

# Complaints and Litigation

---

UNCORRECTED TRANSCRIPT OF ORAL EVIDENCE  
To be published as HC 786-ii

House of COMMONS  
Oral EVIDENCE, TAKEN BEFORE the Health Committee

Complaints and Litigation - Tuesday 15 February 2011

---

Ann Abraham, James Johnstone, Paul Streets and Chris Bostock  
David Flory CBE, Stephen Walker CBE and Sarah Albon

---

Evidence heard in Public Questions 69 - 191

## USE OF THE TRANSCRIPT

1. This is an uncorrected transcript of evidence taken in public and reported to the House. The transcript has been placed on the internet on the authority of the Committee, and copies have been made available by the Vote Office for the use of Members and others.
2. Any public use of, or reference to, the contents should make clear that neither witnesses nor Members have had the opportunity to correct the record. The transcript is not yet an approved formal record of these proceedings.
3. Members who receive this for the purpose of correcting questions addressed by them to witnesses are asked to send corrections to the Committee Assistant.
4. Prospective witnesses may receive this in preparation for any written or oral evidence they may in due course give to the Committee.

Oral Evidence - Taken before the Health Committee on Tuesday 15 February 2011

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper

Yvonne Fovargue

Andrew George

Chris Skidmore

David Tredinnick

Valerie Vaz

Dr Sarah Wollaston

---

Examination of Witnesses:

Ann Abraham, Parliamentary and Health Service Ombudsman

James Johnstone, Director of Customer Service and Assessment, Parliamentary and Health Service Ombudsman

Paul Streets, National Director of Patient and Public Experience, Department of Health

Chris Bostock, Head of User Experience, Department of Health, gave evidence.

Q69 Chair: <<http://www.david-daviesmp.co.uk/>> Thank you very much for coming this morning. If I may, I would like to ask each of you to introduce yourselves very briefly to the Committee and then we will move on to questioning and evidence.

James Johnstone: I am James Johnstone. I am Director of Customer Service and Assessment for the Parliamentary and Health Service Ombudsman's office.

Ann Abraham: I am Ann Abraham. I am the Parliamentary Ombudsman and also the Health Service Ombudsman for England.

Paul Streets: I am Paul Streets. I am the Director of Public and Patient Engagement and Experience at the Department of Health.

Chris Bostock: I am Chris Bostock, Head of Service User Experience in the Department of Health.

Q70 Chair: <<http://www.david-daviesmp.co.uk/>> Thank you very much. Thank you for coming to this inquiry this morning. I would like to lead off, if I may, with some questions to Ann Abraham. I welcome you to what may well be your last appearance before the Health Select Committee, given your-

Ann Abraham: We will see.

Chair: <<http://www.david-daviesmp.co.uk/>> Yes. It is timely, given the report that you published this morning on care of the elderly and some lessons about the quality of care of the elderly that are available to be learnt as a result of your investigation of complaints. This is a series of hearings not about care of the elderly but about the way in which complaints are handled within the Health Service. I would like to begin, if I may, by asking whether you have any reflections based on the evidence that has been produced in the report you published this morning, but also, on your broader experience, about the way complaints are handled in the Health Service and whether we are willing enough to learn, and learn quickly, to listen to what patients say and to learn the lessons of what they have to tell us.

Ann Abraham: Indeed. The Committee will know that I also published a report in October last year entitled Listening and Learning, the first in a series of annual reports on NHS complainthandling performance. In that report we said that the NHS needs to listen harder and learn more. I am very attracted, Chair, by what you say about "learn quickly". One of the benefits of the complaints reforms, which came in in April 2009, is that they give the opportunity for the NHS to learn much more quickly and to have immediate feedback from ourselves, but also from local resolution of complaints. There is a lot in this morning's report which reads across to complaint handling generally. Certainly, as we see it, an open rather than a defensive response to complaints, so that the learning can come through, is key to everything.

Q71 Chair: <<http://www.david-daviesmp.co.uk/>> Looking at the handling of the 10 complaints on which this morning's report is based, do you feel that the earlier stages of the handling of those complaints reflected the kind of attitudes that you would like to see? You used the phrase, I think, in the BBC interview you gave this morning, that the NHS didn't have "the right culture and attitude" towards care of the elderly. Was that a comment only about the quality of the care or was it also a comment about the way complaints are handled before they get to the Ombudsman?

Ann Abraham: There are elements of both in there. The report specifically talked about elderly people, their care and treatment within the NHS and the lack of compassion, despite all the commitments of the NHS constitution. Very many of the complaints we saw-probably all of them-will have some aspect of the old system. Certainly some of those complaints took a very, very long time to work their way through the old threestage system. It was only when they came to us, people will say, that they were listened to and their stories were heard and acted upon. It is very hard to look at the complaints that we see now exclusively as if they were being handled under the new system, and maybe we will come on to that. Fundamentally, in pretty much all of those cases, the distress that was caused by poor care and treatment was compounded by poor complaint handling.

Q72 Chair: <<http://www.david-daviesmp.co.uk/>> Certainly the burden of evidence we heard at an earlier session was that the lower stages of the complaints procedure were too often interpreted by the patient as explaining the case of the NHS rather than the NHS listening to the patient experience on the ground.

Ann Abraham: Indeed.

Q73 Andrew George: <<http://www.andrewgeorge.org.uk>> In relation to this, obviously things are particularly serious if they get to even the point of initially making an approach to the Parliamentary Ombudsman-yourself. Given the situation where a lot of these cases come from patients who are not in a position to necessarily articulate themselves well within the system, does it concern you that the system and the culture you referred to does not seem to be particularly receptive to initial expressions of concern or transparency or whistleblowing within the service? The fact that all of these have come to the Ombudsman in the first place is almost a scandal in itself, is it not?

Ann Abraham: You are absolutely right. It takes considerable tenacity to see a complaint all the way through to the Ombudsman. I think that is less the case now, after the April 2009 reforms, than it was under the previous system, or indeed under any system of NHS complaints, certainly within my living memory. The long-drawn-out independent review system had similar problems. I have been accused of being an eternal optimist, but I believe very strongly that the new system is well designed and has the potential to produce quicker, simpler, better outcomes and better feedback than anything in place before now. We are seeing some signs of that now in the way we are having a direct dialogue with the NHS and I hope that James will be able to come in and talk about some of the daytoday dialogue we are having with the NHS. So, no, it is not great. There is a huge amount of work to do-and some of that is cultural-but we are in a better place now than we have been.

Q74 Chair: <<http://www.david-daviesmp.co.uk/>> Before passing the questioning round the Committee, I would like to bring in Mr Streets, please, to offer the Department's view on what you have heard so far-reflections on the way the current system is working.

Paul Streets: I would like to do that. First of all, I would say the Department takes the report that the Ombudsman has issued today very seriously, and the Chief Executive of the NHS has written to NHS trusts today laying out how he would expect them to deal with that.

Dealing specifically with the point that has just been raised, it is worth saying there were a number of changes that were made in 2009-and the Ombudsman has referred to "from three-stage to two-stage"-with the specific aim of trying to get resolution nearer to the point of the complaint. One was that an explicit offer was to be made to the complainant, at the point of complaining, as to how they wanted their complaint to be handled. That did not happen before. Previously, it kicked immediately into the complaints system. That enables immediate resolution. The other part was that we enabled oral complaints, resolved to the satisfaction of the complainant, to take place within 24 hours without a complaint being logged, effectively. But the requirement was that an oral complaint must be something handled to the satisfaction of the complainant. The push is to try to resolve things much faster because, as the Ombudsman said, patients want to have their complaint resolved quickly.

Q75 Andrew George: <<http://www.andrewgeorge.org.uk/>> Can I check the terminology when you say "complaint"? I know that a lot of people are concerned. You talk to patients and their families and they say, "I don't want to complain, but I am concerned." This is a perpetual theme. Is that something which is, if you like, caught within the system that you are describing?

Paul Streets: Yes. It is a fine dividing line. In effect-and Mr Bostock can speak to this in a minute because he has been close to these regulations for 10 years-we are asking the complainant to define whether they wish to complain or not. Two things may happen to two people. One may wish to register it simply as concern and one may wish to complain. In some respects, it should be in the jurisdiction of the complainant to decide which of those they wish to follow.

The important point that the Department would wish to make is that we would see complaints as part of an overall system of feedback from patients. The truth is that, by the time it gets to a point where the Ombudsman is investigating it, we have already failed. What we need to be doing is resolving these at the point where the problem happens. The critical issue from our perspective, and David Nicholson's letter stresses this, is to ask trusts what systems they have in place to pick up these

things day by day as they occur and to resolve them on the ground before they reach the Ombudsman.

Q76 David Tredinnick: <<http://www.parliament.uk/biographies/commons/25288>> Expanding on this, what were the strengths and weaknesses of the system before the changes in 2009, please?

Paul Streets: When we made these changes in 2009 there was consequent consultation and one of the things we specifically consulted on was the change from a three-stage complaints process, which had pertained to that point, to a two-stage complaints process. There was great public support, through the consultation process, for that change. One of the fundamental problems was that it just took too long to get to the Ombudsman. We had a process that went through three stages. Before the Ombudsman was investigating the kinds of complaints that she has investigated, people could be in the system for an awful long time. But there were a number of other changes made to try to make it simpler. I have referred to the fact, which we clarified, that an oral complaint could be resolved at the point of the problem occurring and resolved much more rapidly. We also lengthened the time in which somebody could complain. For example, previously people could only complain within six months of the event happening. We extended that to 12 months. We enabled people to simultaneously pursue legal proceedings alongside a complaint, if they so wished. Previously they could not do the two together.

Finally, one of the things we did-and there are a number-was to make sure that the published reports were much more action oriented. In terms of a trust indicating how it responded to the complaint, there was a requirement, through the regulations, that it indicated the action it had taken and how it had taken that complaint seriously.

Q77 David Tredinnick: <<http://www.parliament.uk/biographies/commons/25288>> If you take out a stage, or a safeguard, perhaps, are you not, in a sense, reducing the safety net? You are speeding up the process but are you sure that you have not created a system which is making it possible for people to not be able to make complaints properly? Are you really that confident? My second question is on how prepared you were for these changes. Did they come out of the blue or was this something that you had been preparing for a long time?

Paul Streets: There are two questions there. As to taking out a stage, part of the problem was that the complaints procedure in the Healthcare Commission was taking some time to resolve. We want to improve information sharing between the Ombudsman and other players in the system, and in particular the regulator, which is now the Care Quality Commission.

The critical thing for us is that complaints are learnt from. Through the Bill which is currently going through the House, we are enabling the Ombudsman to share the information that she gleans from complaints with the regulator much more clearly. The problem was that it was taking too long as they went from one stage to another. In truth, the Ombudsman herself was spending an awful lot of time investigating complaints against the Healthcare Commission which just delayed the process even further.

Ann Abraham: If I could come in on what were the strengths and weaknesses, the major strength was that, at least at the end of the line, there was an independent statutory Ombudsman. That was the part of the system that did not change. There were a number of things that did change, as Paul has said, but what I would pull out is that the previous system was fragmented across health and social care. It was focused on process, things like time limits, but not on getting good outcomes and good results for people.

One of the things I stressed very strongly in my report in 2005 was the need for advocacy and the recognition of the importance of advocacy. Simply, when you have a patient and their family up against the mighty NHS, advocacy is hugely important to level the playing field. Then I would say learning, learning and learning. What followed my 2005 report in the White Paper and the "Making Experiences Count" consultation very much echoed a lot of the things we were saying, and we did have a smooth transition.

There was the question "Did it come out of the blue?" I was saying this morning that I have been in this job eight years. I think I spent the first five of them arguing for reform of the NHS complaints system and then the next two working on its implementation and the transition to the system we have now. A lot of work and a lot of thinking went into that and it has a very solid rationale. As you will detect, I don't think it should be disturbed because it is a good design, but what we have to do is make that design work effectively.

Q78 David Tredinnick: <<http://www.parliament.uk/biographies/commons/25288>> If you are arguing passionately for it not to be disturbed, what is your view on the Health Bill going through the House now?

