

NHS COMPLAINTS AND THE HEALTH SERVICE COMMISSIONER

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Abbreviations

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| Care Quality Commission | CQC |
| Clinical Commissioning Group | CCG |
| Department of Health and Social Care | DHSC |
| General Medical Council | GMC |

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|---|--|
| General Practitioner | GP |
| Health Service Commissioners Act 1993 | The 1993 Act |
| The Health Service Commissioner for England | Parliamentary and Health Service Ombudsman (PHSO) |
| Local Authority Social Service and National Health Service Complaints (England) Regulations 2009 | The Complaints Regulations |
| National Health Service | NHS |
| National Health Service Act 2006 | NHS Act |
| National Health Service (General Medical Services Contracts) Regulations 2015 | GMS Regulations |
| National Health Service (Personal Medical Services Agreements) Regulations 2015 | PMS Regulations |
| Patient Advice and Liaison Service | PALS |

Introduction

1. Even when those providing and commissioning NHS services strive to deliver the highest possible standards of clinical care and service, it is inevitable that complaints will from time to time be made by patients or those, such as relatives, who are concerned with the welfare of patients. These may range from the vexatious to the highly meritorious, for example a complaint about potentially negligent clinical practice that caused an otherwise avoidable death. Clinicians and managers in NHS organisations may feel that administrative and clinical resources are over-employed in the area of complaints handling. However, the right to complain and the complaints process is a fundamental part of NHS service provision. It is also a right protected by the NHS Constitution and is a matter for regulation by the Care Quality Commission (“CQC”).¹ It is something that all healthcare providers and commissioners should take very seriously. Complaints also provide an invaluable source of information for senior managers to understand patient perspectives and thus assist with service improvement programmes. Bill Gates, the founder of Microsoft observed, “your most unhappy customers are your greatest source of learning”.

¹ Please see Chapter XX on the NHS Constitution for further discussion of how NHS bodies must have regard to the NHS Constitution and Chapter XX on the CQC.

2. Data on written complaints in the NHS, which is published on a yearly basis by NHS Digital, shows that the number of complaints made by or on behalf of patients is rising.² In 2016-2017, 208,415 reported written complaints were made about NHS services. This is the equivalent to 4,008 written complaints a week or 571 complaints a day. This increase in the number of complaints is not *necessarily* a bad thing, however. In recent years, particularly following the Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt Hon Ann Clwyd MP and Professor Tricia Hart, there has been a drive to highlight awareness among patients of their right to complain, either directly or by a representative, about issues with the care and service provided to them. There is also a greater emphasis, at least in theory, on the complaints process being part of an aspiration for a more honest and open NHS culture devoted to continuous learning and improvement of patient safety. It goes hand in hand, for example, with the development of an improved patient safety reporting system and the introduction of the “duty of candour” under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which form the basis of CQC regulation. The duty of candour requires registered providers to act in an open and transparent way and provide an apology in relation to any “notifiable safety incident”.

3. The NHS complaints system allows for complaints to be made on an informal or formal basis. It is also a way for patients who feel there has been a failure with their care to seek appropriate redress, be that a clarification or a fuller explanation of “what went wrong”, an apology, a promise to implement service improvements, or financial compensation.

4. If a complainant has exhausted all complaints processes at the NHS stage and is not satisfied by the substantive outcome, or with the way in which their complaint was handled by the relevant health service organisation, the patient has the right to ask the Health Service Commissioner for England, known colloquially as the Parliamentary and Health Service Ombudsman (hereafter referred to as “the PHSO”), to investigate. The PHSO has a discretion to decide whether to investigate an individual complaint or not to do so. The PHSO conducts a number of investigations but it has limited resources and frequently declines to investigate complaints referred by individual patients. There are certain circumstances, discussed below, where the PHSO is statutorily barred from investigating a complaint. If the PHSO agrees to investigate and upholds or partially upholds a complaint, he can make recommendations as to

² See NHS Digital’s Report, *Data on Written Complaints in the NHS 2016-2017*, 14 September 2017.

remedy to the body complained about. He can also lay reports before Parliament in particularly egregious cases.

5. At this stage, it should be emphasised that making a complaint is an alternative, and different method of seeking redress, to, for example, making a legal claim based on negligence for medical malpractice, judicially reviewing a decision of an NHS body, or making a claim under the Equality Act 2010 for discrimination. It is possible, however, in some circumstances for a complaints procedure to run alongside these other methods of redress. There are also different mechanisms by which patients can raise concerns about poor clinical care or unacceptable conduct by NHS staff including referring individual doctors to the General Medical Council (“GMC”) or making a complaint to the CQC. They do not come within the scope of this chapter but readers should be aware of their existence.

The NHS Complaints Procedure

6. The NHS complaints procedure is governed by the Local Authority Social Service and National Health Service Complaints (England) Regulations 2009 (“the Complaints Regulations”), made under sections 113, 114, 115 and 195 of the Health and Social Care (Community Health and Standards) Act 2003. They govern when, how, by whom and to whom complaints can be made, as well as setting out requirements for the complaints procedure itself and how it ought to be managed.

