment at that point seems to me to be a whole lot more valuable because that is the better place for it to be resolved.

Robert Francis: The longer the complaint goes on without being resolved one way or the other, the more difficult it becomes to resolve. There is absolutely no doubt about that.

Q38 Rosie Cooper: Could the cynic in me appear and say this? We are looking at local resolution and, as a former chair of a hospital, the trust doesn't manage to solve the problem to anybody's satisfaction. Would a trust, knowing the odds of it being sorted out by the Ombudsman, even with the view of taking the narrow limit of maladministration, not take its chances if it was that way out? I think it is really, really difficult to only rely on local resolution because it is like asking the police to investigate the police. There is not necessarily that level of confidence in the independence of a marginal clinical judgment as there sometimes is. Where is that independent oversight that helps the process stop? That is my huge problem. I think you can play the percentages if you are a hard-nosed trust that is not going to deal with these things.

Robert Francis: I think you will do that less with two things that are happening—the chances of changing a bit. One is—and Ann Clwyd mentioned it—the CQC looking at how complaints are managed. What they need to do, in my view, is to pay more attention to individual matters of concern than perhaps has happened in the past. It does not mean taking over the complaint but looking at how it is handled. The second is that, if involved in the mishandling of the complaint there is a lack of candour and that ends up being a claim, then there is at least a possibility, as I understand it, which is being looked at that that will have serious financial consequences for the trust in relation to its cover. So those are two things that are additional threats to the trust which might help the balance. I agree this is very difficult, but even if you have a local appeals system, it may cost less money than the litigation, although I don't know how we are going to measure that. I think we have to expose what trusts are doing. One of the things I recommended, which I think has been accepted, is that we need greater publicity around complaints and how they are resolved, and that should be put into the public domain.

Q39 Rosie Cooper: Could I follow on by asking you how you would publicise complaints? How would CCGs know what the level of complaints was?

Robert Francis: We need to move beyond figures in broad categories, which are pretty useless to man or beast. I think there could be an obligation—obviously anonymised—to publish in summary form what the complaint was, what happened about it and what the trust’s learning from it is. If you did that in summary form—and it could be very summary form—then everyone locally is going to say, “This trust is really not handling complaints very well,” or, “It is doing them differently from the place down the road.”

Q40 Rosie Cooper: But that applies to foundation trusts that do not do it anywhere today—that don’t publish them.

Robert Francis: Should it apply to them?

Rosie Cooper: Foundation trusts.

Robert Francis: Well, of course.

Q41 Chair: Perhaps equally obviously—in my view, but I put the question—should it also apply to NHS patients in private providers?

Robert Francis: Yes, and in primary care as well. I fully appreciate that there is a job to be done in converting some of what I have been talking about into the primary care sector, but it is very important that it is. Indeed, the complaints regulations, of course, apply—as I understand it, I think they apply—to NHS patients who are treated in the private sector.

Chair: Thank you. Charlotte wants to come in quickly; I am not sure whether question 10 has been asked. While you are thinking about that, Charlotte can ask a quick question.

Q42 Charlotte Leslie: We just talked about the remit of the Ombudsman. I want to flag something up about the culture as well. I have just learned—so I would not expect you to comment on this actual fact—that the current Ombudsman has refused to apologise to James Titcombe, the father of Joshua Titcombe, for the way in which the Ombudsman handled the case and currently insists that the way Ann Abraham, the previous Ombudsman, handled the case was reasonable. Given that we have criticised the relationship between the Ombudsman and the then CQC at that point, does it give any rise for concern if bodies are refusing to apologise for errors which they previously made? Even if the remit is expanded, it suggests that—if this is the case and I am correct in what I have just learned—the culture has not. What can we do if, even after all this, the Ombudsman is still refusing to apologise and still calls reasonable the behaviour of her predecessor, which I think most normal people would call not at all reasonable, in refusing to admit anything was wrong in the way it handled the case?

