Mapping the Bodies involved in Health Redress in the United Kingdom

The UK Administrative Justice Institute at the University of Essex has commissioned this research to explain the UK health systems and map the bodies involved in health redress in order to provide a resource for researchers who want to study aspects of the system. It is hoped that it may also contribute to the identification and discussion of pressure points and gaps relating to health redress.

By Carolyn Hirst

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INTRODUCTION

I want to say at the outset that there are two reasons why I have a personal interest in doing this work. The first is that I have recently been involved, along with colleagues from the Scottish Public Services Ombudsman and from Queen Margaret, Glasgow and the West of Scotland universities, in research into **How do complaints affect those complained about? An empirical investigation into the effects of complaints on public service employees**. The second reason is that, as a Non-Executive Director and Board Complaint Champion of a Health Board in Scotland, I have a direct involvement in complaints about health. As both a researcher and a Board Member I have been struck by the number of bodies with a potential involvement in health complaints.

My focus in this article is not, in the main, on the 'front-line' health organisations who are complained about and have internal complaints procedures, or on the courts, which also provide redress for health-care disputes, but on the other organisations that inhabit this complex world. Also, the article focuses on NHS-provided care and does not cover social care except where it overlaps in redress mechanism and/or regulator remit. And this article can only be a snapshot in time of an organic system which is continually subject to change.

THE NHS AND THE IMPACT OF DEVOLUTION

This year is the 70th anniversary of the founding of the National Health Service, established on 5 July 1948 with the coming into force of the **National Health Service Act 1946**. The founding principles of the NHS have remained broadly intact, as it still provides (most) medical services free at the point of contact and is financed through direct taxation. Also, in general and as set down by the 1946 Act, family doctors (primary care) are self-employed and contracted, whilst secondary care is delivered by hospitals who serve populations in geographical catchment areas. Specialist services, such as mental health, tend to be located mainly in the community.

However, along with many others, I would question whether we still have a National Health Service across the UK. Since 1999 health has been a devolved matter. Powers were transferred from the Westminster Parliament to the Scottish Parliament and Welsh Assembly on 1 July 1999, and to the Northern Ireland Assembly on 2 December 1999. The UK Department of Health receives funding directly from the Treasury based on the funding priorities of the UK Government, and the Treasury also sets the Departmental Expenditure Limit for each devolved administration. It is up to each devolved administration to allocate resources to fund services under their control. In England, there has also been some devolution of health and social care to combined authority areas (see later).

A series of reports dating back to 1999, commissioned jointly by The Health Foundation and the Nuffield Trust, have looked at how the publicly financed health-care systems in the four countries of the UK have fared before and after devolution. Of particular relevance to this article is the 2014 report by Professor Gwyn Bevan on ***The impacts of asymmetric devolution on health care in the four countries of the UK,*** which accompanies the jointly authored report ***The four health systems of the United Kingdom: how do they compare?***.

These reports helpfully explain the governance arrangements in the four countries of the UK before and after devolution. They also set out how the devolved governments have made different choices about the level of funding devoted to the publicly financed health system, the structure and governance of the system and the benefits available to their residents - such as free general medical prescriptions and personal care in Scotland.

The NHS in each of the four countries of the UK is composed of a complex network of organisations that deliver, monitor, improve and commission services and there are a variety of organisations that deal with complaints. I am going to start where I know best.

SCOTLAND

Health commissioning and provision in Scotland was integrated under the management of NHS Boards in 2004. The **National Health Service Reform (Scotland) Act 2004** led to the dissolution of NHS Trusts and required NHS Boards to set up Community Health Partnerships in order to achieve greater integration between health and social care.

The **Public Bodies (Joint Working) (Scotland) Act 2014** led to further integration by creating a single system for the joint commissioning of health and social care services. The Act required local authorities and NHS Boards to delegate a wide range of functions to an integration authority: either delegated to a new body corporate (known as an 'integration joint board') or a lead agency model with a local authority delegating its powers to a health board to administer the integrated working (or vice versa). Only Highland has adopted the 'lead agency' model. As of 1 April 2016, the integration authorities assumed responsibility for health and social care funding.

NHSScotland consists of **14 geographical NHS Boards**. In addition, Scotland has a national healthcare improvement body – **Healthcare Improvement Scotland** (see more about this body below) - and there are seven national or 'special' NHS Boards who provide national services:

- **NHS 24**
- **NHS Education for Scotland**
- **NHS Health Scotland**
- **NHS National Waiting Times Centre**
- **National Waiting Times Centre Board**
- **Scottish Ambulance Service**
- **The State Hospitals Board for Scotland**

Each Scottish NHS Board is accountable to Scottish Ministers, supported by the Scottish Government Health and Social Care Directorates.

A good starting point for understanding the health landscape in Scotland is the 2015 report ***Mapping Administrative Justice in Scotland*** produced by the former **Scottish Tribunals & Administrative Justice Advisory Committee**. This report details all public bodies which take administrative justice decisions and has 14 subject-based chapters comprising text and a fold-out map setting out the routes of redress.