Informal complaints

7. The Complaints Regulations create a formal statutory complaints process, which must be adhered to by NHS bodies complained about (and must be followed by complainants who wish to follow through the process). There is, however, the option for patients and NHS bodies to attempt to try and resolve any issues that have arisen informally prior to the patient making a formal complaint. If a patient makes a complaint orally, and this is resolved to the complainant’s satisfaction “*not later than the next working day after the day on which the complaint was made*” then by virtue of Regulation 8(1)(c) of the Complaints Regulations, the body complained about is not required to handle the complaint in accordance with the process. This gives patients and bodies the chance to resolve issues informally, although it is incumbent on them to bring the complaint to a swift resolution.

8. A patient who wishes to make an informal complaint within a hospital setting may want to seek advice from the Patient Advice and Liaison Service (“PALS”) based within the hospital. As described on the NHS Choices website, this service *“offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers”*. They can therefore help patients with health-related questions or help them to resolve any concerns. If informal resolution is not possible, they can also advise about the formal complaints procedure.

Formal complaints under the Complaints Regulations

Responsible bodies

9. The Complaints Regulations came into force on 1 April 2009 and made transitional arrangements for complaints made before that date. Fundamentally, they require what is known as the “responsible body” to “make arrangements” for the handling and consideration of complaints in accordance with the Complaints Regulations. Responsible bodies, and thus those bodies who must have regulations-compliant arrangements in place, are:
 - a. Local authorities (county councils, metropolitan district councils, a non-metropolitan district council for an area where this is no county council, a London borough council, the Common Council of the City of London and the Council of the Isles of Scilly);
 - b. NHS bodies (Special Health Authorities, CCGs, NHS England, NHS trusts and foundation trusts);
 - c. Primary care providers (general practices under GMS, PMS and APMS contracts, general dental services contractors or a provider or dental services in accordance with section 107 of the NHS Act, general ophthalmic services contractors, and providers of pharmaceutical services under the NHS Act); and
 - d. Independent providers (any person or body who provides health care in England under arrangements made with an NHS body and who is not an NHS body or primary care provider – this would therefore include private companies running care homes, for example).

The complaints arrangements

10. The complaints arrangements must be “*such as to ensure that*”:
- (a) complaints are dealt with efficiently;*
 - (b) complaints are properly investigated;*
 - (c) complainants are treated with respect and courtesy;*
 - (d) complainants receive, so far as is reasonably practical—*
 - (i) assistance to enable them to understand the procedure in relation to complaints; or*
 - (ii) advice on where they may obtain such assistance;*
 - (e) complainants receive a timely and appropriate response;*
 - (f) complainants are told the outcome of the investigation of their complaint; and*
 - (g) action is taken if necessary in the light of the outcome of a complaint.*
11. Regulation 16 of the Complaints Regulations requires the responsible body to make information available to the public as to:
- a. Its arrangements for dealing with complaints; and
 - b. How further information about those arrangements may be obtained.
12. It is difficult to see how an NHS body can comply with the duty to have “arrangements” to manage complaints unless the NHS adopts a policy which sets out how it is going to respond to complaints. That policy constitutes the NHS body’s arrangements and thus complies with duty under the Complaints Regulations to have arrangements in place. NHS bodies should make this policy available to the public on its website, and, for example, in paper copy and in other formats and languages on request. The arrangements must also be such as to ensure that complainants receive assistance to understand the process or advice on where they can receive such assistance. Responsible bodies may have PALS which achieve this function. The NHS Complaints Advocacy Service, which was funded by the Department of Health (now DHSC), has now ceased to exist. It is supposed to have been replaced by a number of independent complaints advocacy services commissioned by local authorities. Section 223A of the Local Government and Public Involvement in Health Act 2007 requires each local authority to “*make such arrangements as it considers appropriate for the provision of independent*

advocacy in relation to its area” in the provision of assistance for individuals making or intending to make an NHS complaint or a complaint to the PHSO. Responsible bodies should be aware of local advocacy services (such as VoiceAbility, SEAP, Impetus and POhWER³) and inform potential complainants of these, as well as of other resources available from organisations like Healthwatch and the PHSO.

13. Under Regulation 4 of the Complaints Regulations, a responsible body must designate persons to fulfil two roles:
 - a. The first is the “responsible person”, who is responsible for ensuring compliance with the arrangements and in particular ensuring that action is taken if necessary in the light of the outcome of a complaint. This person must be the chief executive officer of a local authority or NHS body, or if it is another type of responsible body, such as a primary care provider or independent provider, it must be the person who is the sole proprietor, a partner where the body is partnership (such as a GP partnership), or in any other case a director or person with managerial responsibility of the body; and
 - b. The second is a “complaints manager”, who is responsible for managing the procedures for handling and considering complaints. The complaints manager does not need to be an employee of the responsible body, can be the same person as the responsible person, and may also act for another responsible body as a complaints manager. This allows for the possibility of outsourcing or bodies joining together to provide this function.
14. Both responsible persons and complaints manager can delegate their functions to another person.
15. Other management responsibilities in relation to the complaints process include monitoring and the preparation of annual complaints reports. Regulation 17 in relation to monitoring provides that:

³ There are many others and patients looking for a service should seek advice from the relevant responsible body and/or their local authority and/or Healthwatch but these are some known to this author.