Ann Abraham: It is a big Bill. If I take a very parochial view of it, it has some things which will help hugely in enabling us to share information with the public at large and with other players on this broad landscape of healthcare quality, not least the Care Quality Commission and Monitor where we can do our work on individual complaints but they can follow up on the systemic recommendations for improvement. That is a big plus for us. I think there is an appropriate recognition of

advocacy. I would like to see it more explicitly across health and social care, but that is all good.

There are dangers in all of this but all the work that has gone in to developing a coherent complaints system needs to be hung on to and built on. Whatever the configuration is, whatever the commissioning arrangements and the provider arrangements are, we should not lose that expertise and that learning.

Q79 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Of the complaints received by your office, 3% are taken further and investigated. Could you clarify for the Committee how you triage those complaints and how you decide which ones you are going to take forward?

Ann Abraham: Indeed. I have read all the evidence that the Committee has had before it and, clearly, my office has some work to do to correct this misunderstanding about 3% of complaints. That is certainly not how I would present it. We see many thousands of complaints and James's job, at the front end of the organisation, is to triage those. A substantial number of them are premature-there has not been a complaint to the GP practice or to the trust-and we have to say, "Unless something extraordinary is going on here, we think the NHS body should have the opportunity to look at this first." When we have taken out the complaints which are out of remit and are premature, we look at about 4,000 to 5,000 in detail and make our assessment. Again, in many cases there will be an intervention, short of an investigation, which will get a good outcome. Yes, that took us down, last year, to about 350 accepted for investigation. Similar numbers will probably emerge from this year's figures.

The message I would give is that we actually look at thousands of complaints and we can get resolution or a good outcome for many of those people without having to go through all that is involved in a formal statutory report.

Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Thank you.

Q80 Yvonne Fovargue: <<http://www.parliament.uk/biographies/commons/84359>> Can I return to the point you made on advocacy? We heard some evidence that even with only three providers it was fairly patchy and sometimes PALS acted as gatekeepers rather than progressing it. How do you feel about the commissioning of complaints from HealthWatch? Will it improve that, especially with the local authority deciding whether HealthWatch are going to provide the advocacy or commission a different service?

Ann Abraham: Indeed. There are some issues around the commissioning and it is important to get the conflicts of interest out of there. If I may, I would like to bring James in on the role of advocacy and what a difference it makes to people coming to us. Currently, it is patchy. It is patchy in health and across health and social care. If this system is going to work going forward, then that emphasis on advocacy needs to stay there and be sustained. If I may, Chair, I would bring in James to talk about advocacy and how it helps.

James Johnstone: It is hugely beneficial in terms of the cases coming through, especially from particularly vulnerable groups. About one in 10 of the people who come to us on the health side of the office are supported by advocacy. We find them very beneficial in terms of helping people to focus their complaints and focus on the outcome they are seeking from their complaint, allowing them to put forward their case and work with the NHS organisation to try to resolve things locally and then, should it come to the Ombudsman's office, in terms of being able to navigate that process so that people are able to make their best case possible.

Q81 Yvonne Fovargue: <<http://www.parliament.uk/biographies/commons/84359>> Do you think there is enough access to support for people to help make a complaint at an early stage, because advocacy comes, quite often, after they have gone through a number of stages? How many people do you think would give up at the first stage?

Ann Abraham: It is difficult to know, isn't it? Not everybody needs an advocate and lots of people have supporters, friends and family who will help them bring their complaints. From our evidence we can say that we see huge benefit from having advocacy arrangements in place, but the coverage is not comprehensive and consistent. We would like to see it improve.

Paul Streets: Specifically on the advocacy point, if I may, there were about 7,500 cases helped of the 25,600 last year that were referred to independent complaints advocacy.

In terms of the future, one of the reasons we have delayed the transfer of the independent complaints advocacy from the national contracts that we now run to locally, through local authorities, by year, is in order for us to get this transition right because we recognise it is quite a tricky thing to do. It is an additional responsibility on HealthWatch to have a rolling relation to complaints advocacy. We need that time to think about how we best do that in a way that makes sure those people are properly supported going forward. What I would say-and the response to the White Paper made this clear-is we intend to double the funding that is going to HealthWatch specifically to enable it to provide support to people in this sort of way.

We have explicitly provided for it to happen and we are providing more resources for it to happen. But we do have some work to do over the course of the next year to think about how we provide a good advocacy service going forward in a way that is provided locally and commissioned locally through local authorities consistent with the drift of the Health Bill.

Q82 Rosie Cooper: <<http://www.rosiecoopermpp.net/>> I would like to ask you about something else in a second, but, just on that point, you said you have doubled the amount going into this. Is it to HealthWatch nationally or to HealthWatch locally? My understanding was that HealthWatch locally would be funded by the local authority. If that is so, you are expecting them to be in a position of potential conflict, i.e. they will be policing the social care delivered by the local authority that is in fact going to be funding them-their resources, their ability to be independent and bite and really act as a patient representative advocate. Do you see that as a conflict?

Paul Streets: The position is no different than it is now. LINKs, as they are currently configured, are funded through local authorities. In that sense, it has not changed and that funding mechanism continues. There is no evidence that LINKs have shirked in terms of looking at social care. To answer your earlier point about where that resource is going, most of that resource is going to local HealthWatch. It is not going to national HealthWatch, which will have a relatively small budget. One of the things we want national HealthWatch to be able to do is to pick up local issues that are arising. One of those will be if a local HealthWatch is being compromised in its ability properly to scrutinise services locally and to consider how it responds to that.

Q83 Rosie Cooper: <<http://www.rosiecoopermpp.net/>> Could you tell me what national HealthWatch is going to be doing, then, without a great deal of resources? Does it look like a rubber stamp to you?

Paul Streets: We hope it will be much more than a rubber stamp and that is the reason-

Q84 Rosie Cooper: <<http://www.rosiecoopermpp.net/>> With what resources? It can only do the job if it has the resources and the personnel. Quite genuinely, most people think they do a good job as it is, but they set the bar very low because they do not really have the ability to raise that bar to what I, and many of my constituents, would think was an acceptable level in a social care setting.

Paul Streets: One of the things we are doing now is working with LINKs to ask that question. When we did the consultation on the White Paper, one of the things that came through very strongly from LINKs was the need for support. They, themselves, were saying, "Our performance is mixed. We need to be more systematic in the approach we take."

Indeed, the Ombudsman raised that in her own response to the White Paper consultation. One of the things we are doing now is working with LINKs to determine how best national HealthWatch supports them, but we think it could be a much more powerful body than some of its predecessors, not least because it is located in the Care Quality Commission, the regulator. We see real advantage in that. In exactly the same way as we are talking about the Ombudsman having power and sharing information with the Care Quality Commission, we want the same thing to happen with HealthWatch.

Q85 Rosie Cooper: <<http://www.rosiecoopemp.net/>> What I would describe as the various health tragedies that we have had have happened under this regime, so I am afraid I cannot sit here and acknowledge that the Care Quality Commission is the be-all and end-all. If they don't have the resources, you have a potentially big problem. For me, you are putting all your eggs in one basket and I don't think people will have confidence in it. It certainly needs to be much sharper, have much more resource and be much quicker off the mark. My own contact with them is that they have been very good, very kind and all of that, but I want an outcome. I want a result, and that takes too long.

Shall I go to the question I should be asking? The point I am making should not be ignored by the Department of Health. It is something which will come back and bite because the autonomy in the Health and Social Care Bill is hugely high and the accountability, for somebody like me, virtually nonexistent.

If I might turn to the Ombudsman, who I have had contact with many times over the years, I understand you are retiring and I want to put on the record that I think you have done a magnificent job.

Ann Abraham: Thank you.

Rosie Cooper: <<http://www.rosiecoopemp.net/>> The number of complaints has gone up. The cases that you have taken on have gone down. The intermediary stage is not there. Can you prove that more cases are being resolved at local level and, if you can, what is your evidence for that?

Ann Abraham: I cannot prove anything that is going on at local level because they are not my statistics. One of the things that has come out in recent times—certainly for us—is that the complaints information at local level is not good. It is not comprehensive and it is not consistent. And that doesn't help anybody. It doesn't help the NHS bodies, it certainly doesn't help informed choice, it doesn't help the regulator and it certainly doesn't help people like you who are trying to hold organisations to account. Improved complaints information is one of my particular priorities at the moment. I have been agitating about that ever since May 2009 when

it came home to us. Interestingly, when we brought out our Listening and Learning report which has a huge amount of data about complaints that come to us, one member of our advisory board said, "This is all fascinating, but where is the rest of the pyramid? And what is the NHS doing to make sure that information is available?" Therefore, no, I cannot prove it but I can tell you our experience.

Certainly 200910 was a transition year for us. We worked very closely with the Healthcare Commission, as it went into closure, to have a smooth transition, and our complaints numbers in that year went up-they almost doubled-to about 16,000. What we can now do is look at the 200910 figures, and 201011 as that is coming out. If we see anything, we see a levelling off, we see less premature complaints and we see really good responses-I genuinely say this-when we engage with the NHS to give them feedback about the problems that we see. We pull together information on what we call our "frequent flyers", the trusts that generate the most work for us, and one of the things James Johnstone does is to go out and talk to them about the problems we are seeing. He gives them very direct and immediate feedback about how we think they should improve their performance. I can say, as a result of that, that the trust which was top of the "frequent flyer" list nine or 10 months ago is not even in the top five any more. What I can say is that there is an NHS receptive to dialogue with us and we think that is bearing fruit. So we are doing those sorts of local meetings, we are doing regional conferences, we are having a dialogue on a national level and we are starting to see the benefits of it.

Q86 Rosie Cooper: <<http://www.rosiecoopermmp.net/>> I appreciate what you are saying, that complainants, when dealing with issues locally, can simply give up. I say this because there was a case in which I was personally involved. The family was concerned but didn't want to complain. I encouraged them, or I made the contact. The response from the PCT was encouraging the family to lay out their concerns, which was great-and this is somebody who didn't want to complain but had concerns. The father was terminally ill and the mother had dementia. Their response was so defensive, so much in silos and so incorrect that it added great distress. It didn't help. The father then got really upset and they simply gave up. Let me tell you, that was Liverpool PCT, PCT of the year. I make my point.

Ann Abraham: Yes. I did not vote them PCT of the year.

Q87 Rosie Cooper: <<http://www.rosiecoopermmp.net/>> Absolutely. But if, when people are first interfaced, instead of being lifted and going into it and getting it resolved, they are met with a defensive wall, they give up. Do you get much of that?

Ann Abraham: I absolutely agree with you. It is just extraordinary when you think of so many organisations who would think that sort of feedback was gold dust in terms of improving their service. I don't get depressed very often, but there are two things I hear far too frequently. One is complainants, or people with concerns, saying "It's not worth speaking up, nothing ever changes." The other one is where I hear a clinician say, "I have heard everything. I'm sorry you are distressed, but I wouldn't have done anything differently." That sense of "Even though I have had that feedback, I am not going to change my practice" or "I am not going to change my behaviour" or "I am not going to learn from it" are the sort of attitudes we need to identify and spotlight, not least because we are losing so much by way of patient feedback when people think it is not worth speaking up.

Q88 Chair: <<http://www.david-daviesmp.co.uk/>> Can I bring Mr Bostock in at that point? Your title is Head of User Experience at the Department of Health. I am very struck by the evidence we have heard so far. Ann Abraham started off by acknowledging that, in the 10 cases that were the basis of this morning's report, she felt that in the majority of cases-I hope I don't misrepresent-the early stages of the handling of the complaint was not satisfactory. Aren't we in danger of falling into the trap, exactly as Ann Abraham just described, of the clinician that says, "Our system is okay and we will carry on doing it," and not hearing the evidence we started out with, that in real life this system doesn't work as well as it should?

Chris Bostock: There are two points here. First, we need to distinguish between the system that is in place and the operation of that system. I fully agree with the Ombudsman that there are good performers-there always have been good performers-and there are poor performers with regard to complaints handling and other aspects. We need to ensure, as a Department, as best we can, clearly with the help of the experts in the Ombudsman's office, that we work with the poorer performers for them to improve their complaints handling.

Q89 Chair: <<http://www.david-daviesmp.co.uk/>> "Working with" is a lovely euphemism. Could we understand how improved performance can be secured?