Ombuds

Complaints about the NHS in Scotland, which have not been resolved by the body complained about, come under the remit of the **Scottish Public Services Ombudsman (SPSO)**. Set up by the **Scottish Public Services Ombudsman Act 2002** (SPSO Act 2002)**,** the SPSO is also the final stage for complaints about councils, housing associations, colleges and universities, prisons, most water providers, the Scottish Government and its agencies and departments and most Scottish authorities (these 'listed authorities' are set out in **Schedule 2** of the SPSO Ac 2002) . In addition, the SPSO is the **Scottish Welfare Fund Independent Review Service**, carrying out independent reviews of decisions that Councils make on community care and crisis grant applications.

Section 5 of the SPSO Act 2002 sets out the matters which the SPSO may investigate. **Section 7** sets out restrictions on matters which may be investigated. This includes that the SPSO may investigate action taken by or on behalf of an independent health provider if that action was taken in relation to, or consisted of a failure in, or to provide, a service which the independent provider was providing under arrangements with a health service body or a family health service provider. **Schedule 4** of the SPSO Act 2002 sets out matters which the SPSO must not investigate.

The SPSO is entitled to investigate complaints made in writing which relate to **maladministration** and to service failure (this being any failure in a service, or to provide a service which it was a function of the listed authority to provide). **Section 7(1)** of the SPSO Act 2002 states that the Ombudsman is not entitled to question the merits of a decision taken without maladministration by or on behalf of a listed authority in the exercise of a discretion vested in that authority. But **Section 7(2)** goes on to say that Subsection (1) does not apply to the merits of a decision taken by or on behalf of a health service body, a family health service provider or an independent provider to the extent that the decision was taken in consequence of the exercise of clinical judgement.

Provisions in the **Public Services Reform (Scotland) Act 2010** gave the SPSO the authority to develop simplified and standardised complaints handling procedures (CHPs) for Scottish public services (see their **Valuing Complaints** website). The SPSO published the new **NHS Model CHP** (and associated documents) for the health sector in Scotland in October 2016. The **2012 complaints regulations were amended** to comply with this new Model CHP and it replaced the guidance which supported the previous regulations (called "Can I help you"). NHS geographical Boards and primary care service providers needed to implement this revised procedure from 1 April 2017.

The Integration Authorities (see above) are now listed authorities under the SPSO Act 2002, and the SPSO has developed a Model CHP for them based on the one for **Scottish Government, Scottish Parliament and Associated Public Authorities in Scotland**.

NHS Scotland staff who are not satisfied with internal investigations will soon be able to enlist the help of an **Independent National Whistleblowing Officer** (INWO) – a UK first. Legislation will be introduced in the Scottish Parliament to bring the INWO role under the auspices of the SPSO.

Other Bodies

As mentioned above **Healthcare Improvement Scotland** (HIS) is a national body. It was set up by the **Public Services Reform (Scotland) Act 2010** and has a range of roles. HIS took over the functions of NHS Quality Improvement Scotland and, on 1 April 2011, the regulatory functions of the Care Commission in relation to independent healthcare services. HIS is responsible for regulating independent hospitals, voluntary hospices, private psychiatric hospitals and independent clinics. It has a statutory remit in relation to the following types of complaints:

- about HIS itself which may relate to the standard of service provided, treatment by a member of staff, operational and procedural issues or difficulty in communicating with the organisation
- about the Death Certification Review Service (DCRS) run by HIS
- about services provided by the independent healthcare providers regulated by HIS
- about health services raised by **NHSScotland** employees, through the **NHSScotland National Confidential Alert Line** or by contacting HIS direct under the **Public Interest Disclosure Act 1998**

The **HIS Complaints and Feedback Annual Report 2016–2017** records ten complaints about HIS (four relating to Death Certs) and six complaints about independent healthcare services.

The **Mental Welfare Commission for Scotland** was set up in 1960. It has the stated aim of protecting and promoting the human rights of people in Scotland with mental illness, learning disabilities, dementia and related conditions. It does not consider complaints as such, but their **website says** "If we think that someone with a mental illness or learning disability is not getting the right care and treatment we will look into it. We usually find out about cases through our visits to individuals or services. We might also follow up on a call to our advice and information line, or if we see something in a service user's paperwork that concerns us. Our investigation team will review the evidence, put together a picture of what happened, suggest where things went wrong and make recommendations for change. A report will be published and sent to the organisations that we think need to review and respond to our recommendations."

The Care Inspectorate is the body in Scotland responsible for regulating and inspecting care services. All registered care services must have a complaints procedure. Anyone can complain about a registered care service and complainants may choose to complain directly to the service or to the Care Inspectorate, or both. Those who are unhappy with the outcome of a complaint to the Care Inspectorate have the right to take their complaint to the SPSO.

The Children and Young People's Commissioner Scotland's powers of investigation changed following enactment of part 2 of the **Children and Young People (Scotland) Act 2014**. In addition to the existing power to investigate matters on behalf of groups of children and

young people (a general investigation), these **new powers** allow the Commissioner to investigate complaints around whether service providers have failed to uphold the rights, interests and views of individual children and young people when taking actions or making decisions that affect them (an individual investigation). However, the Commissioner cannot carry out an individual investigation if it: relates to matters reserved to the UK Government, concerns the decision-making of a court or tribunal in a particular case, or concerns a case currently before a court of tribunal. The Commissioner also cannot investigate if another body in Scotland, such as the SPSO or the Care Inspectorate, is able to investigate it.

WALES

The coming into force of the **National Assembly for Wales (Transfer of Functions) Order 1999**, on 1 July 1999, transferred most health-related functions from the Westminster Parliament to the National Assembly for Wales.