For the purpose of monitoring the arrangements under these Regulations each responsible body must maintain a record of the following matters—

(a) each complaint received;

(b) the subject matter and outcome of each complaint; and

(c) where the responsible body informed the complainant of—

(i) the response period specified in regulation 13(7)(b); or

(ii) any amendment to that period,

whether a report of the outcome of the investigation was sent to the complainant within that period or any amended period.

16. Under Regulation 18, a responsible body must prepare and make available on request an annual report for each year, ending on 31 March, which must:

(a) specify the number of complaints which the responsible body received;

(b) specify the number of complaints which the responsible body decided were well-founded;

(c) specify the number of complaints which the responsible body has been informed have been referred to—

(i) the Health Service Commissioner to consider under the 1993 Act; or

(ii) the Local Commissioner to consider under the Local Government Act 1974; and

(d) summarise—

(i) the subject matter of complaints that the responsible body received;

(ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;

(iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

17. A responsible body that is not a CCG or NHS England must send a copy of its annual report to whichever of those commissioners commissioned its services.

18. In terms of communications with any complainant, they may be made by email where a complainant has consented in writing or electronically and has not withdrawn that consent (Regulation 15(1)). Regulation 15(2) also allows for electronic signatures.

Who may make a complaint?

19. Regulation 5 of the Complaints Regulations sets out who may make complaints. A complaint may be made by:

(a) a person who receives or has received services from a responsible body; or

(b) a person who is affected, or likely to be affected, by the action, omission or decision of the responsible body which is the subject of the complaint.

20. A representative may make a complaint on another person's behalf if they have died, are a child or unable to make the complaint themselves because of physical capacity or because they lack capacity to make a complaint within the meaning of the Mental Capacity Act 2005, or because that representative has been requested to make the complaint on somebody else's behalf.

21. When a representative has made a complaint on behalf of a child, the responsible body cannot consider the complaint unless there are "reasonable grounds" for the complaint being made by a representative instead of the child. If the responsible body is not so satisfied, it must notify the representative in writing, and state the reason for its decision. Similarly, where a representative makes a complaint on behalf of a person without capacity, if the responsible body is not satisfied that the representative is conducting the complaint in the best interests of the incapacitated person, they should cease to consider the complaint and must notify the representative in writing. This best interests assessment requirement is also applied to complaints made on behalf of children. There is no limit on the factors that a responsible body can consider as "reasonable grounds". There will therefore be considerable latitude for a responsible body to make a decision on this matter provided their decision is rational. It is unclear what the "reasonable grounds" requirement adds beyond the best interests assessment, since it is likely if a representative is making a complaint in a child's best interests that it is reasonable they are acting as their representative. This may be relevant, however, for "Gillick competent" children, who have been deemed to have capacity to consent to and make decisions regarding their own medical treatment notwithstanding that they are under the age of 16, or a child who is 16-17 years and has consented to treatment by

virtue of section 8 of the Family Law Reform Act 1969. One possible area of complaint would be around the provision of treatment to a child who was refusing consent to treatment. Whilst clinicians cannot overrule a refusal by a competent child to give consent to serious medical treatment (and parents cannot give consent on behalf of competent child), it is possible for an NHS body to apply to the High Court to do so. Hence, it would be possible for parents of a competent child who is refusing treatment to complain that the NHS body has failed to ask a Judge to overrule their child's refusal to provide consent to medical treatment.

What types of complaints must be handled under the Complaints Regulations?

22. Under Regulation 6 of the Complaints Regulations responsible bodies have a duty to handle the following broad range of complaints made in accordance with the Regulations:

(1) This regulation applies to a complaint made on or after 1st April 2009 in accordance with these Regulations to—

(a) a local authority about the exercise by the local authority of the following functions—

(i) its social services functions; or

(ii) any function discharged or to be discharged by it under arrangements made between it and an NHS body under section 75 of the 2006 Act in relation to the functions of an NHS body;

(b) an NHS body about—

(i) the exercise of its functions; or

(ii) the exercise of any function discharged or to be discharged by it under arrangements made between it and a local authority under section 75 of the 2006 Act in relation to the exercise of the health-related functions of a local authority⁴;

(ba) a clinical commissioning group or the National Health Service Commissioning Board about the exercise by it of any functions in pursuance of arrangements made under section 7A of the National Health Service Act 2006⁵;

⁴ Please see the section on Care Trusts in the NHS Trusts chapter XX.

⁵ Public health functions of the Secretary of State

(c) a primary care provider about the provision of services by it under arrangements with an NHS body; or

(d) an independent provider about the provision of services by it under arrangements with an NHS body.

23. Regulation 6(5) and (6) create a deeming provision where by, if it appears to a responsible body that complaint, if it had been made to another responsible body, would have fallen to be handled by that second responsible body, and it sends that complaint on to the second responsible body, is deemed to have been made to the second responsible body. This would cover, for example, a complaint about care in an NHS Foundation Trust that was made to a patient’s GP’s practice, to be passed onto the Foundation Trust and treated as if the complaint had been made to the Foundation Trust in the first place.
24. It does not cover, however, situations where a complaint contains material relevant to both bodies. There is a duty to cooperate in that situation under Regulation 9 of the Complaints Regulations, which provides as follows:

(1) This regulation applies where—

(a) a responsible body (“the first body”) is considering a complaint made in accordance with these Regulations; and

(b) it appears to the first body that the complaint contains material which, if it had been sent to another responsible body (“the second body”), would be a complaint which would fall to be handled in accordance with these Regulations by the second body.