Robert Francis: I will not comment on that case. I know about the sad facts of the Titcombe case but not the particular relationship with the Ombudsman. The one thing I would say about apologies is that they are, first, extremely important to those who receive them, but they must be genuine. I am afraid there is a temptation sometimes in some places for an apology to be given at the same time as a denial that anything was wrong, and that adds insult to injury. Sometimes it is necessary to think about an expression of regret that is not an apology, but that is perhaps a debate for another time.

Recognising that mistakes have been made is important, and I believe that an example of that—although some, as they say, have not been perfect at it—would be that the Care Quality Commission in and around much the same issue has accepted that it did not do very well there. That is a step that would not have been contemplated some years ago, so I think there are changes there. I would like to think that any public body or official would apologise if they genuinely, on proper reflection, felt they had done wrong, but I think you cannot expect people to apologise when they don't think anything has been done wrong.

Q43 Rosie Cooper: Mr Francis, your report recommended that standards suggested in the Patients Association's peer review into complaints at Mid Staffs should be reviewed and implemented by the NHS. My real question is: how far do you think the NHS is from achieving those standards?

Robert Francis: It is probably quite a long way—I am just reminding myself of what was in those standards. Point 1 is that the investigation of the complaint is impartial and fair, and we have not talked at all today about the necessary independent element, which is not required at every single complaint but is required, in my view, in the serious ones. My recommendation with regard to that—if I can give it a plug—has been accepted in part, but it is not quite clear to me at the moment which part is accepted.

Q44 Valerie Vaz: Which particular recommendations—which number?

Robert Francis: It is partly recommendation 133. Can I come back to you on the actual number, otherwise we will take up unnecessary time? The answer to your question is that I am sure there is a long way to go, but, Jenny, you have had more experience as to what is happening on the ground.

Jenny Treanor: Yes. We have been doing some work using the standards for using the process of external peer review with a number of trusts looking at using external reviewers to measure with a number of trusts, taking up your point that if you don't measure things, how can you value them? I would say that has shown that there is a fair way to go in terms of developing. A lot of trusts don't even know about the standards yet. What we have found is that there still are trusts that are not aware of the standards; they don't know that they exist. So some trusts have gone some way to implementing them and moving practice forward significantly, and others of them are at the point where they have not even heard of them.

Q45 Chair: These are the same trusts that say they have studied every word of the Francis report, are they?

Jenny Treanor: Absolutely, yes.

Robert Francis: The answer to your question is recommendation 115 about independent investigation.

Q46 Valerie Vaz: Can I touch on that? Actually, it is all in your chapter, and everything you say about independence. You have quoted various people who came before you. It just seems awful that we do not have your recommendations fully implemented, particularly on complaints, but you have actually said all this in chapter 3.

Robert Francis: Yes, and a lot of it does not require a Government Minister to say it should be done. A lot of it could just be done tomorrow by the trust chief executives saying, “This is how we are going to run our complaints procedure.” What I mean by “independent investigation,” of course, varies according to the nature of the complaint. Sometimes “independent” could be someone from a different part of the hospital. In some cases, what you really need is someone from right outside the organisation. What is often forgotten—and lawyers perhaps think about this more than others—is that, so often, you need to get the facts right as to what has happened, and that is often very difficult if it is done by someone who was personally involved or knows the people who were involved. You need something more effective than that.

Q47 Valerie Vaz: I just wanted to add that I was with Lord Hunt, and he pointed out to me that he moved a clause in the Compensation Act which meant that, even if you said sorry, you did not admit liability, so that is out there as well.

Robert Francis: No lawyer would advise that saying sorry for something is an admission of liability for negligence. The NHS Litigation Authority encourages apologies to be used and explanations given as to what has happened, and will not penalise a trust that does that. It would be good if the opposite were the case—that if trusts did not apologise and provoked litigation, the NHSLA might look rather less favourably at covering their costs—but we will see.