Chris Bostock: To some degree, as a Department, we need to get the messages out. It is not just about complaints handling. It is about the wider aspects of feedback, it is about patient surveys and it is about using them. At an earlier stage, the Committee discussed concerns. Yes, concerns may not fall within the regulations, but the lessons to be learned from concerns, from comment and so on, are equally valuable and should be seen as being valuable and to assist in improvement of services.

There is also a message about the new complaints process. Yes, it is focused on outcomes and it is focused on patients. But there are real benefits within that system also for organisations in terms of improving service delivery, which has the potential for resource saving through more effective service delivery and so on, and in terms of reputation. As the choice agenda increases, reputation becomes an important factor. We need to get these messages across. A defensive attitude does not flow from that. They do not work very closely together. It is to the organisation's advantage, not just the person making a complaint's advantage, to listen and to use that information to improve. That is a matter, with feedback in general, that we need to get over to the NHS.

Q90 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> I am sorry if this is directed to you, Mrs Abraham, but you are the focal point for the person in the street who is at the bottom end of the service of the NHS. Some of the harrowing evidence we heard last time was that they felt the system was taking a long time and that you didn't uphold 98% of the complaints. They felt they were battering against the system. Do you have any figures for that?

Ann Abraham: I do. Again, as I have said, we need to explain ourselves better. I might do a followup note to the Committee in terms of explaining how the numbers in our annual report do shake down. Fundamentally, we look at thousands of complaints and we only do these formal statutory investigations on a few hundred. In terms of how long it takes, at the moment we are completing 89% of our investigations within 12 months and we are responding to initial inquiries within 40 working days in 91% of cases.

As to our customer satisfaction research, I was very disappointed to hear one of your witnesses saying there is no customer satisfaction research. Yes, there is and it is on the website if you want to have a look at that. But 90% of people whose complaints we investigated were satisfied with our service overall. 70% of people whose complaints we didn't investigate were happy with our service. The figures and the numbers are there for the Committee if you want to look at them.

Q91 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> It is more the closing down of the cases-you obviously have a discretion to do so-and if you could set out what you take into account when you close down cases. But the fact is you don't uphold many complaints, do you?

Ann Abraham: We do.

Q92 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> You do?

Ann Abraham: We do.

Q93 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> So the figure that was given previously is not right?

Ann Abraham: If you take all of those 15,000 complaints and you then look at the number of upheld complaints at the end of it, you get a completely distorted figure about upheld complaints. In 200910 our upheld complaints were around two-thirds of the cases we looked at. Of the thousands that we look at, as I have said, in many cases we will intervene. Perhaps I could bring James in to talk about some of the stories where we intervene to get an outcome. Lots of people don't want a full statutory report. They want a result.

James Johnstone: In many thousands of cases, what we are doing is looking at the issues raised by the complaint, we are getting independent clinical opinion on the case and we are talking to the complainant and the organisation complained of about the outcome sought by the complainant. For example, we might have a dental complaint where somebody is complaining about the quality of the treatment they have received and they have had to go privately as a result of that. What they are looking for is those costs to be reimbursed. We will get a detailed clinical opinion of that case. If it looks to us like there are service failings, we will talk to the organisation, set out our clinical advice and ask them if they feel they can resolve matters without the need for a full investigation. Very often they will look at our advice and say, "Yes, we can see what has gone wrong here," and they will provide the outcome that the complainant is seeking. In those cases, we can do all that without the need for a full statutory investigation.

Ann Abraham: That would not feature in the statistics as an upheld complaint, but it certainly would be a positive outcome for the complainant.

Q94 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> You are in your office going back to the first source and saying, "This is how you should do it better."

Ann Abraham: Indeed. We try very hard in everything we do to add value. The value we add may be that somebody gets their costs reimbursed. It may be that we add an explanation about what has gone on here, which says "This clinical care was okay". We would share the advice of our clinical advisers with the complainant, there would be explanations about what had happened here and we would try and put some of the medical records into lay language. So the added value may be an explanation. Again, it would not feature as an upheld complaint but, hopefully, it would be a better outcome for the complainant.

Q95 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Just to touch on your discretion, what factors do you take into account when you close down cases?

Ann Abraham: We look at three things once we have gone through the formal process, if you like, of establishing: yes, this is within remit; it is not ultra vires; there are some complex jurisdictional issues that we need to look at, and "Is it premature?" "Has the NHS body or the GP had a chance to respond to this themselves?" We will go through those formalities and that takes us, usually, to around the 4,000 to 5,000 number. Then we ask three questions. We say: Are there any indications here of service failure or maladministration, in our language? Actually, can we see evidence that something has gone wrong or something has happened that shouldn't have happened?

If that is the case, then we will look, because this is how the legislation is framed, at whether, as a consequence of that, there has been an injustice-again to use the language of the legislation-to the individual. Things go wrong all the time but they don't always result in consequences for the individual. If those two tests are passed, the final one is about whether we could get what we would describe as a worthwhile outcome. Hopefully, we would use more sensitive language than that when writing to the complainant. But if somebody is saying to us, "We want this doctor's head on a plate", "We want this hospital closed down," and we can't deliver that, we would have a very grownup conversation with the complainant about what we can and cannot do. If we are talking about serious clinical negligence and what somebody is looking for is a package of care for a braindamaged child for life, we would probably say to them, "You are better off in the courts than with the Ombudsman." We are always trying to see, "Can we add value? Can we get a good outcome for people?"

Q96 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Could that be enshrined in statute, that you have an obligation to go back to whichever provider it is, to say, "This is where it is going wrong," rather than going down a complaint process and saying that they had done something wrong? Say, when you have a finding-

Ann Abraham: It may not be-I shall get in trouble with my lawyers here-explicit in the legislation, but I do not see that there is anything additional necessary in our legislation to enable us to do the things you describe. There is a recognition that it is very much the role of an Ombudsman these days to do the casework, to do the learning and to provide all that feedback, and we put a lot of time and energy into collating information and sharing the learning beyond our office.

Q97 Chair: <<http://www.david-daviesmp.co.uk/>> Can I ask a narrow process question? Do you find the distinction between what you described as an "intervention" and what you described as a "statutory investigation" helpful or unhelpful?

Ann Abraham: In a way it is our distinction and it helps us to count things, so it works for us. Again, we try not to impose too much of our jargon on our customers, but it enables us to know whether we are doing more in this area, and all the time we can see that we are. The simple answer is that it works for us. It is not there in the legislation. It is something that we have created.

Q98 Chair: <<http://www.david-daviesmp.co.uk/>> I wonder whether it works for the complainant to receive a letter saying, "We have intervened but we are not launching an investigation."

Ann Abraham: We probably wouldn't put it in those terms.

Q99 Chair: <<http://www.david-daviesmp.co.uk/>> I am sure you wouldn't.

James Johnstone: Very often we would be saying, "This is what we have achieved. The organisation has agreed to provide" either "the recompense," or "Here is the explanation as to the care that was provided.", or "Here are the further questions answered which you wanted answered.", or "Here is the evidence that your complaint has been learnt from locally and one of our advisers has checked that this is appropriate." We would share it in that way rather than try and use our jargon.

Q100 Chair: <<http://www.david-daviesmp.co.uk/>> You still end up saying, "But we are not going to investigate."

James Johnstone: We would, yes. We would clarify that we are not going to-

Q101 Chair: <<http://www.david-daviesmp.co.uk/>> Surely that is a trigger to somebody saying, "There you are: they don't care."?

Ann Abraham: We have got some learning to do because we get feedback as well from people like yourselves, and indeed from our customers. We recognise that maybe we need to listen to our communications people as well as yourselves. Every time we produce a report we try very hard to make it accessible. These are terms we use for the purposes of our accountability to Parliament and to the taxpayer, but we have to get a better narrative to go with it perhaps.

Q102 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Please take this as an inquiry into how to make the system work, because there are people out there who are very unhappy, and also to save costs, because if they get a resolution then they do not have to go to litigation except in extreme cases, obviously, when they do. You may or may not be able to answer this question, but did you ever get complaints about Mid Staffordshire or Harold Shipman?

Ann Abraham: Not about Harold Shipman. In a way, that predates my time in the office. Mid Staffordshire is interesting because, obviously, when Mid Staffordshire blew up we had a look to see what had come to us. I would like to say if, heaven forbid, Mid Staffordshire happened again, we would know about it. Under the old system, we had a handful of complaints that came through to us and they were all complaints where we were not happy with how the Healthcare Commission had handled them. We sent them back to the Healthcare Commission to be looked at again and we never saw them again.

Q103 Rosie Cooper: <<http://www.rosiecoopermg.net/>> Could I join in very quickly? How do you know that the healthcare organisations, the doctors, hospitals or whatever-when you make recommendations, they may nod and do it once-actually change their practice and become better organisations? How do you know you are having a future influence?

Ann Abraham: Indeed. I would say two things. In terms of recommendations that we make that are specific, whether it is recommendations for financial remedy or apologies or explanations and so on, we can check. We have a compliance team that follows through on that and we have reports through on compliance.

One of the things the new information sharing powers will enable us to do even better than we do now is to share information with the regulators, whether that is the CQC or the professional regulators, often where we think the action that needs to be followed through goes beyond the role of the Ombudsman. I am not a regulator. I don't have all of the resources or skills to run an inspection regime and quality and risk profiles. But what we do have is a memorandum of understanding with the Care Quality Commission. Every time we make a recommendation for systemic change, we share information with them about the summary of the complaint and the specific recommendations we have made, and we have an agreement with the Care Quality Commission that they will follow up on those recommendations. That is the regulator's job and not the Ombudsman's, job, but obviously we have regular liaison meetings with the Care Quality Commission and we get feedback on how things are going.

One of the things I found very satisfying about our Listening and Learning report, where, for the first time, because of the new complaints arrangements, we were able to put information into the public domain about the complainthandling performance of every trust in the country, is that that information was uploaded electronically into the Care Quality Commission's risk and quality profiles. That interoperability, a phrase I have learnt recently, and the information revolution, is something that we are very committed to. Working with others who have this common interest in improving healthcare, whether it is professional regulators on fitness to practise of individual doctors or the Care Quality Commission with its role, is something we see as part of a wholesystem approach that we have described as "strategic alliances". Ombudsmen are a bit iffy about partnerships but we do alliances.

Chair: <<http://www.david-daviesmp.co.uk/>> I would like to move the questioning on to the impact of the current Bill, the Health and Social Care Bill.

Q104 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> I would like to return to the question where it was mentioned about improved complaints data. In the new Bill the Government wants every trust to become a foundation trust, but last year one in seven foundation trusts didn't return their complaints data to the NHS Information Centre. I want to ask the witnesses, first, what you felt about that, whether you thought that was acceptable and the reasons for that, and, secondly, do you believe that it should be mandatory, in light of the Bill, for all foundation trusts to be returning their data?

Ann Abraham: No, I don't think it is acceptable. I am sure my colleagues in the Department of Health know my views about the state of complaints information by now because I have been bending their ears about this for the best part of two years. In a way, if I were writing the Making Things Better report again, knowing what I know now, there would have been a section in there about the importance of complaints information. It lets us all down, whether we are consumers who want information to inform choice, whether we are regulators who want to benchmark performance, whether we are managers or board members, Ombudsmen, policy makers or whatever it may be. There is a hugely important piece of work to do on improving complaints information. I don't want an industry. I don't want so much information that we are all overloaded with it and we can't understand it. I just think that consistent, coherent, comprehensive coverage would serve us all extremely well.

Q105 Chair: <<http://www.david-daviesmp.co.uk/>> Can we hear the Department's response to that question as well?

Paul Streets: It is a good question. We do think that information should be shared more frequently between the Ombudsman and the Care Quality Commission, and indeed trusts. One of the reasons why the Health Bill includes clause 185 is that it enables the Ombudsman specifically to share information more easily. In a sense, the real issue with the complaints information is that it needs to be used locally. In some respects, a large number of complaints is not necessarily an indicator of bad performance. One of the things we have encouraged organisations to do is to increase the number of complaints as a learning opportunity. The key question we will be asking trusts is, "How are you resolving that locally?" "What are you doing locally?" Frankly, it is not about hard data. It is about leadership, culture, whether managers walk the floor and understand what is happening and local resolution. It is not a sterile exercise in analysis of complaints data.