(2) The first body and the second body must co-operate for the purpose of—

(a) co-ordinating the handling of the complaint; and

(b) ensuring that the complainant receives a co-ordinated response to the complaint.

(3) The duty to co-operate under paragraph (2) includes, in particular, a duty for each body—

(a) to seek to agree which of the two bodies should take the lead in—

(i) co-ordinating the handling of the complaint; and

(ii) communicating with the complainant;

- (b) to provide to the other body information relevant to the consideration of the complaint which is reasonably requested by the other body; and*
- (c) to attend, or ensure it is represented at, any meeting reasonably required in connection with the consideration of the complaint.*

25. Complaints which are not required to be dealt with under the Complaints Regulations are set out in Regulation 8. They are the following:

- (a) a complaint by a responsible body;*
- (b) a complaint by an employee of a local authority or NHS body about any matter relating to that employment;*
- (c) a complaint which—*
 - (i) is made orally; and*
 - (ii) is resolved to the complainant's satisfaction not later than the next working day after the day on which the complaint was made;*
- (d) a complaint the subject matter of which is the same as that of a complaint that has previously been made and resolved in accordance with sub-paragraph (c);*
- (e) a complaint the subject matter of which has previously been investigated under—*
 - (i) these Regulations;*
 - (ii) the 2004 Regulations, in relation to a complaint made under those Regulations before 1st April 2009;*
 - (iii) the 2006 Regulations, in relation to a complaint made under those Regulations before 1st April 2009; or*
 - (iv) a relevant complaints procedure in relation to a complaint made under such a procedure before 1st April 2009;*
- (f) a complaint the subject matter of which is being or has been investigated by—*
 - (i) a Local Commissioner under the Local Government Act 1974; or*
 - (ii) a Health Service Commissioner under the 1993 Act;*
- (g) a complaint arising out of the alleged failure by a responsible body to comply with a request for information under the Freedom of Information Act 2000; and*
- (h) a complaint which relates to any scheme established under section 10 (superannuation of persons engaged in health services, etc.) or section 24 (compensation for loss of office, etc.) of the Superannuation Act 1972, or to the administration of those schemes.*

Complaints about an NHS provider that are made to an NHS commissioner

26. One of the perceived weaknesses in the complaints system is that an NHS body investigates and adjudicates on complaints made about it. Hence there is a concern that NHS body could be seen to be biased towards believing its own staff if there is a conflict of evidence or could be more forgiving of systemic failings. The concern is that the NHS body is, in effect, “marking its own homework”. One potential answer to this concern is for a complaint about an NHS provider to be made to the relevant commissioner. Hence a patient complains to the local CCG about unacceptable care provided by the local NHS hospital.
27. Regulation 7 explains how a commissioner is required to handle a complaint made to it about services provided by an NHS provider. A patient may choose to complain to the commissioner for various reasons, including what they perceive to be their ability to take a more distanced and objective position on the matter, or because of a breakdown in relations with and lack of trust in the provider. This might be particularly so, for example, if a patient wanted to make a complaint to NHS England about the care provided by a small GP partnership with only two GPs or where the complaint is about defects in the overall systems operated by a provider as opposed to the conduct of individual clinicians.
28. When a CCG or NHS England receives such a complaint they must:
 - a. First ask the complainant whether they consent to details of the complaint being sent to the provider; and
 - b. If the complainant so consents, the CCG or NHS England must as soon as reasonably practicable send details of the complaint to the provider.

The Regulations do not explain what steps the CCG or NHS England are required to take if the patient does not provide consent to the details of the complaint to the provider. The CCG or NHS England is still required to conduct an investigation into the complaint and to reach a conclusion, but would have to do so without informing the provider that it had received a complaint from the patient. It is possible that the complaint could give rise to generic issues which could be investigated without reference to the individual circumstances of the patient. However, if the complaint is solely about the individual experience of the patient, it is hard to

see how the commissioner can conduct any effective investigation without the patient allowing the details of the complaint to be put to the provider.

29. A CCG or NHS England may feel that it would be better for the complaint to be investigated and adjudicated upon by the NHS provider itself rather than by the commissioner. Regulation 7 sets up a 2-stage process. The first stage is for the CCG or NHS England to decide if it is “*appropriate*” for it to deal with the complaint itself. If so the CCG or NHS England must notify the complainant and provider and continue to handle the complaint itself. If, however the commissioner considers it would be “*more appropriate*” for the complaint to be dealt with by the provider, and (crucially) the complainant “**consents**”, then under Regulation 7(5):

- (a) the group or Board must so notify the complainant and the provider;*
(b) when the provider receives the notification given to it under sub-paragraph (a)—
(i) the provider must handle the complaint in accordance with these Regulations; and
(ii) the complainant is deemed to have made the complaint to the provider under these Regulations.