NHS Wales is the publicly funded National Health Service in Wales. Before 2009, there were 22 Welsh local authorities and 22 Welsh health boards organised around the same geography. The reorganisation of NHS Wales, which came into effect on 1 October 2009, created single local health organisations. These are responsible for delivering all healthcare services within a geographical area.

The NHS in Wales now delivers services through seven Local Health Boards and three NHS Trusts. The three Trusts are:

- the **Welsh Ambulance Services Trust** for emergency services. From April 2007, **NHS Direct Wales** (the 24 hour a day health advice and information service) became part of this Trust.

- **Velindre NHS Trust,** which offers specialist services in cancer care and a range of national support services

- **Public Health Wales,** which is the national public health agency

Two fairly recent pieces of legislation have impacted upon health and social care integration in Wales:

- The **Social Services and Well-being (Wales) Act 2014,** which introduced a legal duty on local authorities to promote integration of health and social care when carrying out their social services functions. It also required the establishment of partnership boards (organised along Local Health Board geographies) between Local Health Boards and local authorities

- The **Well-being of Future Generations (Wales) Act 2015,** which required all local authority areas to create a Public Service Board (PSB), including representatives from local authorities and Local Health Boards. This replaced the previous, non-statutory Local Service Board model. Under the Act, PSBs are required to produce a local well-being plan.

The **National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011** set out the process for making NHS complaints in Wales and for access to the redress arrangements. These Regulations were made in exercise of the Welsh Ministers' powers under Section 113(2) of the **Health and Social Care (Community Health and Standards) Act 2003** and the **NHS Redress (Wales) Measure 2008**.

The redress arrangements apply to claims worth up to and including £25,000. Regulations 25 to 33 cover the arrangements that apply when redress is to be considered by a Welsh NHS body. They say that if at any time during the management and investigation of a concern it is considered that a qualifying liability that would attract financial compensation of £25,000 or less exists or may exist, a Welsh NHS body must determine whether or not an offer of redress should be made.

These Regulations came into force on 1 April 2011 except part 7 (relating to cross-border application of redress), which came into force on 1 April 2012. They apply to all Health Boards in Wales, NHS Trusts in Wales, independent providers in Wales providing NHS-funded care and primary care practitioners in Wales. The redress elements of the Regulations and the Guidance relating to those aspects do not apply to primary care practitioners or to independent providers.

Ombuds

The final stage for complaints about the NHS in Wales comes under the remit of **the Public Services Ombudsman for Wales (PSOW)**, The role of the PSOW was established by the **Public Services Ombudsman (Wales) Act 2005** (PSOW Act 2005). This Act brought together the previous functions and powers of the Local Government Ombudsman, the Health Service Commissioner for Wales, the Welsh Administration Ombudsman and Social Housing Ombudsman for Wales.

Under the PSOW Act 2005, the PSOW can investigates complaints by members of the public concerning maladministration, failure in a relevant service or failure to provide a relevant service by any 'listed authority' in Wales. **Schedule 3** of the PSOW Act 2005 sets out these listed authorities, including local Health Boards, NHS trusts, Special Health Authorities not discharging functions only or mainly in England and family health service providers.

The PSOW had previously been only able to consider complaints made by individuals whose care has been arranged by public services (or by someone acting on their behalf). However, from 1 November 2014, the PSOW's jurisdiction changed (as a result of **Part 10 of the Social Services and Well-being (Wales) Act 2014**) with these new arrangements being that the PSOW can now also consider complaints from people who arrange and fund their own care.

Matters which the PSOW may and may not investigate are set out in **Section 7**, **Section 9** and **Schedule 2** of the PSOW Act 2005. Like the SPSO (see above) the PSOW is entitled to investigate matters relating to maladministration and service failure and can investigate the merits of a decision taken in consequence of the exercise of clinical judgement.

The PSOW has some discretion in relation to the investigation of complaints. **Section 3** of the PSOW Act 2005 provides for the alternative resolution of complaints, saying that 'the

Ombudsman may take any action he thinks appropriate with a view to resolving a complaint which he has power to investigate' and 'the Ombudsman may take action under this section in addition to or instead of conducting an investigation into the complaint'.

The PSOW **website** includes information relating to **Complaints Wales,** which is a telephone and web based signposting service it has developed that offers advice to people in Wales on how to complain about a public service. This service has a separate identity from the PSOW and was launched in 2011.

In 2015 the Finance Committee of the National Assembly for Wales carried out an inquiry into extending the powers of the PSOW. The **report** from this inquiry made 18 recommendations. These included extending the powers of the PSOW, by the granting of 'own initiative powers' (the Ombudsman is currently only able to investigate if a complaint has been made or referred to him), allowing oral complaints to be accepted (currently they have to be in writing), and to extending the PSOW jurisdiction to allow investigation of the whole complaint when a combination of treatment has been received by public and private healthcare providers and when that treatment has been initiated in the NHS.

The Public Services Ombudsman (Wales) Bill, which includes these recommended changes, was laid before the Welsh Assembly on 2 October 2017 and a **debate** resulting in agreement on the general principles in this Bill took place on 21 March 2018.