Anna Bradley: Can I say a word about this? Robert is talking about the things which institutions in health and social care could do of their own volition if they wanted to. He is absolutely right that there is so much of this that people should not have to be told to do; it should be standard practice. There are two ways to encourage that to happen. There are some of the things which you have already talked about, which various of you have raised—the top-down mechanisms, whether that is inspection, targets or transparency about the information in the way complaints have been dealt with or the number of complaints and so on, and getting those bits right is clearly very important.

One of the things that we have not talked about as much in this session so far is the local scrutiny that could and should happen, which can bring about a remarkable amount of change simply by exposing what is going on. I will give you an example of a local Healthwatch—Peterborough—that asked for a randomised sample of complaints letters from the local trust, who obliged, as they should and one would expect would have to. The local Healthwatch reviewed the letters and were quite horrified with the quality of the response and the language that was used, and so on. So they asked to have a meeting with the board and they took their views on the letters to them—which you might think the board would have seen but they had not—and, as a result, the nature of those letters in that trust has substantially altered. It is a very simple thing and it just flows from local scrutiny. You talked, Robert, about the role of commissioners in that respect but also the role of scrutiny committees and local Healthwatch, where lots can be achieved by simply asking the question, reviewing what is being done and making sure the right people in the right positions know that it is not what is expected.

Chair: I should explain that Jenny is standing up because—as I was told in advance—she suffers, as I do, from a weak back. As a fellow sufferer, I sympathise.

Q48 Barbara Keeley: I do too actually.

To comment on the debate we have just had, I had a recent case whereby, in the end, what it boiled down to was a bereaved person who was really very upset about the difference between what was said to him in meetings—orally, his situation and the regret could be handled well—and all the formal letters, which were really upsetting. Every time we had to have a formal written response, it was the difference between that and how people were with him when they were discussing it in meetings. That is something that does need to be bridged and I can really see why perhaps I should have followed up on that—that the letters themselves were a cause of great pain.

Robert Francis: I have absolutely no doubt about that. Notoriously, there was a letter written, which was part of my inquiry, in the case of John Moore-Robinson signed by the chief executive, which I suspect he had not drafted himself, although he might have done, in which there was an apology and an expression of satisfaction that a reasonable settlement of the claim had been reached—which was a paltry sum of money for a young man who had died—and said words to the effect of, “We hope that, in view of the satisfactory settlement, you will now be able to move on.” The family were of course appalled by that. Those who drafted the letter, I am afraid, were unable to see that there was anything wrong with it. I know, as I am sure you do, that writing a letter back to someone who is bereaved and distressed, who has gone through these experiences, is about the most difficult thing I have to do, and no one is suggesting that I am responsible for anything that has happened. But care does need to be taken about them, and I think it is all too easy for people to slip into a sort of template which just does not work.

Q49 Barbara Keeley: No, I agree. The question I was going to come to was about your views—largely, Healthwatch, I would guess—on PALS and complaints advocacy services. You commented, I think, to the Public Administration Select Committee, on “the current complexity” of those services and the support offers, and said that that needs resolving. That does seem to be a generalised concern, and I am sure members of this Committee share it. Can you give us your view of the current state of those services and what needs to be done about them?

Anna Bradley: We need a single integrated advocacy service across health and social care, with a brand that people recognise so they know where to go and are not lost on the internet trying to find who they can get help from. Lots of people have suggested—and you heard Ann Clwyd suggest—that the right place for that to sit is with local Healthwatch. It does in some cases, so some local authorities have commissioned that service to local Healthwatch and others have not, so at the moment it is quite disparate, unhelpfully. There is no question but that it is a powerful combination for the local Healthwatch to be in touch with all those people who want to give concerns, feedback and raise complaints because they are providing the advocacy service, and then also to be in the position of advocating for change in the local health and social care system and taking broader issues to things like the Health and Wellbeing Board. It has a lot to be said for it, but the most important thing is that there is a single integrated advocacy service.