30. There are some important things to note with regards to this ability of the commissioner to pass over the complaint to the provider. The first is that the test is whether it is more appropriate for the complaint to be dealt with by the provider rather than the commissioner, not merely whether it would be appropriate for the provider to deal with the complaint. The commissioner’s assessment of this matter must be rational, taking into account all the relevant factors put forward by the complainant including the fact that the complainant chose to complain to the commissioner rather than the provider. If the rationale is that there has been a breakdown in trust and communication, and the patient has complained to the commissioner for that very reason, it is, in this author’s view, highly unlikely to be more appropriate that the complaint be dealt with by the provider. Secondly, and crucially, the complainant must consent to his or her complaint being passed from the commissioner to the provider, regardless of the commissioner’s view of the appropriateness. If consent is not given, the commissioner must continue to handle the complaint itself. It is not lawful for the commissioner to create a hybrid process whereby it lets the provider investigate and adjudicate on the complaint and then reviews their decision after an investigation. A patient’s choice is protected by the need for consent. Thirdly, if the complaint is passed on to the

provider, it is deemed to have been made to them and the provider must handle the complaint in accordance with the Complaints Regulations.

When must a complaint be made?

31. Under Regulation 12 there is a 12-month time limit for making a complaint, although a responsible body may waive this time limit:

(1) Except as mentioned in paragraph (2), a complaint must be made not later than 12 months after—

*(a) the date on which the matter which is the subject of the complaint occurred; or
(b) if later, the date on which the matter which is the subject of the complaint came to the notice of the complainant.*

(2) The time limit in paragraph (1) shall not apply if the responsible body is satisfied that—

*(a) the complainant had good reasons for not making the complaint within that time limit; and
(b) notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly.*

32. The question of whether the time limit should be waived is a matter for the responsible body's discretion and is inherently fact-specific. Situations where the discretion could be exercised include, for example, where a person has been grieving the death of a person whose care they are complaining about, where there have been difficulties in obtaining advice or advocacy services from the independent advocacy provider, or where the complainant has been pursuing other avenues such as a legal claim or attempts at informal resolution.

Investigation and response to a complaint

33. Regulation 13 concerns the procedure that must be adopted before investigation. It provides:

(1) A complaint may be made orally, in writing or electronically.

(2) Where a complaint is made orally, the responsible body to which the complaint is made must—

(a) make a written record of the complaint; and

(b) provide a copy of the written record to the complainant.

(3) Except where regulation 6(5) or 7(1) applies in relation to a complaint, the responsible body must acknowledge the complaint not later than 3 working days after the day on which it receives the complaint.

(4) Where paragraph (5) of regulation 6 applies, and a responsible body (“the recipient body”) receives a complaint sent to it by another responsible body in accordance with that paragraph, the complaint must be acknowledged by the recipient body not later than 3 working days after the day on which it receives the complaint.

(5) Where regulation 7(1) applies to a complaint—

(a) clinical commissioning group or National Health Service Commissioning Board which receives the complaint must acknowledge the complaint not later than 3 working days after the day on which it receives it; and

(b) where a responsible body receives notification given to it under regulation 7(5)(a), it must acknowledge the complaint not later than 3 working days after the day on which it receives the notification.

(6) The acknowledgement may be made orally or in writing.

(7) At the time it acknowledges the complaint, the responsible body must offer to discuss with the complainant, at a time to be agreed with the complainant—

(a) the manner in which the complaint is to be handled; and

(b) the period (“the response period”) within which—

(i) the investigation of the complaint is likely to be completed; and

(ii) the response required by regulation 14(2) is likely to be sent to the complainant.

(8) If the complainant does not accept the offer of a discussion under paragraph (7), the responsible body must—

(a) determine the response period specified in paragraph (7)(b); and

(b) notify the complainant in writing of that period.

34. Regulation 14 governs the investigation. Regulation 14(1) provides as follows:

(1) A responsible body to which a complaint is made must—

(a) investigate the complaint in a manner appropriate to resolve it speedily and efficiently; and

(b) during the investigation, keep the complainant informed, as far as reasonably practicable, as to the progress of the investigation.

It is axiomatic but the duty is therefore to “investigate” the complaint, which may involve requesting and assessing clinical records, requesting further information from any clinicians implicated in the complaint or the complainant themselves, or seeking clinical advice. The investigation should be directed at subject of the complaint itself. The investigation should be resolved speedily and efficiently and the complainant should be kept informed of its progress. Where there is a statutory duty on a public body to investigate a complaint, the public body has a duty to reach conclusions on the key elements of the complaint. That duty is not discharged if the public body simply notes a conflict of evidence without reaching a conclusion as to where the truth lies or adopts the approach that it can only accept evidence of facts which are recorded in medical records: see *R (Williams) v Merseyside Police Authority* [2011] EWHC 1119 (Admin).