Q106 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> Surely the data helps, though. The Committee were concerned that, in the formal consultation on the Information Revolution, obviously a huge part of the White Paper, there was no mention whatsoever of complaints data. Was that a slip or was that anything in particular, that you feel complaints data is not relevant to the information revolution that the Department wishes to propagate elsewhere in order for the benefit of patients across the NHS?

Paul Streets: No. We have been talking to the Ombudsman about how complaints data could be used more effectively because, as she has said, she is concerned that it is used more effectively. One of the things we have looked at is the use of complaints data within quality accounts. From our experience, looking more broadly at patient experience, one of the most powerful things in terms of board culture and managerial behaviour, frankly, is not hard dry statistics, which people will always argue with. The best boards will often use patients' stories of things that have gone wrong, literally stories or videos at board meetings that convey a sense of the richness that was in the report the Ombudsman published today. In terms of getting boards and trusts to think more seriously about complaints, we think that is far more powerful than incorporating hard, dry data in a report on patient experience.

Q107 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> There is no requirement at the moment for any trust to put data online. If you want it, as a patient you have to go and seek that data, put in a Freedom of Information request, or whatever. Do you not think there should be a duty on trusts to report that data, perhaps by putting it online?

Paul Streets: Yes. As you will know, we are looking at the responses to the Information Revolution consultation currently. One of the things we will be considering is the role of commissioners potentially in commissioning for information. You are absolutely right that, in terms of trusts being accountable, it is important that information is available and in the public domain and that there is a commitment to transparency. We need to work through how that will play into the commissioning system with the Commissioning Board and GP consortia.

Q108 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> In terms of your own communication with foundation trusts currently, what are their reasons-the one in seven-for not submitting their complaint data?

Paul Streets: I am not sure I can answer that question. Chris, do you know?

Chris Bostock: When this issue came up -the technicalities of which I would need to look up, but we could supply if you wished-the return of statistics, the KO41 statistics, which includes the complaints data, came up for review for the year 20062007 and the Department of Health contacted Monitor to see if they would sign up to continuing to provide these statistics. They felt that making it a requirement to provide was inappropriate, being foundation trusts, but they would not prevent individual foundation trusts from providing the data. I suspect that is probably a question that ought to be addressed to Monitor rather than to the Department of Health.

Q109 Chair: <<http://www.david-daviesmp.co.uk/>> Just to be clear, this is a straightforward disagreement between the Department and the Ombudsman.

Ann Abraham: I don't know.

Q110 Chair: <<http://www.david-daviesmp.co.uk/>> The Ombudsman is not sure and the Department is shaking its head. I heard the Ombudsman to say you were in favour of more aggregated national information as a form of accountability.

Ann Abraham: Absolutely.

Q111 Chair: <<http://www.david-daviesmp.co.uk/>> We have heard explanations from the Department as to why that is not appropriate.

Chris Bostock: I am sorry, but we need to bear in mind that at the moment we have to question the usefulness of the data that are collected nationally. The Ombudsman is absolutely right that it is poor, we need to improve it, we need to be able to benchmark, we need to be able to allow patients to use it for choice and so on and so forth. The current data are the number of complaints received, which is, as Paul has described, not necessarily a reflector on quality of handling. Then there are 25 or 26 categories, of which clinical matters takes account of somewhere in the region of 50% of complaints. This is a longer term issue of using the correct data that will be of use both to the organisations, to the Department and to individuals.

Q112 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> I have two further points. Currently there is no guidance, I think, nationally, about how to present data or how to collate it, and I know, Mrs Abraham, in your written evidence, point 22, you said you had been working with colleagues from the Department and various coalition bodies and that you are hoping to have "meaningful, comparable complaints information". You have said you will be presenting a joint statement in the New Year and I wonder whether you are in a position to make any comment now about that and also whether the Department will consider producing national guidelines or guidance on the development of the complaints procedure?

Ann Abraham: I can tell you that there is a joint statement. I chaired a small working group which included representatives from the National Health Service, from the Department, from the Information Centre, Care Quality Commission, Monitor and National Voices—so a number. We have a joint statement. I have, in the last week, discussed how we are going to get signed off with both the permanent secretary at the Department and the Chief Executive of the NHS, and I hope we will do that soon.

Q113 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> Can we have a copy?

Ann Abraham: Yes, absolutely. We will share a copy with you.

Q114 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Can I come back to the usefulness of data? Do you think that if the public could see there was a deluge of complaints about the cleanliness of a particular hospital or the rudeness of a particular clinician that that might not force some change?

Paul Streets: It could be, and Chris will speak to this in a minute, but one of the things we are doing is putting more complaints data on NHS Choices. In that sense, we are not saying it has no value. We are saying that, as a lead indicator for a problem, it is probably the wrong thing to be looking at. There are other ways in which trusts should be looking at patient experience, not just complaints. In the way it is analysed at present it could be better, but it is still hard data, which makes it very difficult for a person to discern. We would be concerned if a trust was penalised because it had a lot of complaints. It could be just an indicator of that trust taking complaints very seriously and encouraging its customers to complain.

Chris Bostock: Could I add that in the 2009 regulations there is a statutory requirement on all providers of NHS commissioned care, not simply trusts, to provide an annual report? The annual report not only contains data on the number of complaints that have been received, the number that were well founded and the number that find their way to the Ombudsman, but, importantly, it also contains a narrative on, effectively, what are the major issues within those complaints, what has been learnt and what is being done to address those issues. There is a requirement to enhance local accountability in that that annual report has to be made available to anyone who requests it.

Ann Abraham: But it is not made available automatically and they all do it differently. All these points are well made. There is no point just having bald statistics without a narrative. I have a report to my board twice a year on complaints about my organisation. It has a lot of statistics in it but it also has the outcomes and it has the learning and what we are doing differently as a result of complaints about our service. You need both those things. It seems to me that unless you can look at these fundamentals of complaints information in a way which enables you to look across the piece for the NHS, then you do not have comparable information, you do not have consistent ways of counting and it is no use to anybody. The Department is well aware of the problem, and I hope we can make good progress on this in the months ahead.

Paul Streets: It is a very difficult thing to get right because the real trick for the Department is getting the balance right between data we collect nationally and data that is used locally for improvement. The problem is if we over-prescribe-prescribe too much locally-the game will be producing data for the Department of Health rather than data that is going to help local improvement. If you look at what we are doing in patient experience in terms of the Outcomes Framework, we specified an indicator that, for us, is an overall indicator of responsiveness, "Is your service responsive?" It does not try to do all the diagnostics.

The diagnostics are for local resolution. It will tell you if you have a problem and it is five or six questions. It seems to us the way to go, as opposed to where we have been, which is asking 70 questions, where it becomes a massive administrative exercise and the focus of it is collecting the data rather than improvement. It is a tricky balance between- absolutely, as the Ombudsman has said- creating data that is comparable for performance and, frankly, for consumers so they know how one service measures up to another, but balancing it with a real focus which is about data that you can use locally to improve your service. It is a really tricky thing to get right.

Mr Skidmore asked about guidance. Clearly, one of the things that we will be doing as we design the way the Commissioning Board will operate is thinking about how the new regulations play out. The regulations will stay, obviously, with the changes subject to the Bill, but we will think about what that means in terms of guidance perhaps that the NHS Commissioning Board will, for example, issue to consortia. Is there scope for us to be more prescriptive in terms of guidance? That is the question we are asking right now. But we need to get that balance right because we have seen a situation where trusts focus on providing data to us and that is completely useless. We want the data used locally to improve things.

Q115 Andrew George: <<http://www.andrewgeorge.org.uk>> On this issue, the nuts and bolts of what is going on, so that I understand, in terms of a complaint which goes entirely through the system and reaches the end of the Ombudsman process, what is the average time, or the potential length of time, between the event and the final resolution of that complaint? Also, you provide feedback to the services, clearly, in that process. To what extent does any of that feedback have resource consequences? In other words, it is not just an attitudinal or a professional issue. It is a question that you have identified stresses in the service because of insufficient resources going in to satisfy your requirement that the service was adequate for purpose.

Ann Abraham: Indeed. That is a multifaceted question.

Andrew George: <<http://www.andrewgeorge.org.uk>> Two-faceted, I think.

Ann Abraham: I will see what I can do. We have two measures. The first is we aim to give a substantive response to what, in effect, is a request to investigate a complaint within 40 working days. The figure we are running at there is 91%. Once we have taken a case on for investigation, we aim to complete 90% of those within twelve months. Some cases, by definition, take a lot longer to assess and some cases take a lot longer to investigate. Those are the smaller numbers. Those are the broad figures I can give you today.

In terms of the events complained about, one of the things, for me, that was such a joy in the early days of the new system after April 2009 was that we found ourselves assessing complaints sometimes within weeks of the events complained about. That was completely new for us. The legislation has within it a 12 month timeline with discretion to waive that deadline if we think it appropriate to do so. In fact, under the old system, we waived it all the time. The chances of us looking at something within 12 months of the events complained about were remote. Now it is not remote at all and it happens very frequently. It is very good to be going back, talking to witnesses to these events within memory of the events and where the chief executive of the trust is still the same chief executive of the trust, which again would have been a rare event under the old system. We are in a different sort of place. I have completely forgotten the second facet of your question.

Q116 Andrew George: <<http://www.andrewgeorge.org.uk>> It is the resource implications of the conclusions you reach.

Ann Abraham: Yes. I don't think I have any numbers I can give you on that, certainly today. As we do these annual reports on complaint handling performance, those are the sorts of statistics we would want to develop. Clearly, sometimes we will make recommendations for financial compensation. We do not do that in every case. We do not do that in the majority of cases, and they are not often high. As with so much of our work, what we see is that the taxpayer would benefit hugely if people got things right first time and if people weren't having to bring their complaints right through to the Ombudsman system.

Q117 Andrew George: <<http://www.andrewgeorge.org.uk>> Could I ask Mr Streets that question? In terms of the conclusions of these complaints, would you agree that some of them not only have attitudinal, professional and other considerations, but some clearly indicate that, in fact, further resources are needed in order to address the problems that have been identified as a result of the complaint?

Paul Streets: That may be true, and clearly it is for a trust chief executive and a trust board to consider what those might be. The evidence suggests that trusts that are good at dealing with complaints also are very good at providing decent quality outcomes for patients. So there is a link between quality and complaints handling and their ability to address things properly.

Q118 Rosie Cooper: <<http://www.rosiecoopermp.net/>> The future of foundation trusts and health organisations will be based on their ability to attract patients and have a good response or rapport with the commissioners, so won't there be an internal pressure to keep complaints either down or secret in the world we are about to enter? Forgive me, Mr Streets, you used lots of words like "local diagnostics".

Local diagnostics failed Mid Staffordshire. You used words like "not over-prescribe" where, for me, I am asking you whether we shouldn't be saying, "Just tell the truth." Will allowing trusts not to report complaints lead to more failed patients and shouldn't a point of principle be that we tell our organisations "Own up. Tell the truth. Get it fixed"?

Paul Streets: The answer to your last question is yes, and the regulations that were published in 2009, alongside the changes to the legislation-

Q119 Rosie Cooper: <<http://www.rosiecoopermp.net/>> So it is wrong that trusts do not publish their complaints?

Paul Streets: It is right that trusts deal with things locally quickly with the complainant as far as physically possible.

Q120 Rosie Cooper: <<http://www.rosiecoopermp.net/>> If that is true, how did Mid Staffordshire happen? It is just not true, is it?

Paul Streets: Clearly, Mid Staffordshire was a case of this failing.

Q121 Rosie Cooper: <<http://www.rosiecoopermp.net/>> But it is not on its own, and how do you stop it happening again? You stop it happening again by shining a light on it, by switching the light on, by doing, as my hon. Friend over there-

Chair: <<http://www.david-daviesmp.co.uk/>> Chris Skidmore. You can say it.

Rosie Cooper: <<http://www.rosiecoopermp.net/>> I am sorry, Chris, I couldn't remember your constituency and I was struggling.

As Chris said, we are asking organisations now to publish expenditure over £500, but not publish whether we have done something really bad or stupid or the place isn't clean. This is nonsense. You need to find a way of working through it. The public will demand nothing less.