There is a second question about the role of an organisation like PALS. In some respects, PALS is a sort of pre-complaints service, and maybe there is a place for something like that—to bring people together in a non-adversarial way, as some of you have raised. The current difficulty with the PALS service is that it is only in hospitals. There is no equivalent to speak of in primary care, certainly not in social care, and it is very varied. It

is part of the hospital and, if you are looking for something independent, it clearly is far less independent than something like the advocacy service outside in the community. In some hospitals the PALS service also is responsible for handling the complaints on behalf of the hospital, so it is internally conflicted. In other places we hear from local Healthwatch that there is a fantastic PALS service which does a great job, and the patients and users of their service who have been in receipt of their support can do nothing but praise them. So I think we—and I hope you will—need to look at all these various different services that we have at present and work out what the best characteristics of each of them are, and whether we need just one, which does both perhaps some of the PALS-type of pre-complaints, bringing together of people as well as the advocacy and support through a complaints process. That is a point that you might like to look at.

Q50 Andrew George: I want to come back to a theme I was developing earlier about the problem with the word “complaint.” When the word “complaint” takes on its other noun form “the complainant,” you can put the prefixes “serial” or “vexatious” in front of it. Just playing the devil’s advocate for a moment, I wondered whether we are, and your recommendations are, getting the balance right in terms of making sure that we don’t set up a system which allows the Munchausen kind of equivalent, inclined to simply tie up a system which is overly receptive—so I am going to argue the other side of the coin—to people who are offering feedback and want to have their day in the adversarial process, particularly if it is very receptive and makes that system easy for them to use. To what extent could one make sure that the system is able, at the earliest possible stage, to ensure that the complaints that are being brought forward are robust, genuine and do not tie up what is an extremely valuable resource for the organisation?

Robert Francis: The first point I would make is that I would be depressed if we had to design a system the prime purpose of which was to exclude the vexatious complainant. They exist; they are a tiny minority; and you need a system which deals with the vast majority of cases. But a flexible system with people exercising their judgment, in conjunction preferably with the patient, will, I think, weed out, or should be capable of weeding out, at an early stage the complaint that either has no merit or, more usually, frankly, is one that may have some merit but is relatively—“trivial” is the wrong word, as it may be important to the individual—easy to deal with, which is probably a polite way of putting it. But if you have an entirely rigid system, whereby all complaints are dealt with by the same grinding process, then you play into the hands of the sort of vexatious nuisance that you are suggesting is there.

So I think it is about judgment at an early stage. What is it that this complaint needs? Some of them may require quite a sophisticated investigation to decide there is no merit in it, and we must not have a system which is afraid of coming to a conclusion that someone has complained through a misunderstanding or misinformation or just having got it wrong, but even so, they are entitled to a proper explanation as to why the matter is being rejected. So often, I think, that explanation is missing, which is why we see letters running to 20 or 30 pages that come from the same individuals week in, week out, because no one has ever stopped and been able to explain to them what the problem is. Of course, even then, some won’t be satisfied, but most will.

On your first point, might I say this? I utterly agree—and I have made a recommendation to this effect—that concerns that have not been complained about should be treated with

the same seriousness as those that have, so that if something comes to the attention of the staff in one way or another which is in fact a concern about the treatment of an individual patient, then it ought to be looked at in the same way, I think, as if a complaint was made. That does not necessarily have the same formal process, if there has to be one, but the attitude should be the same. Part of that attitude is likely to be going and talking to the patient about it at an early stage. In that way I think you will forestall many complaints that occur sometime later after someone has left hospital and they actually work out that something has gone wrong which should not have gone wrong.

Andrew George: Thank you; that is helpful.

Q51 Valerie Vaz: I want to pick up a point that you raised earlier. I suppose it would help everyone if you could explain how you fit into everything, how Healthwatch fits in—the local Healthwatch and the national Healthwatch—because I think you talk to the Department of Health as well, don't you?

Anna Bradley: Yes, we do indeed. Healthwatch England is a statutory body operating at national level, and we have a given responsibility to advise the national bodies in health and care—so explicitly not just health, as in our name, but also social care, and it is local government as well as national Government, Monitor, CQC, NHS England and so on—on the basis of what is in, if you like, the consumer interest. We are explicitly called a consumer champion on the face of the legislation.