35. Once the investigation is complete, the responsible body should come to a conclusion as to whether the complaint is upheld (which may be partially) or not, and what the outcome of the complaint is in terms of any remedy. The responsible body must produce the conclusions of their investigation in a report:

(2) As soon as reasonably practicable after completing the investigation, the responsible body must send the complainant in writing a response, signed by the responsible person, which includes—

(a) a report which includes the following matters—

- (i) an explanation of how the complaint has been considered; and*
- (ii) the conclusions reached in relation to the complaint, including any matters for which the complaint specifies, or the responsible body considers, that remedial action is needed; and*

(b) confirmation as to whether the responsible body is satisfied that any action needed in consequence of the complaint has been taken or is proposed to be taken;

(c) where the complaint relates wholly or in part to the functions of a local authority, details of the complainant's right to take their complaint to a Local Commissioner under the Local Government Act 1974; and

(d) except where the complaint relates only to the functions of a local authority, details of the complainant's right to take their complaint to the Health Service Commissioner under the 1993 Act.

36. NHS England's Complaint Policy published on 12 June 2017 provides that its response, if it is the investigating body, will include:

- *An explanation of how the complaint has been considered.*
- *An apology if appropriate*
- *An explanation based on facts.*
- *Whether the complaint in full or in part is upheld.*

The conclusions reached in relation to the complaint including any remedial action that the organisation considers to be appropriate.

- *Confirmation that the organisation is satisfied any action has been or will be actioned.*

- *Where possible, we will respond to people about any lessons learnt.*

- *Information and contact details of the Parliamentary and Health Service Ombudsman as the next stage of the NHS complaints process.*

37. It also makes clear that, “A key consideration is to make arrangements flexible; treating each case according to its individual nature with a focus on satisfactory outcomes, organisational learning and those lessons should lead to service improvement.”
38. As stated above, remedial action might include an apology, further clarification or an explanation, promises to implement service improvements or financial redress. Good complaints handling will mean the responsible body’s process is informed by the expectations of the complainant and what he or she seeks to achieve from the process. As part of the process, or after the responsible body has concluded its investigation, it may want to consider holding local resolution meetings with the complainant, for example if the complainant has indicated that they may take their complaint further to the PHSO. If appropriate, a responsible body could consider offering reconciliation or mediation. If so, and in any event, it should make clear to the complainant what options there are for obtaining the assistance of an NHS complaints advocacy service.
39. Unless the complainant and responsible body agreed a different response period, the response must be provided within six months from the day the complaint was received:

(3) In paragraph (4), “relevant period” means the period of 6 months commencing on the day on which the complaint was received, or such longer period as may be agreed before the expiry of that period by the complainant and the responsible body.

(4) If the responsible body does not send the complainant a response in accordance with paragraph (2) within the relevant period, the responsible body must—

(a) notify the complainant in writing accordingly and explain the reason why;

and

(b) send the complainant in writing a response in accordance with paragraph (2) as soon as reasonably practicable after the relevant period.

Contractual obligations with regards to complaints

40. As well as their statutory duties under the Complaints Regulations, all NHS providers who work under contracts with NHS commissioners ought to have contractual obligations concerning complaints handling and their cooperation with any complaints handling by the commissioner.
41. There are provisions in the NHS Standard Contract which require NHS providers to operate complaints systems which comply with the Complaints Regulations. GP practices holding GMS contracts are under a like duty. Regulations 79-80 of the GMS Regulations 2015 provide that the commissioning contract must require the practice to have a Complaints Regulations compliant procedure in place, and also that the practice must co-operate with any investigation which it is implicated in. A failure to do so might mean the contractor is in breach of its contractual obligations:

79.— Complaints procedure

(1) The contractor must establish and operate a complaints procedure to deal with complaints made in relation to any matter that is reasonably connected with the provision of services under the contract.

(2) The complaints procedure must comply with the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

80.— Co-operation with investigations

(1) The contractor must co-operate with—

(a) the investigation of any complaint made in relation to a matter that is reasonably connected with the provision of services under the contract by—

(i) the Board, or

- (ii) the Health Service Commissioner; and*
- (b) the investigation of any complaint made by an NHS body or local authority which relates to a patient or former patient of the contractor.*
- (2) In paragraph (1)—*
- “NHS body” means—*
- (a) in relation to England, the Board or a CCG; and*
- (b) in relation to England and Wales, Scotland and Northern Ireland, an NHS trust, an NHS foundation trust, a Local Health Board, a Health Board, a Health and Social Services Board or a Health and Social Services Trust;*
- “local authority” means—*
- (a) a local authority within the meaning of section 1 of the Local Authority Social Services Act 1970 (local authorities);*
- (b) the Council of the Isles of Scilly;*
- (c) a council constituted under section 2 of the Local Government etc. (Scotland) Act 1994 (constitution of councils); [or]*
- (d) the council of a county or county borough in Wales; and*
- “Health Service Commissioner” means the person appointed as Health Service Commissioner for England in accordance with section 1 of, and Schedule 1 to, the Health Service Commissioners Act 1993 (The Commissioner).*
- (3) For the purposes of paragraph (1), co-operation includes—*
- (a) answering any questions which are reasonably put to the contractor by the Board;*
- (b) providing any information relating to the complaint which is reasonably required by the Board; and*
- (c) attending any meeting held to consider the complaint (if held at a reasonably accessible place and at a reasonable hour and if due notice has been given) if the contractor's presence at the meeting is reasonably required by the Board.*

The Health Service Commissioner for England

42. The Health Service Commissioner for England is a statutory appointment under section 1 of the Health Service Commissioners Act 1993 (“the 1993 Act”). The Parliamentary and Health Service Ombudsman, as it is colloquially known, combines the two statutory roles of Parliamentary Commissioner for Administration (the Parliamentary Ombudsman), whose

powers are set out in the Parliamentary Commissioner Act 1967 and Health Service Commissioner for England (Health Service Ombudsman). The legislation governing the powers of the Parliamentary Ombudsman and the Health Service Ombudsman is materially the same in most respects. As a general rule, case law applicable to one ombudsman is applicable to any discussion of the powers of the other. The current Ombudsman is Rob Behrens, who was appointed on 6 April 2017 to succeed the previous Ombudsman, Dame Julie Mellor.