Paul Streets: I don't think I would disagree with what you said, but where you started from was: Would there be a perverse incentive for trusts in a competitive environment not to report on complaints? Our argument would be absolutely not. Complaints, as with any patient feedback, are an opportunity to improve the service that you are giving. In that sense-

Q122 Rosie Cooper: <<http://www.rosiecoopermp.net/>> I used to chair a hospital. I get that. I understand it. The problem is, if you are trying to get "I want to go to the hospital that is the cleanest, safest, healthiest, whatever," but you are hiding the complaints, you are not trusting me to make the best decision for me. You are making the best decision for you as a healthcare organisation. The Department of Health are allowing it to happen by not being open, by allowing them to hide as foundation trusts and not declare. It is just not right.

Chris Bostock: In terms of the national statistics-and that was a decision taken by Monitor, not the Department of Health-I appreciate the limitations of the annual reports as described by the Ombudsman. But in terms of foundation trusts, they are under a statutory requirement to produce details in the annual reports of the number of complaints received and the general narrative of how they have handled them.

Q123 Rosie Cooper: <<http://www.rosiecoopermp.net/>> Do they publish them by cleanliness, by staff, for example, by rudeness, or by what detail? What do they really do? How can one in seven foundation trusts decline to return the complaints data? If they are not doing that, do you go round trawling each of the annual reports for that level of detail? No, you don't.

Chris Bostock: No.

Paul Streets: The important point you have made, though, is about transparency, isn't it? The Department would absolutely get that. That was the reason why we consulted on the information revolution and why we are considering how this will work in the new world with the NHS Commissioning Board and GP consortia. We need to think through what that means in terms of what they require.

Q124 Rosie Cooper: <<http://www.rosiecoopermp.net/>> Will the Health Service be subject to reporting all expenditure over "X" on their websites, like councils? Have you considered that?

Paul Streets: I don't know the answer to that question.

Rosie Cooper: <<http://www.rosiecoopermp.net/>> No. Have you considered it?

Chair: <<http://www.david-daviesmp.co.uk/>> It's more suitable for the next point, if I may suggest, Rosie.

Q125 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Could I move from foundation trusts to general practice now? There have been some concerns about where scrutiny of general practices will sit under the new arrangements. At present, people complain either to their PCT or direct to their practice. Could you perhaps clarify for the Committee what the arrangements will be under the new proposals and whether you think those are satisfactory or there need to be changes?

Paul Streets: The new arrangements will be consistent with the 2009 regulations, and Chris can speak to this in a minute with more detail because he was responsible for bringing these in a couple of years ago. In principle, as a complainant, for my GP, if we take that example, I can complain directly to my GP as a provider or, if I wish, I can complain to the commissioner of that service. In respect of primary care, the commissioner will be the NHS Commissioning Board. I have that choice. I can't do both.

Q126 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> I am sorry, they can complain to the Commissioning Board, not to the-

Paul Streets: Or to the-

Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> -consortia.

Paul Streets: Because the consortia will not be commissioning primary care. It will depend on who the commissioner is. The rule of thumb is you can complain in the new procedure, the new regulations since 2009, to the provider of the service or the commissioner of the service, whoever that commissioner will be.

Q127 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> It will be nationally the Commissioning Board or direct to their GP.

Paul Streets: The GP, in terms of primary care, yes.

Q128 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Do you feel there are any changes that should be made to the legislation as it passes through the Committee stage?

Chair: <<http://www.david-daviesmp.co.uk/>> The Department of Health probably can't answer that question. They will say no.

Paul Streets: It would be rather career limiting if I answered that question.

Q129 Chair: <<http://www.david-daviesmp.co.uk/>> Would Ann Abraham like to answer the question?

Ann Abraham: I am interested in this in terms of future proofing legislation, particularly for us. The fundamental point and one of the things we argued very strongly for when the regulations were being revised in 2009-and this was something that came out of Shipman-is that it should be possible to complain not only to your GP but to the commissioner of that service if you so chose. The reassurance that that concept is to be retained does the job for me in terms of it is not just the person or the practice with whom you have this ongoing relationship. You can go beyond that to take your complaint to the commissioning organisation. As long as that is followed through, that would work from our point of view.

Q130 Chair: <<http://www.david-daviesmp.co.uk/>> This is more by way of a comment than a question, but it is quite striking that we have been in session now for an hour and a quarter and it is only in the last three minutes that the concept of commissioning using complaints and information from complaints has come into the conversation. Up until this moment, the whole conversation has been around providing this information to the Care Quality Commission, the word "regulator" has been used repeatedly, and, as I say, only in the last three minutes has the concept that it might be of use to a commissioner been raised.

Ann Abraham: It is interesting, but what I would say is for us that is automatic. Our legislation, as put in place all those decades ago, provides for the Ombudsman to send copies of reports to the commissioning body. It is already there, from our point of view, and in the way we operate there is an underlying assumption that the commissioning body will need this information. In the various configurations of the NHS since the 1970s, when this legislation was put in place, my office has worked out "What does that mean under the current setup?" and is perfectly capable of working out what it means going forward. It is really good to have this much more permissive information sharing provision that is in the Bill, from our point of view, but certainly we would expect to be communicating with commissioners as well as the providers of the service.

Paul Streets: If I may, on that point-and it is a very good point in terms of feedback from patients being really critical to commissioning-we would not want complaints to be the only source of feedback. We need to bear in mind that it is one in 1600 people who use the NHS every day that actually complain. As a source of primary feedback from patients, one of the things the Department is now doing is working on what we have called the Commissioning Outcomes Framework, as opposed to the National Outcomes Framework. That will set how the NHS Commissioning Board commissions services, in this case, for primary care, if we take that example: What outcomes will we expect of primary care? How will those be defined?

That will include, as with the National Outcomes Framework, patient experience, of which complaints is a part. The key thing will be that we will look at a spectrum of information coming back from providers on patient experience, probably linked to the GP Patient Survey, which I am sure you will be very familiar with, of which complaints would be a piece of a picture, but only a piece of a picture in terms of feedback to commissioners.

Q131 David Tredinnick: <<http://www.parliament.uk/biographies/commons/25288>> To go back to resources, since the Healthcare Commission review stage was taken out, a lot of work has come up to you. Are you under pressure in terms of the number of people you have? How many investigative teams do you have?

Ann Abraham: On our resources, during the transition we discussed with the Treasury-because the relationship that I have about funding is with Parliament, with Treasury sanction-what we needed by way of startup funding and what we needed by way of additional funding in the first year without the Healthcare Commission in place. We negotiated a perfectly satisfactory settlement and we were happy with that-a bit less than the Healthcare Commission's complaints function cost. I have recently received confirmation from the Treasury of a fouryear funding settlement based on a submission we put in in October. I have no complaints about resources.

Q132 David Tredinnick: <<http://www.parliament.uk/biographies/commons/25288>> You didn't answer the question about the number of investigative teams.

Ann Abraham: Yes, indeed. I have about 430 staff and two offices-in London and in Manchester-and James' directorate, which is our customer services and assessment, front end, has about 100 staff.

James Johnstone: There are 100 people working on casework, yes.

Ann Abraham: And in terms of the assessment teams?

James Johnstone: They are split into 13 teams.

Ann Abraham: There are 13 teams. In terms of investigations, we have Parliamentary work and health investigation work, with directors of investigations there. In the health investigations directorate I think there would be six investigation managers. There are smaller numbers in the investigation teams, and again it makes the point that the amount of work that goes on in assessing cases and resolving cases at the front end is a very substantial part of our operation.

Chair: <<http://www.david-daviesmp.co.uk/>> Thank you very much indeed for your contribution. Thank you, in particular, to Ann Abraham for this and previous appearances before this and previous Committees. Thank you very much.

### **Examination of Witnesses**

David Flory CBE, Deputy NHS Chief Executive

Stephen Walker CBE, Chief Executive, NHS Litigation Authority,

Sarah Albon, Director for Civil, Family and Legal Aid Policy, Ministry of Justice, gave evidence.

Q133 Chair: <<http://www.david-daviesmp.co.uk/>> Good morning. Thank you for coming this morning. Could I ask you very briefly to introduce yourselves and your respective roles in Whitehall?

David Flory: I am David Flory. I am the Deputy NHS Chief Executive.

Stephen Walker: I am Stephen Walker. I am Chief Executive at the Litigation Authority.

Sarah Albon: I am Sarah Albon. I am the Director of Civil, Family and Legal Aid Policy in the Ministry of Justice.

Q134 Chair: <<http://www.david-daviesmp.co.uk/>> Thank you very much. I would like to start, please, by asking for clarification in respect of the Litigation Authority. What is the purpose and the form of the industry review which is currently in process and when is it likely to reach a conclusion?

David Flory: Yes. The industry review, which has recently started, is an action that came out of the Department's review-indeed the broader review-of arm's length bodies. As to the purpose, it doesn't start with a preconception or a hypothesis about the existing efficiency with which the Litigation Authority does its business. It is a way of reviewing the current operational form and way of working of the business and looking at whether some of that can be delivered more efficiently and effectively in a different way. On the timescales to report, in the first instance there will be an initial report by Easter.

Q135 Chair: <<http://www.david-daviesmp.co.uk/>> Have the terms of reference of this review been published, and the participants? How is the review being conducted?

Stephen Walker: The terms of reference have been published, but not widely. We are very happy to make them available to the Committee, of course.

Chair: <<http://www.david-daviesmp.co.uk/>> We would appreciate that.

Stephen Walker: I don't think it is a breach of confidence to say that the reviewing organisation is Marsh, the major insurance broker, and the work began last Monday, the 7th, with a series of interviews and requests for data. The first feedback session to the steering board, which is a DH board, although I am sitting on it with my chair, is this afternoon. There will be successive review meetings over the next six or seven weeks. They are already in the diaries.

Q136 Chair: <<http://www.david-daviesmp.co.uk/>> It is an odd title to have given this review, that it is an "industry review". Is it, in effect, a review designed to bring commercial risk management principles into the operation or to extend their operation within the Litigation Authority? Is that the purpose?

David Flory: It is designed to explore the potential for that, and the opportunity, without determining that that will be the outcome.

Q137 Chair: <<http://www.david-daviesmp.co.uk/>> Thank you. Could you explain to us how the clinical negligence scheme for trusts operates? How does it operate currently?

Stephen Walker: It is a risk pooling scheme, very closely analogous to a mutual insurance fund. It operates on a pay-as-you-go basis. It has no tangible reserves. We only ask, in any given year, for what we have actuarially calculated we may spend in resolving claims in the following year. So it has that huge pay-as-you-go cashflow benefit, as it were, for the NHS. It operates very much on insurance principles. Claims are dealt with on a tort basis as though they were going in front of a judge. Of course only about 2% of cases ever actually see a judge for determination, with another 2%, perhaps, for approval because we deal with many patients who are under some kind of disability, whether age or otherwise. We operate very much on the same principles as a mutual insurer would. We investigate, we negotiate, we resolve, we agree, we pay or we repudiate.

Q138 Chair: <<http://www.david-daviesmp.co.uk/>> That is available to all NHS trust healthcare providers, both foundation trusts and non-foundation trusts, is it?

Stephen Walker: Indeed. Over the last few years we have also provided indemnities to what were independent sector treatment centres, ISTCs. Then, with the successive waves which were brought in, the private providers, we have provided an indemnity to them, too, in so far as they were providing NHS services.

Q139 Chair: <<http://www.david-daviesmp.co.uk/>> But it is not available in the primary care sector?

Stephen Walker: No.

Q140 Chair: <<http://www.david-daviesmp.co.uk/>> Could you just talk us through the reasoning for that?

David Flory: Certainly. My hesitancy, Chair, is that for the type of setup, the centralisation of these arrangements in the mid 1990s when it was determined that these schemes would cover the centralisation, I don't know all the context of the consideration of primary care services from that time. But that was the time it was determined that it would be the centralisation type.

Q141 Chair: <<http://www.david-daviesmp.co.uk/>> You might well be telling me that it was my determination and that you should be asking me. Given that it is a policy that is continuing, do you think it is a correct policy in the current framework to offer this kind of cover for trusts and other private sector providers but not primary care providers?