We also have a responsibility to lead, support and guide the local Healthwatch network, but we can tell them to do nothing, which is a very interesting and potentially very powerful relationship in the sense that we have to be very mindful of what it is that they want, and they, in turn, have to be very mindful of what their local communities want. So the sorts of issues that we will pick up and address should be issues that are resonant in local communities because we are in touch with local Healthwatch. There are 152 local Healthwatches to be commissioned, each one by a local authority. There are some parameters for that commissioning, but a lot of freedom was explicitly part of the legislative arrangement—that local authorities could do this as they wished—and they have a statutory place on the Health and Wellbeing Board, so they too are built into the system. Many of them are also observers on the clinical commissioning groups—not all, but some—and they have some of the powers that the old LINKs had. So they can enter and view; they can go and turn up on the doorstep of any provider and talk to patients and users, find out what is happening and give advice and recommendations about that.

But the power of this network is that they can tell us things that we can aggregate and then use our advisory powers to talk to the players at the national level about, and we can take an interest in, issues that are national. Let's take complaints as one, where we are doing a lot of work—we are calling it a complaints campaign, if you like—which involves working with very many of the local Healthwatches too where we are all doing local work in the area of complaints.

Q52 Valerie Vaz: Is there a case for streamlining this whole process? Is there a case for local Healthwatch absorbing PALS and ICAS, so you have that at one level where everyone knows where to go to?

Anna Bradley: The same legislation that set us up and local Healthwatch also gave local authorities responsibility for commissioning what was ICAS, and they were given an option to commission it to local Healthwatch or to commission it elsewhere. Some have commissioned it to local Healthwatch and some have not. So there is absolutely an option to consider streamlining that and making it something that sits within local Healthwatch as a matter of course. That would be the case for advocacy—certainly something which the Clwyd-Hart report looked at and we are keen to see explored.

The question of whether or not PALS gets put into that arrangement as well, I think, is less well explored, but it is important to recognise that, as I said earlier, PALS is only in hospitals. It is a small part of the piece and it fulfils a particular function, but I think it is certainly a question that would be good to have asked and answered. Whoever delivers this, if we could arrive at a point where we said, “This is the advocacy service, the support and guide that is available to users of health and social care in the system going forward, and it is called this,”—it is one name, whoever it is who is delivering it—“and this is how you can find it,” that would be a great step forward.

Q53 Valerie Vaz: That was my point—that you are the local focus. Rather than the local authority commissioning lots of different people, there is a statutory basis on which they have Healthwatch and everything comes in it.

Anna Bradley: Yes.

Q54 Valerie Vaz: Is that possible?

Anna Bradley: That is certainly something we think is very much worth exploring. It is always better if other people suggest that these things come to the organisation that you are responsible for, but it certainly makes sense to us.

Q55 Valerie Vaz: I was just going to move on to exactly what is a consumer issue and what is a serious issue. Clearly, when a baby dies, for instance, or someone has a perforated bladder, that is a case of negligence and that goes out of the local area. Is there a case for defining this? I am touching on your fundamental standards, but is there a case, for example, for having something like your fundamental standards publicised in a hospital so that people know when they go into hospital what to expect when they get there, just as you say the nurse comes and talks to them and says, “This is what you would expect. This is how to complain”?

Robert Francis: I would very much hope so, as and when we know what the fundamental standards are going to be, which I hope would be—progress is genuinely being made there and the sort of debate I envisage happening about those is happening, but they have not yet been, it seems to me, quite yet defined.

Q56 Valerie Vaz: Could you tell us what the debate is and when it is going to come to an end?

Robert Francis: The CQC has had its consultation and it has had responses which have listed rather more—quite rightly so—standards than I originally put out there for discussion. I am honestly not quite sure what the current position is in that regard. I don’t think we have got beyond publishing the response that the CQC had—I think I am right in that.

Q57 Valerie Vaz: Are you part of that discussion then?

Robert Francis: Not in any formal sense, no.

Q58 Valerie Vaz: So you have just produced the report and nothing has happened since then other than some recommendations have been accepted.