Other Bodies

The **Children's Commissioner for Wales** was established by the **Care Standards Act 2000**. Part V of this Act sets out the Commissioner's functions and powers, including the review and monitoring of arrangements for dealing with complaints, 'whistleblowing' and advocacy arrangements; the examination of particular cases; and providing assistance, including financial, to a child in making a complaint or in other proceedings.

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. It was established on 1 April 2004 by the National Assembly for Wales as an autonomous unit within the Assembly under the remit of the Health and Social Care (Community Health and Standards) Act 2003. Its purpose is to review and inspect NHS and independent health care organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and health-care providers that services are safe and good quality. HIW also has specific responsibility to ensure that the interests of people whose rights are restricted under the Mental Health legislation are properly protected.

HIW carries out reviews of healthcare organisations or services in response to concerns arising from an incident or incidents, dependent upon seriousness and/or frequency of occurrence. A decision to undertake an investigation may also be determined or influenced by intelligence either collected by HIW or by other audit, regulation and inspection bodies. An NHS body may also refer itself and request that HIW undertakes a review of an issue or service.

A report from the Parliamentary Review of Health and Social Care in Wales called **A Revolution from Within: Transforming Health and Care in Wales** was published on 16

January 2018 and recommends action on improving health and wellbeing and on reducing health inequalities for people across Wales.

NORTHERN IRELAND

Health and Social care are integrated in Northern Ireland. The **Health and Social Care (Reform) Act (Northern Ireland) 2009** led to a reorganisation of health and social care delivery in Northern Ireland. This Act established the **Health and Social Care Board** (HSCB) which commissions health and social care services.

The Northern Ireland Executive through its **Department of Health, Social Services and Public Safety** (DHSSPS) is responsible for funding the HSCB. The DHSSPS also funds the **Public Health Agency,** which was established in April 2009 and is the executive agency responsible for policy, legislation and administrative action to promote and protect the health and well-being of the population of Northern Ireland. The HSCB commissions and manages the performance of the **Northern Ireland Ambulance Service Health and Social Care Trust,** which operates across Northern Ireland.

The 2009 Act also led to the formation of five regional Health and Social Care Trusts (Western, Northern, Southern, South Eastern and Belfast) with responsibility for the delivery of primary, secondary and community health care. In addition, it established five local commissioning groups (LCGs) to function as committees of the HSCB. Each LCG is co-terminus with its respective Trust area and is responsible for assessing needs and commissioning health and social care for its local population.

A **Government-commissioned review in 2011** suggested that this system was unsustainable and recommended a shift towards community care. The report led to the formation of 17 Integrated Care Partnerships across Northern Ireland, joining together GPs, social care, voluntary bodies and other services. There has been a further **review by Professor Bengoa** - launched in 2016 - whose recommendations, although accepted by the NI Executive and the then Minister for Health, have not been implemented due to the suspension of the Assembly. Building on the 2011 review, the Bengoa report recommended closer partnerships between health trusts and community services and greater patient empowerment.

The DHSSPS guidance *document **Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning,*** effective from 1 April 2009, sets out the standards and guidelines for health and social care complaints handling, to which it applies equally. Annex 2 of this document contains details of the relevant legal framework including Regulations and Directions.

Ombuds

Complaints about the NHS in Northern Ireland, which have not been resolved by the body complained about, come under the remit of the **Office of Northern Ireland Public Services Ombudsman** (NIPSO) which was established in April 2016. NIPSO replaced and expanded the functions of the former offices of Assembly Ombudsman and Commissioner for Complaints,

bringing them together into a single statutory office. NIPSO's jurisdiction in health and social care is provided for at section 15 of the **Public Services Ombudsman Act (Northern Ireland) 2016** (the PSO Act 2016).

NIPSO can investigate maladministration about all public service providers of health and social care in Northern Ireland and can also investigate the professional judgement of those providers in health and social care matters. Its remit includes independent health care providers such as general practitioners and residential care homes. NIPSO has wider data-sharing powers with other health bodies where there is an issue of health and safety (referral to GMC or NMC) and where their jurisdiction might overlap with that of the Ombudsman such as the Regulation and Quality Improvement Authority (see below).

NIPSO can also investigate complaints about most public services in Northern Ireland. This includes councils, Northern Ireland government departments and agencies, the Northern Ireland Housing Executive, housing associations, universities and colleges of further and higher education (from October 2016) and schools (from April 2017). An oral complaint can be accepted by NIPSO where previously only a written complaint was acceptable.

Section 10 of the PSO Act 2016 provides for the NIPSO to take a decision to resolve a complaint without carrying out an investigation. This is described in the **NIPSO Annual Report 2016-2017** as a settlement. The Annual Report states that NIPSO staff can identify the action needed to resolve or remedy the cause of complaint. This may take the form of timely service provision, an apology for failures in service, reimbursement of expenses incurred or an improvement in service. In 2016- 17 settlement was achieved in 11 cases.

From April 2018 the NIPSO will have own-initiative powers and so may investigate systemic maladministration or systemic injustice in health and social care where no complaint has been made or one or more complaints have been made (**Section 8** of the PSO Act 2016).

The PSO Act 2016 also contains provisions to establish NIPSO as a complaints standards authority (CSA). These provisions, in **Part 3 of the Act** must be commenced separately by the Northern Ireland Assembly. They have been modelled on the provisions introduced for the SPSO in 2010 (see above).