David Flory: The statutory basis of the different aspects of provision, clearly, is quite different. The primary care providers, as independent contractors, have their own arrangements for covering the liabilities from their work, which are independent and quite separate, and, I believe, quite effective also. The current situation is the continuation of an arrangement whereby there is a central way, a single way, of managing cases on behalf of NHS trust providers, and a lot of the cases go back a number of years. There is still casework being done where the statutory responsibility sits with the Secretary of State following reorganisations that have taken place over previous years. Therefore, the work that the Litigation Authority does, at arm's length from but on behalf of the Secretary of State in managing that process, has been very effective in bringing together expertise and in bringing together the financial arrangements that Mr Walker has described in the way that the CNST works. I think it is an effective arrangement for NHS hospital providers.

Stephen Walker: Could I add to that, Mr Chairman? There was, of course, when CNST was created—and it was in your time, of course, you are absolutely right—an existing market for GPs and for the private sector generally through the defence organisations. At least one of your Members is almost bound to be a member.

Chair: <<http://www.david-daviesmp.co.uk/>> She is.

Stephen Walker: Those organisations provide a range of services, including indemnity provision, advisory services, representation at professional hearings and that kind of thing, which we don't. There is absolutely no reason why we could not take it on, but there has never been a demand for it and I am not aware that there is a perceived shortfall in what is being provided by the defence organisations.

Q142 Chair: <<http://www.david-daviesmp.co.uk/>> That world is not part of the industry review-the primary care world, the defence organisations. The industry review is focused purely on the current scope of the Litigation Authority. Is that right?

Stephen Walker: Yes.

Q143 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> It is interesting you mention that there is no demand, because certainly it is perceived as a cost that primary care practitioners have to bear which their hospital colleagues do not have to bear, and some of them would welcome it being part of the review.

Stephen Walker: It would be wrong for me to use this hearing as a sales opportunity, though.

Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Exactly, yes.

Q144 Chair: <<http://www.david-daviesmp.co.uk/>> Your basic proposition seemed to be that the medical defence unions "ain't broke" so there is no need to fix them.

Stephen Walker: Yes.

Q145 Chair: <<http://www.david-daviesmp.co.uk/>> It may be a proper question whether the Medical Defence Union approach is a more expensive way of solving the problem than the Litigation Authority because it is tax revenue that ultimately pays for it.

Stephen Walker: Yes. If you remember, all those years back-

Chair: <<http://www.david-daviesmp.co.uk/>> I don't.

Stephen Walker: How could you? CNST was created to meet a demand. The newly emerging trusts had realised that they were accepting liabilities or incurring liabilities and a solution needed to be found. CNST was that solution. There was no perception, at that time, of a similar problem vis-à-vis the defence organisations so far as private practice was concerned. The Department of Health did, of course, absorb a great volume of financial liability from the defence organisations at or around that time.

Chair: <<http://www.david-daviesmp.co.uk/>> Indeed.

Stephen Walker: You probably will remember that.

Chair: <<http://www.david-daviesmp.co.uk/>> That I definitely remember, yes.

Q146 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> The number of claims received under the CNST has gone up by 21% in the last three years and we wondered why that was the case.

Stephen Walker: And it is getting worse this year, massively so. We are looking at perhaps a 25% to 30% increase this year, in the year to date. I can't prove this, but we think clinical negligence claims have become a very, very attractive proposition for claimant lawyers and for claims farmers by virtue of the recoverability of success fees and after the event insurance premiums. The timing is beyond the possibility of it being a coincidence, we think. As a mature market for after the event insurance developed and became available, the numbers began to rise. A significant proportion of our claims are now funded on conditional-fee arrangements and, when successful, of course, there is the potential for an uplift of up to 100% and the recoverability of after the event insurance. It is profitable for the lawyers-and this is not a criticism of lawyers-as it is a system that allows them to make that profit. They didn't create it. They jibbed against it, if you remember, when legal aid was taken away. But who can blame them for exploiting it? After the event insurance simply takes any financial interest out of the equation in so far as the claimant himself or herself is concerned. They are actually told, from day one, "You will never have to worry." We think that is a major factor.

That, in turn, has sucked in so-called claims farmers who advertise for claims and, in turn, sell them-their verb, not mine. I think it is odious, but they sell their claims on. They don't sell them on the basis of merit. They sell them on the basis of who is on whose panel. Excuse my language, but you will appreciate that I feel very strongly about this.

Q147 Chair: <<http://www.david-daviesmp.co.uk/>> That is a very direct answer, but it is worth drawing the attention of the Committee to the figures in the brief that we have been given which suggest that the cost to the NHS budget of the CNST in the last financial year was £651 million. Could you give us an indication of where you think that figure is headed?

Stephen Walker: We have asked for more from the trusts for the forthcoming year, in the aggregate about 10% more. Judicial inflation continues at between 10% and 12% per annum. Legal costs continue to escalate and claim numbers, as has already been observed, are rocketing, after what appeared to be three years of a plateau.

Q148 Chair: <<http://www.david-daviesmp.co.uk/>> The figure rose from £456 million to £614 million, an increase of-

Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> That is just CNST. If you look at the Department's evidence from the NHSLA it is £821 million.

Stephen Walker: That is correct.

Q149 David Tredinnick: <<http://www.parliament.uk/biographies/commons/25288>> You described the selling of claims as odious and many will agree with that. Do you have a view about what should be done? Having worked in this field for a very long time, what advice would you give the Committee and the Government?

Stephen Walker: I am assuming that the Committee would, as Parliament has done, continue to deal with claims on a tort basis. Many people talk about no fault or a tariff scheme or changing the basis, but assuming that we stay with tort, negligence or breach of duty, causation and then quantum, we made very strong recommendations to Sir Rupert Jackson a couple of years ago. I am very pleased to say that most of our recommendations-not all, but almost all of them-were adopted in his report last January, reinforced by Lord Young in, I think, October of last year, and Sarah's colleagues have just concluded a consultation on the implementation of many of the recommendations that Sir Rupert made.

Q150 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> Coming back to the £821 million figure, because you have brought up the issue of lawyers' fees, do you have the figures for just direct compensation payments made? Is it possible to separate out the overall litigation costs?

Stephen Walker: Yes, and if they are not before you, we can easily send that to the Committee.

Q151 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> I was struck also by your evidence saying that there are lawyers in the City of London who are now charging £818 an hour.

Stephen Walker: That includes the success fee, of course.

Q152 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> Yes. But, at the same time, you are able to obtain solicitors for £205 an hour.

Stephen Walker: We are indeed, and we have held those rates for several years now. My panel is anticipating no increase from 1 April going forward.

Q153 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> Is that because you use particular practices?

Stephen Walker: It is, but they are practices which have had to adapt their business models to satisfy the demand from consumers such as my organisation, but also the insurance industry, and having said earlier that I think claimant lawyers are doing awfully well at the moment-

Q154 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> It would be very interesting if we could have the figures for the direct compensation payments-

Stephen Walker: They are easily provided.

Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> -certainly since 2004/05 because I am sure you will see the two lines on the graph.

Stephen Walker: I am sorry if you have not had them. They will be with your admin team. I am sure they are on our website, but you will have them by the end of the week-no problem.

Q155 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Following on from David's point, what steps do you think you could take to stop the escalation of costs? Is it something like fixed costs? Where the figure went up, is that coincidental, or does it coincide with conditional-fee agreements?

Stephen Walker: We think it very much coincides with conditional-fee agreements, not just the fact that conditional-fee agreements became viable-and legal, even-but because an after the event insurance market matured so that the solicitors who wanted to work on that basis could reassure their clients that they would have no exposure to costs in the event of an unsuccessful case. Yes, I have no doubt about that at all.

I am sorry, I think there was another part of your question.

Q156 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Do you think fixed costs is a way forward? What other steps do you think could be taken?

Stephen Walker: Fixed costs are something that we are currently discussing. Following Lord Young, we put together some ideas for a small claims scheme. I had perhaps best explain that, with a small claims scheme, there is a threshold to be agreed, say, £25,000. For lawyers who determine that their client's claim is worth no more than that, entirely voluntarily, they can come into that scheme. We will trade, for that agreement and for fixed costs, a guarantee of an early apology-there should always be an apology for something going wrong, but sometimes it is an apology for doing something wrong-an explanation, no exposure to costs and within-and we are still negotiating, I would love to say six months, but I am not sure we can deliver-maybe eight months a guaranteed offer or a detailed repudiation with an explanation, shared early medical evidence that we will pay for, and no exposure to costs for the claimant. We have written a paper, but that is the broad-brush, words-of-one-syllable approach.

Q157 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Have you considered alternative dispute resolution?

Stephen Walker: We talk of little else, if I might adopt that phrase. It is often taken to mean mediation, per se. We take it to mean any resolution short of putting it in front of a judge. As I said earlier, about 96% or 97% of our cases settle by negotiation, correspondence, round table meetings and the like.

As to mediation, we launched a big initiative some years ago. We won the Public Sector Mediator of the Year Award because we dealt with the postAlder Hey claims, the organ retention claims, by mediation. But we find it very, very hard to persuade people to mediate, for all kinds of reasons. I will bore you with them if your Chairman will allow me the time, but we find mediation very, very difficult to have people engage with. Again-and there was an invitation to us from Sarah's people this morning-there is a re-launch of the Government's drive towards more mediation and more ADR. We are very supportive but it is very hard to suck people into it-very hard.

Q158 Rosie Cooper: <<http://www.rosiecoopermp.net/>> May I ask you what you think of the practice of solicitors advertising in hospitals? Hospitals taking-

Stephen Walker: I abhor it. I cannot speak too strongly in language that would be appropriate to this Committee. I think it is appalling. But neither we nor the NHS in the round necessarily have the control. Nowadays, buildings are very often managed by external organisations. The last time but one I sat in one of these rooms, I was asked about a poster in the north of England immediately outside the gates of a new hospital. "Did the doctor or the nurse make you worse?" was the huge caption, with a man swathed in bandages and on crutches. That was for a claimant legal firm. That was on a bus stop, which was technically outside the domain of the chief executive.

Q159 Rosie Cooper: <<http://www.rosiecoopermp.net/>> I appreciate where it is technically outside or technically not your building, but there are many NHS buildings, hospitals and surgeries which allow advertising and take a fee for putting up those posters.

Stephen Walker: The fee is the dilemma. We have been asked whether we will match the fee if they kick the advertising out.

Q160 Chair: <<http://www.david-daviesmp.co.uk/>> Can I be counterintuitive for a second. You abhor it, but what the advertising does, in a rather provocative way, is to draw the patient's attention to their rights. In the earlier part of the evidence session this morning we were hearing about patients who felt they were not taken seriously and the NHS was too willing to brush aside their complaints.

Stephen Walker: That is a point well made, Mr Chairman, but these adverts are not necessarily from the best lawyers to do the job. These ads, rather like claims farmers selling them, direct people to whoever has paid for the advertising. They are not necessarily-

Q161 Chair: <<http://www.david-daviesmp.co.uk/>> It is not the fact of the advertising. It is the individual of the advertiser that you are more concerned about.

Stephen Walker: Yes. And I know for a fact that a majority of the responses to those posters tend to go to people who are dealing with the Road Traffic Act or employers' liability claims, for example. We see the logic, though, of the NHS advertising lawyers who will then sue the NHS. I sat through this morning's session so I am very sympathetic to almost everything that was said, especially by Ann.

Q162 Rosie Cooper: <<http://www.rosiecoopermp.net/>> I was going to develop that. You have adverts saying, "Sign up" and, as the Chairman quite rightly says, if you have a problem, you need to get your correct redress. But, as a chair of a hospital, I also saw the other side to that coin. No complaint in the Health Service is minor, but where a complaint of a lower financial magnitude is brought against a doctor then you might settle, rather against the wishes of the doctor, on the basis that it would be less costly to deal with it now than allow it to take its course.

Stephen Walker: Are you saying that is what they did at your hospital?

Rosie Cooper: <<http://www.rosiecoopermp.net/>> They have done that, via your good selves as well.

Stephen Walker: I hope that was when we had excesses so that it was your money, not ours. We try not to do that. We try not to make so-called ex gratia payments to make things go away even when it would be more cost effective to do so because we worry about the landslide or floodgates syndrome.

Rosie Cooper: <<http://www.rosiecoopemp.net/>> Absolutely, and I really fear that, but I do know there are-

Stephen Walker: And the fair city in which you were a chair, of course, is the capital of that kind of claim and that kind of claim settlements.