Robert Francis: The recommendations around the concept of fundamental standards were accepted and the way they are being implemented is to make them part of the CQC's inspection regime and standards. The fundamental standards will, as I understand it, be part of their five questions, but they have not yet been formulated, even though Sir Mike Richards' inspections are beginning any moment now, if they have not already started.

Q59 Valerie Vaz: I suppose what I am leading to is this. There is a specific definition for a serious untoward incident, but how many patients going into hospital actually know what that is?

Robert Francis: I could ask the question, "How many members of staff know what that is?"

Valerie Vaz: Exactly.

Robert Francis: It probably needs to be out there and is probably more simple than it is.

Q60 Valerie Vaz: Is that part of the debate that we should be having under complaints—how you define whether, if you are asking for a blanket, that is a small issue, a small concern, or there is dehydration, you have a perforated bladder, or if you have been given the wrong treatment or medication?

Robert Francis: For myself, I would prefer to see that left as a matter of judgment on the individual complaint, because it might be easy to say that a complaint about, "I got the wrong order for my food" is at one end of it, but if you have an allergy or specific medically-related dietetic requirements, that could actually kill you. Equally, a car parking complaint is one that is likely to make all people groan in one sense, because everyone has them, but if it is about delaying someone getting into hospital because they can't find anywhere to put the car, or something like that, it could become very serious. I think you have to look at each individual complaint, and a judgment, I am afraid, has to be made, looking at it from the patient's point of view, about what the consequences were for the patient. Are those serious? If they are, then it should be taken seriously.

Q61 Valerie Vaz: Finally from me, what are the major concerns that your Patients Association have raised with you that you would like to tell us about?

Robert Francis: It is an early stage of our relationship, but I think the concerns that I hear—and Jenny will add to this, I am sure—are that the patients who contact the Patients Association still do not feel listened to. That is why they contact the Patients Association. I think many of them feel lost in a system—something has gone wrong, they don't know where to go and they feel alone. I think it is appalling that a service which is there to treat people, to make them better and, in one sense, look after them, seems to let them down so badly at that point. Jenny, I don't know what you think.

Jenny Treanor: Yes; we hear from patients, as you say, who just don't have the confidence to make a complaint, even though they have had, often, some quite appalling care and are either fearful of making a complaint or they just feel they don't have the skills to put a letter together or know where to go. We also hear from patients or people who have made a complaint, are not happy with the response and also don't know where to go at that point. Again, they come to us and ask us to help them to know what to do next. Often, as you say, it is not going to the Ombudsman; it may be that we help them to go back to the trust and just give them that little bit of support.

The other thing from the trust or the provider side is that there is a huge need for training for staff. Dealing with complaints is not about the complaints team. It is about everybody in the trust, all the clinical and non-clinical staff and senior staff, as we have mentioned, being clear about what their role is, being confident to deal with concerns and complaints appropriately. That is something that we get asked about. Will we train staff? Can we help them to find out where there is training? I think there is a huge need there, and that will address cultural issues and some of the poor practice that we see as well.

Valerie Vaz: Thank you.

Q62 Barbara Keeley: Can I take you back to the issue of complaints handling within primary care and social care? I think you have touched on primary care, in that the systems seem non-existent, that it is extremely difficult, there are no leaflets and so on. Are there views across the panel on the same thing with social care? I have to say, I think a lot of the ones in my constituency about GPs and social care are coming to me, because I seem to be spending a lot of time handling these, possibly because people don't know where to go with them, how to do it or are afraid—particularly in the case of nursing care and social care—to make a complaint directly. Could you give us your view and how we can go forward on that?

Anna Bradley: What we hear from users of primary and social care is, absolutely, those issues about feeling vulnerable and the possibility of being struck off your GP list, the possibility of finding yourself the subject of dislike in a home or a set of services where you have a long-standing relationship. It is potentially even more difficult when you are receiving domiciliary care in your own home and it is only a one-to-one relationship with someone delivering your care. You are absolutely right that people feel particularly vulnerable in those circumstances.