Other Bodies

The **Northern Ireland Commissioner for Children and Young People** was established under the **Northern Ireland Commissioner for Children and Young People (NI) Order 2003**. Article 12(1) of the Order gives the Commissioner the power to conduct an investigation into a complaint made by a child or young person that: (a) His/her rights have been infringed by any action taken by a relevant authority; or (b) His/her interests have been adversely affected by any such action. Some matters fall outside the remit of the Commissioner, such as complaints against private organisations and complaints which fall inside the remit of another body.

The **Regulation and Quality Improvement Authority** (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and for encouraging improvements in the quality of those services. Its inspections are based on minimum care standards which aim to ensure that

both the public and the service providers know what quality of services is expected. RQIA does not investigate individual complaints, but through its regulatory activities it ensures that all regulated services have an effective complaints procedure, take complaints seriously and investigate complaints thoroughly, in line with DHSSPS complaints guidelines.

ENGLAND

The **Department of Health & Social Care** (DHSC) is the ministerial department in England which provides NHS funding and is supported by a number of **agencies and public bodies**. This includes **NHS England,** which leads the National Health Service in England.

The structure of the NHS in England has undergone significant change in recent years. Simply put, it is structured along the lines of an internal market with a separation between the purchaser and the provider of care. Extensive reorganisation of the NHS in England took place when the **Health and Social Care Act 2012** came into force on 1 April 2013. This formally abolished Strategic Health Authorities and NHS Primary Care Trusts.

- **Strategic Health Authorities**. In 2002, the existing regional health authorities were renamed and merged to form 28 new strategic health authorities. On 1 July 2006 these were reorganised into ten geographic Strategic Health Authorities (SHAs). Each of these ten SHAs contained the various NHS trusts, which took responsibility for running or commissioning local NHS services. For example, **NHS North West** had regional oversight of 24 Primary Care Trusts, 23 acute NHS trusts, eight mental health trusts, seven specialist trusts, as well as the North West Ambulance Service.

- **Primary care trusts** (PCTs) had been part of the NHS in England from 2001. Mainly administrative bodies, PCTs held their own budgets and were responsible for commissioning primary, community and secondary health services. Until 31 May 2011 they also provided community health services directly.

A stated purpose of the 2012 Act was to liberate the NHS from direct ministerial control. It transferred responsibility to NHS England to deliver on an annual mandate from ministers. NHS England oversees local **Clinical Commissioning Groups** (CCGs), which replaced Primary Care Trusts on 1 April 2013 and allow the GPs in a geographical area to decide on the commissioning of certain services from 'any qualified provider'. From April 2013, CCGs have been given most of the English NHS budget to 'buy' relevant services for their patients.

Public Health England (PHE) is an operationally independent executive agency of the Department of Health & Social Care and was established under the 2012 Act on 1 April 2013. It supports local authorities in their duty to improve public health and has national responsibility for protecting the public against major health risks.

The Health and Social Care Act 2012 established **Health and Wellbeing Boards** (HWBs) in each local authority, with a 'duty to encourage integrated working'. The Act required NHS England and the CCGs to promote integration of health services where this would improve quality or reduce inequalities. HWBs became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

The **Care Act 2014** requires local authorities to promote the integration of health and care provision where this would promote wellbeing, improve quality, or prevent the development of care needs. In 2015, 50 '**vanguard'** sites were chosen to pilot and develop new care models. In December 2015, NHS England published **planning guidance** which asked NHS organisations and their partners to create area-based plans for the five-year period from October 2016 to March 2021. The plans are intended to show how local services will improve quality of care, promote population health, and become more financially sustainable. There are currently 44 'footprint' areas across England, which consist of NHS providers, CCGs, local authorities and other health and care services, known as **Sustainability and Transformation Partnerships** (STPs).

There has also been devolution of a different type in England. On 1 April 2016, health and social care commissioning budgets from all **Greater Manchester** CCGs and local authorities were pooled across the combined authority area. Commissioning decisions are now made by a Joint Commissioning Board (JCB) consisting of the CCGs, 10 local authorities and NHS England. In December 2015, the Mayor of London, along with 32 London CCGs, 33 London local authorities, Public Health England and NHS England signed **the London Health and Care Collaboration Agreement**. At time of writing there was also a Liverpool City Region devolution agreement and others are being established.

The **NHS Constitution for England** was established in 2012 and sets out the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of the Constitution in their decisions and actions. The NHS Constitution includes guidance on how to make a complaint about NHS services.

Patients have the right to have their complaint acknowledged within three working days and to have it properly investigated. They have the right to take an unresolved complaint to the independent Parliamentary and Health Service Ombudsman or Local Government & Social Care Ombudsman (see below). There is also the right to make a claim for judicial review if directly affected by an unlawful act or decision of an NHS body or local authority. A person can complain to either the organisation that provided their healthcare or to the organisation that commissioned that NHS service (such as the local CCG for hospital care, or NHS England for GP, dental, pharmacy and optical services).

Ombuds

Complaints about the NHS in England, which have not been resolved by the body complained about, come under the remit of the **Parliamentary and Health Service Ombudsman** (PHSO). The PHSO combines the two statutory roles of Parliamentary Commissioner for Administration (the Parliamentary Ombudsman) and Health Service Commissioner for England (Health Service Ombudsman). Its powers mainly come from the **Parliamentary Commissioner Act 1967** and the **Health Service Commissioners Act 1993.** The PHSO website contains **information** about their history and the legislative framework within which they work.