Rosie Cooper: <<http://www.rosiecoopemp.net/>> Don't be so-

Chair: <<http://www.david-daviesmp.co.uk/>> I don't know if we have time to go through that.

Q163 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> I want to turn to legal aid, Sarah. I know you are just a spokesperson for the Department, as opposed to the Secretary of State, but I wondered what sort of consultation you had with the Secretary of State for Health on removing legal aid for clinical negligence cases.

Sarah Albon: I am not aware that there was a meeting between the Secretaries of State. Obviously we had the normal interdepartmental clearance process and we have certainly worked very closely with colleagues in the Department of Health around the twin packages of the reform to civil costs regime, which was initiated by Lord Justice Jackson, and the removal of clinical negligence from the scope of legal aid. It is extremely important that those two things are considered together and that the overall impact on individuals then wanting to bring a claim for clinical negligence-the different funding routes and the changes that we are proposing-are considered together so that we fully understand the range of impacts for individuals who want to bring a claim. It is important that those people who have a claim against the NHS, or against any other medical provider, should continue to be able to fund appropriate legal advice and assistance where they need that.

Q164 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Do you think it is going to have a consequence on that? Do you think that is going to stop the claims?

Sarah Albon: It will undoubtedly reduce some claims, but, as we have heard, there are some claims that are being brought with absolutely no financial consequence at all to the individual complainant. We have heard about the aftertheevent insurance. Those insurance premiums are not payable by the individual claimant. They are payable only by the losing defendant, if ultimately the defendant loses. So even the insurance premium is not something, at the moment, that the claimant pays. They have no financial stake at all in the proceedings and we do feel, and Lord Justice Jackson felt quite strongly that the balance of costs in civil litigation has swung too far in favour of claimants and to the detriment of defendants.

Q165 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> But he said, did he not, that it should still be there for clinical negligence cases?

Sarah Albon: That legal aid should?

Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Yes.

Sarah Albon: He did say that. We believe that the amended CFA regime will still allow claimants with a good case to bring proceedings, although we do recognise that there will be some cases where the early investigative stages are so very, very difficult and expensive that they will not be suitable for a CFA regime. We propose to maintain what we are calling in the consultation paper an exceptional funding route that will allow people with those very, very serious claims, who may otherwise be absolutely denied any access to justice in any fair route through to justice, to be able to be funded on an individual case-by-case basis still through legal aid.

Q166 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> But that is the basis of legal aid, is it not? Really, it should apply to everyone. But you cannot accept some of his recommendations and not the main one. You have heard about the increase in costs with CFA. By cutting back legal aid, do you see that that would have a consequence to increase costs?

Sarah Albon: It would do if we didn't also do something about the CFA regime at the same time, but we believe-and we have worked quite closely with colleagues in the Department of Health-that the overall impact of the introduction of the Jackson proposals will be to see a reduction in the region of £50 million a year to the NHSLA.

Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Thank you.

Q167 Chair: <<http://www.david-daviesmp.co.uk/>> To be clear, is that something that is shared within the Department of Health, that the combined effect of these changes will be to reduce cost from what it otherwise would have been by £50 million?

David Flory: As to the specific figure of £50 million, which Sarah has raised, there are a number of assumptions and caveats behind that. We can see the potential for a reduction, and possibly a substantial reduction, in costs but at this stage we are not formulating plans on a specific level of reduced costs.

Stephen Walker: I have two points. First of all, of course, no matter when the changes are introduced, it will take some years to work through into our accounts because these are almost, by definition, long-tail claims. You might like to know that our submission to the MoJ consultation urges that clinical negligence should not be an exclusion but that special provision should be made by way of legal aid as a startup or a pumppriming potential fund. We are working on some other alternatives, too, behind the scenes for the catastrophically injured, whether they be infants or the victims of neurological damage, on how you define that and how we make it fair. We are not in the business of trying to deny people access to justice.

Q168 Chair: <<http://www.david-daviesmp.co.uk/>> Does it not follow from the arithmetic you have given us that if there is going to be an increasing reliance on CFAs but the total cost of the scheme is going to be less than it otherwise would have been, there are going to be fewer claims granted at higher cost to the taxpayer because the fewer claims granted are going to be on a CFA basis and therefore more expensive than they would have been?

Stephen Walker: We are arguing that CFAs' recoverability should be abolished entirely for clinical negligence, save possibly for start-up costs on the severe neurological cases. But our first choice would be that legal aid remain for them.

Q169 Yvonne Fovargue: <<http://www.parliament.uk/biographies/commons/84359>> Still on the legal aid area, I have had concerns that about 500,000 people, it has been said, will lose out on legal aid if the changes go through. How many of these do you estimate will be clinical negligence cases?

Sarah Albon: I do have that figure as part of our impact assessment, but I am going to have to write to the Committee because I don't have it straight in front of me. I can tell you how many people were assisted on legal aid. We are not predicting that all of those would come out of scope, which is why I am going to need to write. The Legal Services Commission-and this is taken from their annual report 200910-have two levels of assistance, what they call legal help, which is some early advice, and then representation as the cases go forward towards litigation. They had 3,288 instances of legal help, of certificates granted, in 200910, and full representation was granted in 158 cases. That is by volume.

By cost, the costs are significantly on the representation side because legal help is at a fixed fee, generally, of £217, whereas legal representation will vary enormously. Ultimately, of those cases where the Legal Services Commission has granted certificates, the LSC met the cost of litigation in 200910-and these are historical certificates, you will see from the numbers-in 2,330 cases, whereas the other side met the costs in 1,457. Obviously, generally speaking, the LSC would be bearing the costs where the applicant is a losing claimant and the other side would be bearing the costs where the applicant is a winning claimant.

Q170 Yvonne Fovargue: <<http://www.parliament.uk/biographies/commons/84359>> Over 3,000 people had legal help, which is the first stage. From my perspective, that would mean those people would possibly be pushed into a CFA scheme, which we have heard is a lot more expensive, because legal aid will not be available for the majority of those.

Sarah Albon: The current CFA scheme is a lot more expensive, but the proposals we are consulting on at the same time are that the uplift, which currently can be up to 100% of the solicitor fees, should be severely curtailed and also that the after the event insurance should no longer be recoverable. We are also consulting on the possibility that any uplift should be paid by the claimant, potentially from their damages. We think the Jackson proposals will significantly reduce the cost of CFA supported litigation. It is worth bearing in mind that where a claimant's solicitor who is on legal aid wins a case, their costs are usually not at legal aid rates against the other party but they are at full private client rates. The actual difference in costs between an amended CFA regime and between winning, having been on a legal aid certificate, should be significantly reduced.

Q171 Yvonne Fovargue: <<http://www.parliament.uk/biographies/commons/84359>> My other concern is, for these 3,000 people or more, how is the new scheme going to guarantee that they have access to justice? That was a concern of Lord Justice Jackson in his report. How is the new scheme going to guarantee that they have some access to justice? At the moment, they have chosen to go on the legal aid route because they probably feel more comfortable with that scheme than going through a claims management, and so on.

Sarah Albon: It depends very much on the type of claim that is being brought. There is a huge range of claims, obviously, in clinical negligence and we have some sympathy with the points that Mr Walker was making, particularly with young children during the birth process. But, irrespective of the causation, where there are catastrophic injuries to individuals, it takes a number of years before quantum, and sometimes causation, can be determined. It is very difficult to see how those cases could all be funded through a CFA regime.

We accept that we need some sort of exceptional funding mechanism to sit behind, that will remain legally aided, to support those people. On the other hand, there are much more straightforward cases, with much more minor injuries, where the level of expert report and such things that are needed in order to support the case are much less and it is much more straightforward for a potential claimant's solicitor to make a decision about prospects of success and give the client advice in a way that doesn't require significant legal aid investment.

Q172 Yvonne Fovargue: <<http://www.parliament.uk/biographies/commons/84359>> Where will that payment come from for the solicitors to give that advice? I appreciate claimant reports are very expensive. That is one of the issues, that the reports from doctors can be extremely expensive and, without legal aid, where are they going to get the money to get those reports?

Stephen Walker: We think that is one of the attractions of our proposed small claims scheme, that we would fund the initial joint instructed report and have simultaneous delivery to the claimant and to us. If the claimant then wants to take it on, the claimant has to find funding in the usual way. But there is no exposure at the initial stage until we reach the point of admitting liability and beginning to negotiate or repudiating liability, in which case he or she can take that case onwards, or not, as the case may be.

Sarah Albon: It is important to remember that various insurance packages will continue to exist and be capable of being purchased by potential claimants. The change that we are recommending is that the after the event insurance will no longer be recoverable from defendants, not that there should be no insurance available for individual applicants. We would expect to see the cost of insurance probably reducing as a result of these changes because what is being insured is a narrower set of possibilities.

Chair: <<http://www.david-daviesmp.co.uk/>> Could we move on? One of the other areas which could clearly impact on the cost of these settlements is a more open attitude by NHS providers as to what is often summarised as a duty of candour.

Q173 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Yes. I want to ask a question to Mr Walker. The NHS Litigation Authority issued a circular to its members encouraging them to apologise when things go wrong. What evidence do you have that more NHS organisations are making timely and appropriate apologies to patients?

Stephen Walker: Probably only less complaints that they are not, is the honest answer to that. The wording of our circular, I think, is the third iteration. We first did that in 1997. I don't manage the NHS, and I have very limited powers beyond managing litigation. What we decided we could do was to remove any legitimate hiding behind the risk of litigation by issuing that circular and expressly saying that it would never be an honest attempt at an explanation; a good faith explanation and apology would never be used as an excuse to avoid liability. Probably everyone on the Committee is too young to remember that insurance certificates used to have "Do not apologise. Do not say sorry" stamped on the back, or words to that effect. We wanted to undermine that mindset, which said "I had better not say anything. They might sue." That was the best we could do.

We have subsequently done road shows and we have supported initiatives from the Being Open initiative that the NPSA promoted. We are 100%, inevitably, behind the constitution which says pretty much the same thing. People are entitled to explanations. There are a number of dilemmas, human nature being one of them. No one likes to admit to a mistake, I guess, and professional people are no different to anyone else. There is also the risk of professional regulatory action. People in your profession do worry about that, understandably. There is also what we would call the latent patent problem in that the clinicians are not always aware that something has gone wrong at the instant it goes wrong. If they are aware and they can remedy the problem immediately, their mindset is not about "I had better do a full explanation and an apology," but in some cases people leave the hospital and the problem only comes to light many years later. So the opportunity for that instant "I am sorry. What happened was A, B, C" isn't there.

Here I appear to be defending your profession, but I am certainly defending the administration in the trusts as well. Things have improved simply, as I say, because we see less complaints about a failure to explain. I am not personally convinced that increasingly rigorous regulation, and even statutory imposition of a duty of candour, is going to make the difference. There has been a duty to report road traffic accidents for eons and people still don't if they think they can get away with it.

Q174 Chair: <<http://www.david-daviesmp.co.uk/>> That is not quite the question, though, is it? The question, surely, is whether the duty to report leads to more accidents being reported than the absence of the duty to report.

Paul Streets: I don't know the answer, I am afraid.

Chair: <<http://www.david-daviesmp.co.uk/>> Mr Flory wants to come in as well.

David Flory: Thank you, Chair. As Mr Walker has highlighted, there are a number of different strands, if you like, to the theme of encouraging and requiring openness from NHS organisations and professionals working within them. We have referred to a duty to be open in the NHS Constitution, part of the 2009 Act. The work that the Litigation Authority has done is very important in supporting professionals to be more open without there being adverse consequences in any subsequent litigation and the Patient Safety Agency's campaign has been an important part of this.

But when we think about how we want to change behaviour and how we want to change the way things are done and handled in local NHS organisations, it is a dilemma. A statutory duty is not necessarily the best way to do it for the reason that you allude to, Chair. We have had an example quite recently as part of the Government's, or the Secretary of State's commitment to eliminate mixedsex accommodation. The action taken in that is to introduce a system whereby, when there is a breach of that duty, there is a fine to be paid by the body that has failed in the standard that would be expected. In that sense there is a significant and practical issue for the organisation that has not lived up to and met the standards we expect in terms of a financial penalty, but also the reputational damage that comes to the organisation from that when those things are reported locally. We have seen in a number of examples-and we hope to see it in the elimination of mixedsex accommodation-where those sorts of things can change behaviour and approach locally. That is an alternative way forward to a statutory duty and the redress that would come with that for something like this.