As local Healthwatch are going out and doing the kind of mystery shopping I talked about earlier on, in relation to primary and social care, what is coming back is this. I talked about primary care earlier on, but I will give you a different example. In West Sussex, they have started talking to and trying to find out from care homes what information they are able to give them about the complaints process, and they got pretty much a nil response to their first request, such was the sense that this was not an important issue. So they are obviously pursuing this further, but I think you are absolutely right that the issues are, if anything, more difficult and the systems are less well developed in primary and social care. That is one of the reasons why we in Healthwatch England and in local Healthwatch are really keen that our own work and your inquiry look beyond hospitals because, for all that that is a very important and particularly acute—if you will excuse the pun—kind of situation for people, most of us have much more longer-term relationships with people in primary and

social care than we do with hospitals. It is not true for some people but it is the case for most of us, so it is really time to focus some attention on that area, I think.

Q63 Barbara Keeley: Do the Patients Association have a view about how this should be?

Robert Francis: I can't really comment about social care. The route, as I would understand it, in relation to a complaint about your general practitioner—if you have exhausted whatever complaints procedure the practice ought to have—will, I suppose, now be through the clinical commissioning group. There is a system that could end up, if it was a service concern, with the practitioner being removed from the list. There is a potentially quite stringent system there, but I rather doubt that many people know about it.

Barbara Keeley: Okay.

Anna Bradley: That is partly the issue that Sarah was raising earlier, which is that the clinical commissioning group does not commission GP services, of course—

Barbara Keeley: It is NHS England.

Anna Bradley: So it is further afield. I think that does raise other issues.

Chair: One or two.

Q64 Charlotte Leslie: Finally, to finish off, I am going to return to the culture because, again, a lot of what we have been talking about is symptoms of a good culture and how you promote an open culture. I want to return to what we can do for historic whistleblowers, who have perhaps lost their jobs and who have not been able to use the complaints system, not only from the obvious sense of justice that people who have contributed to making our health service a safer place should not suffer for it, but also, in a pragmatic sense, for changing culture. It is still very difficult for people to speak out comfortably if there are very tangible illustrations of people who have lost their livelihoods and everything. I am dealing with one whistleblower who is battling cancer and does not have any income to do it with because she was a whistleblower in the NHS previously. What can we do to redress that for historic whistleblowers who are still out of work and struggling? It is quite an important thing if you are going to talk meaningfully about culture change because these people don't just disappear.

Anna Bradley: I think you raise a very important issue, Charlotte, but probably the answers to it sit in the hands of both those who represent the staff who work in health and care and those who employ them, and I hesitate to suggest solutions. My brief is very much focused on the consumer user side, but I think it is clearly an issue which should be addressed because whistleblowers, whether they are staff or consumers and users of service, can end up in some incredibly difficult positions, which I truly understand from the consumer perspective; so it is important that you look at that.

Robert Francis: First, it is not a solution for all whistleblowers, but personally I welcome very much the recognition that was given in the honours list to Helene Donnelly as a real statement of the value that whistleblowers can bring. Also, not wishing to personalise it, in her case but in at least one other case of which I am aware, they have been given jobs in

prominent positions within the system, and that is another way in which that can be done. Obviously, there is a diaspora of whistleblowers who suffer greatly for what they do and who get little recognition, and I am not sure what the answer is with regard to that. I am not at all sure we have got the protection generally of whistleblowers right; they can, of course, if they have been victimised, claim compensation, but the route to that is quite complex and tortuous, and does not always work. I do wonder whether—and this is not a formulated proposition—we need to look for some sort of external body or person who can, first, receive information from whistleblowers, secondly, give them advice, and, thirdly, provide some level of protection they don't currently get, but I can't think of a system where you can offer somebody a job, frankly. That is a difficulty.

Q65 Charlotte Leslie: I was aware that it would be very difficult for you to give solutions, but it is heartening to hear you realise that it is an issue.