In relation to health, the PHSO is the final adjudicator on complaints that have not been resolved by the NHS organisations in England. The PHSO cannot investigate complaints about privately funded healthcare services. However, they can look at complaints about healthcare services provided in a private hospital if the NHS paid for it. They can also look at complaints about NHS-funded health-care services which privately funded patients receive in an NHS hospital.

As is the case with the other UK Ombuds who deal with complaints about health (see above), the PHSO is entitled to investigate matters relating to maladministration and service failure and can investigate the merits of a decision taken in consequence of the exercise of clinical judgement.

There is no right of appeal against the decision of the four UK Ombuds considered in this article, but their decisions can be subject to judicial review. Relevant to a consideration of to health complaints is the recent UKAJI **series of blog posts** about the Court of Appeal decision in ***Miller v Health Service Commissioner*** [2018] EWCA Civ 144 (February 2018).

England has a separate Ombuds, the **Local Government Ombudsman & Social Care Ombudsman** (LGSCO), as the final stage for complaints about adult social care complaints (including care homes and home care agencies). This includes care that is funded privately without council involvement. So that complainants do not need to complain to two ombuds services about services provided by both health and social care organisations, the PHSO and the LGSCO have set-up a **Joint Working Team** which can investigate these issues together.

On 5 December 2016, the Cabinet Office published a **Draft Public Service Ombudsman Bill**, which would create a Public Service Ombudsman for UK reserved matters and public services delivered solely in England.

Other Bodies

The **Children's Commissioner** for England was created by the **Childrens Act 2004**. Section 2(5) of this Act says that "The Children's Commissioner may not conduct an investigation of the case of an individual child in the discharge of the primary function." The **Provisions reforming the office of Children's Commissioner** in 2012 state that the Commissioner will continue to be prohibited from conducting investigations into the case of an individual child. It goes on to say that "the intention is that this will allow the Commissioner to concentrate on strategic issues that affect a larger number of children, rather than provide an ombudsman service for individual children on issues that are only relevant to that child."

Until 1 April 2016, the NHS Trust Development Authority and Monitor worked as separate regulators of NHS Trusts and NHS Foundation Trusts in England:

- The **NHS Trust Development Authority** (NHS TDA) was an executive **non-departmental public body** of the **Department of Health**. Established as a special health authority on 1 June 2012, NHS TDA was responsible for overseeing the performance management and governance of NHS Trusts, including clinical quality, and managing their progress towards foundation trust status.

- **Monitor** was an executive non-departmental public body of the Department of Health and the sector regulator for health services in England. It was established in 2004 under the **Health and Social Care (Community Health and Standards) Act 2003,** which made it responsible for authorising, monitoring and regulating NHS foundation trusts. To become a foundation trust, NHS trusts had to demonstrate to Monitor that they were well led and able to provide good quality services for patients on a sustainable basis.

These two regulators were combined on 1 April 2016 to form **NHS Improvement,** which has the responsibility for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHS Improvement say on their website that they cannot help to resolve a complaint about care or treatment received, but they can help the complainant get to the right place. However, NHS Improvement can investigate complaints when commissioners or providers are restricting patient choice or behaving anti-competitively.

NHS Improvement works alongside **the Care Quality Commission** (CQC) to act when the CQC reports that a hospital trust is failing to provide good quality care. The **Care Act 2014** sets out specific areas where co-ordination of their respective functions is necessary. The CQC has been operational since 2009 and is the independent regulator of health and adult social care in England. It regulates both NHS organisations and independent providers. The CQC registers and inspects hospitals, care homes, GP surgeries, dental practices and other health-care services. It publishes ratings of each trust and its core services. To make their assessments, the CQC can look at information received from the provider itself, its patients, staff, information other organisations, and conducts its own inspections. If services are not meeting fundamental standards of quality and safety, CQC has powers to issue warnings, restrict services, issue a fixed-penalty notice, suspend or cancel registration, or prosecute the provider. The CQC also has a role in protecting the rights of vulnerable people, including those whose rights are restricted under mental health legislation.

As of April 2017, the following NHS organisations operate under the umbrella name of **NHS Resolution**:

- The **NHS Litigation Authority (NHS LA),** which was established in 1995 as a Special Health Authority. It provides indemnity cover for legal claims against the NHS in England, assists the NHS with risk management, shares lessons from claims and provides other legal and professional services for its members. The NHS LA handles negligence claims made against NHS bodies through **five schemes**. Three of these relate to clinical negligence claims (Clinical Negligence Scheme for Trusts **(CNST**), ELS and the ex-RHAs scheme), while two cover non-clinical risks, such as liability for injury to staff and visitors along with property damage (LTPS and PES, known collectively as **RPST**). Where appropriate, they participate in mediation or other forms of alternative dispute resolution as a means of resolving disputes fairly.

- The **National Clinical Assessment Services (NCAS)** Set up in 2001, this is a service for the NHS and the independent health sector in England, Northern Ireland and Wales. It provides independent expert advice, support assessments and training to help resolve concerns about the professional practice of doctors, dentists and pharmacists

working in primary and secondary care, including locums and postgraduate trainees. Most requests come from the employer/contracting body of the practitioner and NCAS is not able to take referrals directly from members of the public. NCAS became an operating division of the NHS LA in April 2013.