Q175 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> I want to clarify the duty of candour. You hear this from judges all the time-and I have litigated for the Government. It is when you get to the stage where a piece of information could have been given at an early stage. You have it in judicial review where you pass information from both sides, evidence, etcetera, so everybody knows where they are. The duty of candour really applies to getting the information early on. It is not about admitting liability. It is so that everyone has the facts beforehand.

Stephen Walker: Forgive me, I only conflated it with admissions of liability because people used to use the fear that they were admitting liability as an excuse not to do it. We tried to eliminate that excuse for them. It doesn't make them do it. It just removes one excuse, or one barrier.

Q176 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> But the idea of this is that you prevent getting to the judge, who then says, "Why didn't you have this document in the first place? You ought to have had that." That might have prevented extreme litigation.

Stephen Walker: That is a fair point.

Q177 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Almost the other side of this argument is that Action against Medical Accidents has accused the NHS Litigation Authority of sometimes themselves admitting liability ridiculously late in the process. I wondered how you reacted to that charge.

Stephen Walker: I saw that they had said that and I reacted by saying, "They always say that."

Chair: <<http://www.david-daviesmp.co.uk/>> But is it true?

Q178 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Is there truth in it, though? That is the important thing.

Stephen Walker: I am, of course, going to address it, Mr Chairman. We admit liability as soon as we can. It is cost effective to admit liability as soon as possible. It stops the claimant lawyers running up an excess of bills. The truth is we do not always know all the facts on day one. We can't sometimes know all the facts on day one. If the facts are disputed, whether they relate to a breach of duty or to causation, there is an ongoing process whereby the claimant's lawyer produces his or her evidence. We may find that persuasive and admit then. We may get independent evidence of our own, which may or may not support the original trust argument that they were not liable in the first place. But, believe me, we admit liability as soon as we possibly can, not least because we have no brief to deny claimants their remedies. Quite the opposite. But we do it primarily to stop the claimant's lawyer continuing to run up costs in relation to liability.

Since Jackson, we have changed our way of working to address this issue. We used to place a great deal of reliance on what we were told by the trust. Our trust members will read the reports of this Committee, so I had best say that we still do place great reliance upon them. But rather than repudiating liability on the basis of a trust report now, we always, before repudiating liability, get independent evidence to back that. If we cannot find the independent evidence, we admit liability sooner. That is an additional frontloading of the costs, but we think that that, first of all, gets us to the point of an admission or a sound repudiation earlier and also, in the long run, saves considerable costs. I come back to what I said at the beginning, "They always say that."

Q179 Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> If they came back with evidence where they thought that had occurred, you would look into those complaints.

Stephen Walker: Every one of the lawyers on their panel knows that they have a direct line to me and they are not shy about using that, either in correspondence or by telephone.

Dr Wollaston: <<http://www.parliament.uk/biographies/commons/81217>> Thank you.

Q180 Rosie Cooper: <<http://www.rosiecoopermp.net/>> What influence can you bring on individual doctors in the process to make their reports as early as possible? In cases where I have been involved or have watched, it can be that an inordinate time is wasted waiting for a doctor's report to come.

Stephen Walker: Forgive me, are you talking about a doctor employed at the organisation that is being sued or the independent expert?

Q181 Rosie Cooper: <<http://www.rosiecoopermp.net/>> I am sorry, the organisation that is being sued. In other words, it takes an inordinate time to get-

Stephen Walker: Sadly, not a lot-

Rosie Cooper: <<http://www.rosiecoopermp.net/>> -the basic facts.

Stephen Walker: You are forwarding one of our arguments. We would love to be able to apply pressure locally to get reports completed faster and more comprehensively. It is a huge problem for us.

Q182 Rosie Cooper: <<http://www.rosiecoopermp.net/>> And that builds into the delay?

Stephen Walker: Yes, it does. We don't have the levers. We are not a commercial insurer who could, for example, randomly refuse to indemnify, or threaten to.

Q183 Rosie Cooper: <<http://www.rosiecoopermp.net/>> What if you put the premium up for that organisation that delayed doctors getting the reports into you by 0.5%, or something, each year? You would soon get a perverse incentive to get your reports in quick.

Stephen Walker: It is an idea, but it is not a minority of organisations.

Rosie Cooper: <<http://www.rosiecoopermp.net/>> No, absolutely.

Q184 Chair: <<http://www.david-daviesmp.co.uk/>> Rosie must be right, mustn't she, that there is an avoidable cost here? You say that you don't have the commercial lever, but the NHS is not short of levers, and the man on your right has quite an array in front of him.

Stephen Walker: We will explore it.

Chair: <<http://www.david-daviesmp.co.uk/>> We can't just sit here and say, "This is a problem. We cannot do anything about it."

Stephen Walker: We will explore it. We now have the weight of this Committee by way of protection when the trusts criticise us for it, but we will explore it. I guarantee-

Q185 Rosie Cooper: <<http://www.rosiecoopermp.net/>> It is our money, the public's money-

Stephen Walker: Absolutely.

Rosie Cooper: <<http://www.rosiecoopermp.net/>> -that could go to patient care. I was grateful for your comments before because that is where I was leading. I feared that we were going to jeopardise the people who had major claims with the new systems, that major claims were not going to be met and those of smaller claims would get through the system because, "Just dispense with them." We do need some levers to say to all the organisations and the doctors involved, "The quicker you report, the quicker we get it settled," and "Just because you choose to be in Australia for two months, and then go somewhere else and then be too busy and five months later we are still waiting for a piece of paper, is not acceptable because it adds to the cost for everyone."

Stephen Walker: Ms Cooper, trust me. I am mentally drafting the letter as you speak.

Chair: <<http://www.david-daviesmp.co.uk/>> I think you have scored.

Rosie Cooper: <<http://www.rosiecoopermp.net/>> You settle their premiums. Everybody kills themselves to get CNST Level 1, 2 and 3 and have to go through giant hoops just to get a small discount. Here is a huge discount, "If you don't do what you are required, up your premiums go."

Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Follow that.

Stephen Walker: I hope the young man behind me is writing this down as we talk. Yes. I knew he would do.

Q186 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> This is a tidyup question. The NHS Redress Act seems to have been sitting there for a long time and I wondered as to all your views on it. Given that the much quoted and saintly Lord Justice Jackson has said he approves of it, what steps are you taking to put it into effect?

Stephen Walker: I did say that we endorsed Sir Rupert's recommendations in most respects. When the Act was a Bill going through Parliament and when it became an Act, the redress scheme was not described or defined and it has come, over time, to mean very different things to different people. Some people even think it is a no-fault scheme or an easier fault scheme, if you like. It cannot be, because the Act expressly says tort. Given that it has not been implemented in the meantime and we, at the Litigation Authority, never saw the need for a second scheme anyway, I think a small claims scheme of the kind I described earlier, but managed within CNST, would answer all of the questions that were being posed by a potential Redress Act without the need for further statutory instruments. I hope that answers your question.

David Flory: That is what our expectation would be. Indeed, the formality of the Government's position at the moment is that we will wait and see how the new complaints arrangements that were introduced settle down and look again in the context of the new way of working on complaints. As Mr Walker says, our expectation would be if we can make progress on a different type of arrangement for the small claims, then that would effectively overtake what the Redress Act was looking to do.

Chair: <<http://www.david-daviesmp.co.uk/>> It remains in reserve without any early plan to implement it.

David Flory: Yes.

Q187 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> There is some mention in our briefing about this road traffic scheme. I know you all have reservations on this, so why would you consider one thing when-

Stephen Walker: I know I am going to be taking that one. It was Lord Young's preferred model.

Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Yes.

Stephen Walker: He was, I think, frustrated by the insurance industry, not just by us, and the ability of the litigation world to deliver something quickly, cheaply and economically that would satisfy many of the outstanding questions. He had seen the Road Traffic Act portal, which was introduced 12 months ago, approximately now, I guess.

Sarah Albon: It was 30 April 2010.

Stephen Walker: That is close enough. He had seen that working. Although we don't know how well it is working yet-the management information flow isn't as good as it might be-it is a model which allows both sides to feed into a central point with almost automatic feedback outward. We said, "We will try and cobble something together"-to use the language we used with Lord Young-"that is akin to it but which accounts for the additional complexity or sophistication of clinical negligence," because RTA claims, by and large, do not have causation issues, for example, and if they do they come out of the scheme anyway. That is what we did. What we have produced is now sitting with Ms Albon's senior colleagues, and indeed one of her Ministers, and with our Ministers and with Mr Flory. It is a proposal that we are discussing with APIL, the claimant lawyers' organisation, for what will effectively be a clinical negligence parallel to the Road Traffic Act portal. Does that make sense?

Q188 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> Yes. Do you all think that is a good idea? What stage are you at?

Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> Can you apply it to the NHS, effectively? If someone has a road traffic accident, they have a road traffic accident, and you know this is the point of causation. In terms of the pace of the road traffic accident scheme, it is 15 days, another 15 days and then another 20 days, otherwise you cut off-

Stephen Walker: No. We have made it clear we cannot meet those timetables. With an RTA we have put different periods in, basically-

Q189 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> Would you be willing to share that with the Committee?

Stephen Walker: -and a further stage for causation. Of course we would-no problem. I am sure my young man is writing that down as we speak as well. Certainly the MoJ has it, the Department of Health has it and APIL have it. How could I possibly refuse it to this Committee?

David Flory: From the Department's point of view, we are looking to the Litigation Authority and to the MoJ to take the discussion forward and to see where we get to and we will then respond.

Sarah Albon: We are very happy to continue discussing it, but we are also mindful of the discussion that you were having at the beginning of this session, that the NHSLA only covers a proportion of clinical negligence schemes. We need to think carefully about what value we will get for having online portals, etcetera, that cover a proportion but not all schemes. Anything that we can work up jointly and test the process would at least be extremely helpful learning for us because, as you say, there are significant differences between clinical negligence and road traffic. The current road traffic scheme covers cases where the damages are up to £10,000. Following Lord Young's report, we are looking at what we can do to extend that to cover cases up to £25,000 of damages.

Q190 Valerie Vaz: <<http://www.parliament.uk/biographies/commons/84905>> What was your view on the Redress Act?

Sarah Albon: We do not have a different view from the Department of Health. The key thing is to do all that we can to get the early factfinding stages right and have that early exchange of information. Colleagues in NHSLA are focusing on that with the sort of small claims issue that we were talking about earlier.

Stephen Walker: Ms Cooper might be interested to know that it was one of the issues we raised with Lord Young and we were going to use his considerable political weight to put some pressure on trusts to drive it faster if we got the scheme up and running. Sadly, he has gone so we will now have to use this Committee.

Q191 Chris Skidmore: <<http://www.parliament.uk/biographies/commons/62314>> Coming back to compensation schemes, the previous Health Select Committee recommended to the Department that they looked at the New Zealand Accident Compensation Corporation as a model. I wondered if the Department had made any consideration of that model at all. Obviously, we are talking about the road traffic accident scheme, but has New Zealand been actively looked at since the previous Health Select Committee's report?

David Flory: I am afraid I could not tell you what specific consideration that scheme has been given. I would need to come back to you further with that.

Chair: <<http://www.david-daviesmp.co.uk/>> The Department has had quite a full agenda in the intervening period. Are there any other points from the Committee or from the witnesses? No. Thank you very much. That has been very helpful to us. Thank you for coming.

---

---

©Parliamentary copyright <<http://www.nationalarchives.gov.uk/information-management/our-services/parliamentary-copyright.htm>> Prepared 23rd February 2011

#### Footer links

- \* [A-Z index](http://www.parliament.uk/site-information/azindex/)
- \* [Glossary](http://www.parliament.uk/site-information/glossary/)
- \* [Contact us](http://www.parliament.uk/site-information/contact-us/)
- \* [Freedom of Information](http://www.parliament.uk/site-information/foi/)
- \* [Jobs](http://www.parliament.uk/about/working/jobs/)
- \* [Using this website](http://www.parliament.uk/site-information/using-this-website/)
- \* [Copyright](http://www.parliament.uk/site-information/copyright/)