Secondly, I was again very heartened to hear you talk about accountability for those who may be found to have suppressed whistleblowers and that they should be sacked. One of the practical problems is who would do the sacking, and, of course, culture is to a tremendous extent a sense of confidence. Again, I do not expect you to comment on this at all, but it is just one of those things that you see and your heart sinks when you talk about culture change in that there were allegations, with some quite interesting significant evidence on paper, against Barbara Hakin, accusing her of suppressing whistleblowers. She was only able to be investigated because she was a member of the GMC. Then we learned at our last hearing, when the GMC were here, that in conducting the investigation the GMC broke their own protocol in not sharing conflicting evidence. I think they have yet to provide us an answer on why they broke their own protocol or what happened, but you see the lack of confidence that gives anyone that the culture is changing, when you have someone sitting very high up in NHS England who has this question mark hanging over them.

What can we do about this? We can all pump out fine words, but the fact is that people don't feel there is any independence because there is no one there to do the sacking, because people feel that the people in a position to do the sacking are friends with the people they perhaps should be sacking. How on earth can we begin to break down what many perceive as this kind of Mafia network or people all protecting themselves? How can we do that? Many people feel it just isn't happening. I am not sure if you have any solutions, but any ideas would be nice.

Robert Francis: I am not going to comment on that case for all sorts of reasons, not least of which is that I don't know the details of it. All I would say is that we need in our public comments to be very careful about ensuring that we actually know the facts. If we don't know the facts, then clearly someone else needs to find them out, and I suspect we don't have very good processes for doing that. At the end of the day, we do need fairness in this. Part of the problem often—and I am not in any way intending even implicitly to comment on the case you mention—is that whistleblowers and their relationship with whoever they are whistleblowing about, and/or whistleblowing to, have a back story which often gets confused with the message being whistleblown about. We need to be very careful to separate out those two things and to ensure that the proper whistleblowing message is valued and dealt with, but also whatever else is there needs to be dealt with as well.

Charlotte Leslie: But also, I suppose, with organisations like, say, the GMC—I don’t know the rights and wrongs of the case and I would not pretend to—given that it is such a high-profile case, it was incredibly unfortunate that the GMC were seen not to have adhered to their regular procedures in dealing with it. Again—

Chair: I think that is an issue, Charlotte, for the GMC, if I may say so.

Charlotte Leslie: It is, of course. It is just a question of bodies performing their functions.

Q66 Dr Wollaston: Could I just ask this on a final note about whistleblowers? If clinicians are genuinely going to put patients first and we want to see the best possible investigations of complaints, do you think it is time to put an end to anonymous whistleblowing? The priority should be to put in the procedures that make them feel safe but also to put patients first by making sure complaints can be properly investigated. As you point out, often there is a back story and there may be all sorts of other issues behind a complaint, so it is difficult to investigate it properly without knowing who is making the complaint. I wondered whether you had any thoughts on that.

Robert Francis: Personally, I would prefer the whistle to be blown anonymously than not at all. That would be my first point. It is always important to have some channel through which anonymous information can at least be given if it can’t come out any other way. After all, we are usually talking about places with an unhealthy culture where things have become really difficult for one reason or another. I think we need to have at least the ability to receive information and do something about it. Of course, having such a route does not in any way abrogate from the professional duty of the individual doctor or nurse to exercise a duty of candour towards the patient, to protect patients and so on, and they have to be accountable for that, so in a sense, if they don’t break cover, then they are arguably already in breach of some form of professional duty. I have to say, of course, that I want to see the best protection for genuine whistleblowers as possible, but at the end of the day whistleblowing is never ever going to be the full answer to these issues. We are only talking about whistleblowing because the system has failed at some earlier stage to listen to some concern anyway.

Q67 Chair: That is, for me, the major “take away” from this and many other sessions—that the culture in the organisation needs to change. You have made the point several times in your evidence that sunlight is the best disinfectant, and it renders the whistleblower a relatively minor part of the improved accountability we are all looking for.

Robert Francis: Yes.

Chair: On that note, I am going to draw it to a close. Thank you very much for your attendance.