- The **Family Health Services Appeal Unit (FHSAU)** The FHSAU acts to resolve contract disputes between health practitioners, (including GPs, dentists, pharmacists and opticians) and their local primary care decision-making body. The FHSAU also maintains a database of primary care health practitioners in England, Wales, Scotland and Northern Ireland who have had restrictions placed on their work.

In 2015, the Public Administration Select Committee (PASC) of the Westminster Parliament, in their ***Investigating Clinical Incidents in the NHS*** Report, called for an independent body to be established to conduct patient safety investigations in the English NHS. The Government accepted this PASC recommendation in its ***Learning not Blaming*** response. The May 2016 independent ***Report of the Expert Advisory Group: Healthcare Safety Investigation Branch*** advised the Secretary of State for Health on the creation of the **Healthcare Safety Investigation Branch** (HSIB). This came into operation in April 2017 as a division of NHS Improvement.

The original intention was for HSIB to investigate up to 30 safety incidents each year. These would not replace local investigations and are focused on looking at the wider opportunities to learn from exploring where harm may have or has happened. The specific incident must have: happened after 1st April 2017, taken place in England and been within NHS-funded care. In November 2017, the Secretary of State announced plans expanding HSIB's role, tasking the body with undertaking approximately 1,000 investigations into neonatal deaths and all pregnancy-linked maternal deaths. At the time of writing, there is a draft **Health Service Safety Investigations Bill** going through the Westminster Parliament to set out the powers of a Health Service Safety Investigations Body (HSSIB), which will take forward the work of the current HSIB. It is planned that the HSSIB will publish detailed reports after each completed investigation which will:

- make recommendations for system-wide learning across the NHS
- help develop national standards on investigations
- provide advice, guidance and training to improve investigative practice across the health service

The draft bill also proposes to give the HSSIB the power to establish an accreditation system across the NHS – supporting trusts who receive accreditation to conduct their own investigations.

In 2016 the **Better Births** national maternity review in England made recommendations to improve the safety of maternity services. A key recommendation was that the Department of Health (DOH) consider a Rapid Resolution and Redress scheme for families affected by severe avoidable birth injuries. The DOH published a **Consultation Response Report** relating to this on 27 November 2017, stating within it that it was their intention to present a final policy option in Spring 2018.

UK-WIDE

The Department of Health & Social Care retains some UK-wide responsibilities for health. For example:

- The **Human Fertilisation & Embryology Authority** (HFEA) is the UK Government's independent regulator who set standards, licences, monitors and inspects fertility clinics and projects involving research with human embryos. A person who has complained to a fertility clinic and is not happy with how they have handled it can complain to the HFEA.
- The **Medicines and Healthcare Products Regulatory Agency** (MRHA) is an executive agency which regulates medicines, medical devices and blood components for transfusion in the UK.

The Department of Health & Social Care also sponsors Non-Departmental Public Bodies such as the **National Institute for Health and Care Excellence** (NICE). The way that NICE was established in legislation means that its guidance is officially England-only. However, it has **agreements to provide** certain NICE products and services to Wales, Scotland and Northern Ireland. Decisions on how its guidance applies in these countries are made by the devolved administrations.

In relation to private health care, the **Independent Sector Complaints Adjudication Service** (ISCAS) is a voluntary subscription scheme which represents most of independent healthcare providers across the UK. The **ISCAS Complaints Code of Practice** sets out the standards that ISCAS subscribers agree to meet when handling complaints about their services. The Code is a three-stage process which focuses on local resolution wherever possible. Stage 3 adjudication affords those complainants using ISCAS member hospitals and clinics an independent review process for complaints that cannot be resolved locally. ISCAS represents providers in the four devolved UK countries and has slightly different relationships with the devolved health-care regulators.

- In England, ISCAS has signed an Operating Protocol with the CQC, whereby the CQC signposts complainants to ISCAS in the first instance. The CQC does not investigate individual patient complaints unless a breach of regulations is believed to have occurred. Adjudication reports about ISCAS members in England are sent to the CQC in an anonymised form.
- In Wales, ISCAS has signed an Operating Protocol with Healthcare Inspectorate Wales (HIW). As with the CQC in England, HIW signposts complainants to ISCAS. All ISCAS Adjudication reports about ISCAS members in Wales are sent to HIW in an anonymised form.
- In Scotland, ISCAS is working towards a statement of understanding with Healthcare Improvement Scotland (HIS). Healthcare Improvement Scotland reserves the right to investigate complaints about an independent health-care provider at any stage of the complaints procedure.
- In Northern Ireland, ISCAS hopes to agree a statement of understanding with the Regulation and Quality Improvement Authority.

The **Dental Complaints Service** aims to help private dental patients and dental professionals settle complaints about private dental care. They provide a free, impartial service and are funded by the General Dental Council.

The **Optical Consumer Complaints Service** is an independent and free mediation service for patients of optical care and the professionals providing that care. The service is funded by the General Optical Council

REGULATION OF HEALTH PROFESSIONS

Professional regulators are responsible for ensuring that health and social care professionals provide safe care. Their focus is on the individuals who give care, rather than organisations that provide care. The Westminster Parliament is responsible for the regulation of health professions in England and Wales. Regulation of health and care professionals is a devolved matter in Northern Ireland. In Scotland it is devolved for health professionals who entered regulation after the passing of the Scotland Act 1998.

There are nine health regulators in the United Kingdom. Each oversees one or more of the health professions. They set the standards of behaviour, competence and education that health professionals must meet to be considered as 'fit to practice' in the UK and keep registers of professionals who meet their standards. The Regulators also deal with concerns from patients, the public and others about health professionals who are unfit to practise because of poor health, misconduct or poor performance. The regulators can remove professionals from their registers and prevent them from practising if they consider this to be in the best interests of the public.

Seven of the nine regulators have a UK-wide remit:

- **General Medical Council -** Doctors
- **Nursing and Midwifery Council -** Nurses and midwives
- **General Dental Council** - Dentists, clinical dental technicians, dental hygienists, dental nurses, dental technicians, dental therapists, and orthodontic therapists
- **General Chiropractic Council** - Chiropractors
- **General Optical Council** - Opticians (optometrists and dispensing opticians)
- **General Osteopathic Council** – Osteopaths
- **Health and Care Professions Council** - Arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists,

paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, social workers in England and speech and language therapists

Two Regulators have a geographical remit:

- The **General Pharmaceutical Council** is the regulator for pharmacists, pharmacy technicians and pharmacy premises in England, Scotland and Wales

- The **Pharmaceutical Society of Northern Ireland** regulates pharmacists and pharmacy premises in Northern Ireland

The practice of these nine regulators differs (details can be found on their respective websites), but their general approach on receiving a concern or complaint about a registrant, is for this to be investigated and the resulting findings considered with a view to whether further action is needed. This may lead to the matter being referred to a public hearing by a Fitness to Practice Committee, who if they decide that fitness to practice is impaired, can take a range of actions including removal from the Register (sometimes referred to as 'erasure' or 'striking off').

In relation to doctors, the **Shipman Inquiry's Fifth Report** recommended greater separation between the GMC's adjudication and investigation functions. As a result, the **Medical Practitioners Tribunal Service** (MPTS), which is a statutory committee of the GMC, was created in June 2012. In March 2015 the UK Parliament, Scottish Parliament and the Privy Council approved a Section 60 Order amending the Medical Act 1983 and introducing changes which applied to MPTS hearings concluding on or after 31 December 2015. These included that the GMC has a right of appeal against decisions made by MPTS tribunals. Doctors already have a right of appeal to the High Court in England and Wales, Court of Session in Scotland or High Court of Northern Ireland.

It may be of interest to read the recent press coverage about the GMC exercising this right in relation to the **MPTS decision about Dr Hadiza Bawa-Garba** and the concerns raised by some in the medical profession about the tensions between individual and systemic responsibilities. The GMC appeal succeeded, and the **High Court directed** that the MPTS decision to impose a sanction of 12 months' suspension be quashed and substituted with a sanction of erasure.

The **Professional Standards Authority** (previously known as the Council for Healthcare Regulatory Excellence) is responsible for overseeing the nine health professional regulatory bodies. It also oversees the regulatory bodies for social care and sets standards for organisations holding voluntary registers for health and social care occupations (and accredits those that meet them). As well as reporting on the performance of the health regulators on an annual basis, the Professional Standards Authority audits decisions made during investigations into complaints about a registrant's practice and can make referrals (or appeals) to the relevant court if it considers that a final fitness to practise decision does not protect the public.

On 31 October 2017, the Department of Health & Social Care published a UK-wide Government consultation paper **Promoting professionalism, reforming regulation**. This

sought views, amongst other matters, on whether there should be fewer regulatory bodies (cutting the number of regulators from nine to three or four), on speeding up decisions about poor performance and misconduct and on setting up a single adjudicator responsible for all fitness to practise decisions, built on the GMC's Medical Practitioners Tribunal Service. This consultation closed on 23 January 2018 and will be followed by a government response.

IN CONCLUSION

The aim of this article was to attempt to find the bodies currently involved in health redress in the UK, to identify their distribution, roles and responsibilities and so to assist in identifying the data sources which might be available to researchers working in this area. What has been found is a complex and moveable feast and there is much more to do on analysing both the gaps and the overlaps. Observations and comments relating to this are very welcome. The article has focused in the main on NHS-provided healthcare and it is acknowledged that there is much more to write on redress relating to the private health sector and on redress through the legal system.

This mapping exercise highlights the confusion and uncertainty which must exist for those seeking health redress. Depending on the type of redress they want (such as monetary, service improvement, apology or professional sanction), complainants often need to make a choice at an early stage about which body to approach. There is an ongoing need to simplify this cluttered redress landscape. And now more than ever there is a need to make real the concept of the **multi-door courthouse**. Put forward by the **late Professor Frank E. A. Sander** as a system to direct disputants to the most appropriate route to resolution, this would assist complainants to make informed choices about the type of redress they are seeking.

There must also be complexity and confusion for those being complained about. In health-related complaints there is often a named professional whose alleged actions or omissions can be open to scrutiny and sanction by several different organisations. In addition to being challenging for the professional involved, this multi-agency approach can result in lengthy processes with the focus on an individual as opposed to systemic issues. Again, this speaks to the need to simplify the landscape. And also for redress to take **Clinical Human Factors** into account in order to enhance both learning and improvement – but that is a whole different article!

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Carolyn Hirst is an independent researcher and mediator.

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