43. As set out on the PHSO website:

We were set up by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments.

We share findings from our casework to help Parliament scrutinise public service providers. We also share our findings more widely to help drive improvements in public services and complaint handling.

44. The PHSO⁶ is accountable to the Parliamentary Public Administration and Constitutional Affairs Committee. The PHSO's role is primarily to investigate individual complaints against health service providers where the complainant has sustained injustice or hardship in consequences of a service failure or maladministration (a term which is broadly defined). He also has the power under section 14 of the 1993 Act to lay reports before each House of Parliament, either in relation to a specific case where the injustice sustained has still not been remedied or pursuant to any of his functions. A recent example of the latter is a report published by the PHSO on 6 December 2017, *Ignoring the alarms: How NHS eating disorder services are failing patients*, a study of failures in several NHS organisations to properly care for patients with eating disorders. This report was triggered by a specific complaint about the tragic death of Averil Hart, who had anorexia nervosa and died on 15 December 2012, aged only 19.⁷ The PHSO therefore has an important public function.

⁶ I refer hereafter to the "PHSO", although this should be taken as a reference to the PHSO insofar as it relates to the specific functions of the Health Service Commissioner under the Health Service Commissioners Act 1993.

⁷ Available here: <https://www.ombudsman.org.uk/sites/default/files/page/ACCESSIBLE%20PDF%20-%20Anorexia%20Report.pdf>

45. As a general rule, complainants will be able to take a complaint about NHS care or services they have received to the PHSO after they have exhausted the NHS complaints process explained above. The process is statutorily designed to be an informal one, and inquisitorial rather than adversarial. As explained by Sir Ernest Ryder, Senior President of Tribunals, in the recent Court of Appeal case, *Miller v The Health Service Commissioner for England* [2018] EWCA Civ 144 at [55]:

I would also emphasise that it is important that this court does not import into the informal, non-judicial process of administrative and complaints adjudicators like the ombudsman the procedures of courts and tribunals. The adjudication process is an informal resolution of a complaint or problem where other remedies are not reasonably available or appropriate. The procedure is a matter entirely within the gift of the ombudsman provided that her decision-making process is lawful, rational and reasonable.

46. Despite the informality of the procedure, however, courts appear increasingly likely to scrutinise the fairness of the PHSO's processes, including on those complained about, influenced by the fact that the outcome of a complaint could lead to "serious criticism of the [body or person complained about's] professional practice [which] might ruin their reputation, professional standing and ability to earn a livelihood" (see *Miller* at [46]).

The PHSO's powers and duties

The PHSO's discretionary powers and their amenability to judicial review

47. By way of a preliminary point, the 1993 Act confers on the PHSO a number of broad discretions, including whether to investigate a complaint in the first place, whether to discontinue an investigation, whether to investigate notwithstanding that the complainant may have another remedy, what standard he shall adopt to assess whether there has been a service failure or maladministration, what procedure for conducting an investigation is appropriate in the circumstances, and so on. In these circumstances, the Ombudsman's exercise of discretion will only be reviewable by the courts on public law grounds, including whether the exercise of discretion was a reasonable one. The requirements of procedural fairness are also particularly relevant to the Ombudsman's procedure, given that it is designed

by statute to be informal and flexible. What fairness demands in a particular situation will depend upon the context and the nature of the complaint (see *R v Home Secretary ex p Doody* [1994] 1 AC 531). It has thus traditionally been difficult for claimants to successfully challenge a range of decisions taken by the PHSO.

48. Case law has consistently established the threshold for challenging a matter of the Ombudsman’s discretion is “a very high one indeed”. In *R (Morris) v The Health Service Commissioner* [2014] EWHC 4364 (Admin) Jay J, quoting Collins J, who was himself quoting Simon Brown LJ in the seminal case of *Dyer*, said:

“... the courts have consistently recognised that the defendant’s investigatory powers under section 3 of the Health Service Commissioners Act 1967 are very widely drawn. In R (on the application of Mencap) v Parliamentary and Health Service Ombudsman [2011] EWHC 3351 (Admin), Mitting J referred to “an unfettered discretion”. I interpret that as meaning a very broad discretion, reviewable only on a conventional Wednesbury basis, including demonstrating that the decision maker has plainly asked itself the wrong question or has plainly misinterpreted the complaint. In R (on the application of Jeremiah) v Parliamentary and Health Service Ombudsman [2013] EWHC 1085 (Admin), Collins J said this:

*“30. The law, as set out by both the Act and its interpretation in previous decisions, is that the hurdle which has to be surmounted by any claimant seeking to persuade a court that an exercise of discretion by the Ombudsman is unlawful is a very high one indeed. The relevant leading decision is *R v Parliamentary Commissioner for Administration ex p Dyer* [1994] 1 WLR 621 where Simon Brown LJ, as he then was, giving the judgment of the Divisional Court made it clear that the width of the discretion was, as he put it, made ‘strikingly clear’ by the legislature. That is a reference to the provision which is now in section 3(5) that the Commissioner should act in accordance with his own discretion. He said that it would always be difficult to mount an effective challenge on what may be called the conventional ground of Wednesbury unreasonableness. While manifest absurdity perhaps did not have to be shown, it would be almost as difficult to demonstrate that the*

Commissioner had exercised one or other of his discretions unreasonably in the public law sense ...”

49. One caveat should be given here with respect to the application of the case law above to the Ombudsman’s discretion to set aside the statutory one-year time bar (discussed below) and investigate a complaint if he considers it reasonable to do so under section 9(4) if the 1993 Act. It was held in a recent case, *Newman v PHSO* [2017] EWHC 3336 (TCC)⁸ by Jefford J that the decision to investigate if reasonable was not a broad discretion but a specific decision, and thus the usual rationality standard would apply:

...the authorities that consider the nature and breadth of the discretion under s.3(1) and (2) (or their equivalent) are not directly relevant. The decision that is challenged in this case is a decision under s.9(4). That does not involve the exercise of the broad discretion under s. 3(2) but involves the specific decision as to whether it is reasonable to investigate a complaint made out of time and the issue I have to consider is whether the decision that it was reasonable to do so was irrational (in particular in the sense of lacking logic) or failed to take into account relevant considerations.

There is an argument (which may well have merit) that this judgment was wrongly decided. Section 9(4) gives the PHSO an ability to investigate if he considers that it is reasonable to do so. This appears to give the Ombudsman a wider discretion than the Judge suggests. There is the question of compatibility of this decision with the power in section 3(2) to act in accordance with his own discretion in determining whether to initiate an investigation, which comes within section 3 establishing the “general remit” of the commissioner. A first instance judgment is not binding as a matter of precedent and so it will remain to be seen whether this case is followed by the Court in future.

⁸ A case in which this author appeared for the PHSO with James Maurici QC, also of Landmark Chambers.

What does the PHSO investigate?

50. In terms of the Ombudsman’s investigatory remit, section 3 of the 1993 Act gives him a discretion to investigate a complaint made by a member of the public who claims to have sustained injustice in consequence of service failure by, or maladministration in connection with an, action taken by or on behalf of a “health service body”. That power is extended to independent providers on materially the same terms, and to investigating actions in connection with services provided by “family health service providers”. It is important to note that the PHSO will only uphold a complaint if a complainant has actually *sustained* injustice as a consequence of a service failure or maladministration. If there has been poor service, but the organisation or person complained about has already made amends and put things right to a level the PHSO deems acceptable, he may acknowledge failures but will not uphold a complaint if there is nothing left to remedy.

51. The PHSO’s overview guidance explains to complainants:

If we uphold your complaint it means that we found the organisation got things wrong that have had a negative effect on you that hasn’t been put right. We can recommend what the organisation should do about this. We investigate around 4,000 complaints a year and we uphold, in full or in part, around 40% of these.⁹

52. Although the PHSO’s primary function is to investigate maladministration, by virtue of amendments made to the 1993 Act in 1996, he is empowered to investigate the merits of an action taken by a medical practitioner in the exercise of his or her clinical judgment (see section 3(7)). This means the PHSO can consider complains about unsatisfactory care or treatment.

53. Section 3 provides as follows:

⁹ Available here: https://www.ombudsman.org.uk/sites/default/files/PHSO_Overview_leaflet_0.pdf

(1) On a complaint duly made to the Commissioner by or on behalf of a person that he has sustained injustice or hardship in consequence of—

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

the Commissioner may, subject to the provisions of this Act, investigate the alleged failure or other action.

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

- (a) the health service body,*
- (b) a person employed by that body,*
- (c) a person acting on behalf of that body, or*
- (d) a person to whom that body has delegated any functions.*

(1A) Where a family health service provider has undertaken to provide any family health services and a complaint is duly made to the Commissioner by or on behalf of a person that he has sustained injustice or hardship in consequence of—

- (a) action taken by the family health service provider in connection with the services,*
- (b) action taken in connection with the services by a person employed by the family health service provider in respect of the services,*
- (c) action taken in connection with the services by a person acting on behalf of the family health service provider in respect of the services, or*
- (d) action taken in connection with the services by a person to whom the family health service provider has delegated any functions in respect of the services,*

the Commissioner may, subject to the provisions of this Act, investigate the alleged action.

(1C) Where an independent provider has made an arrangement with a health service body or a family health service provider to provide a service (of whatever kind), or has undertaken to provide direct payment services, and a complaint is duly made to

[the Commissioner by or on behalf of a person that he has sustained injustice or hardship in consequence of—

(a) a failure in the service provided by the independent provider,

(b) a failure of the independent provider to provide the service, or

(c) maladministration connected with any other action taken in relation to the service,

the Commissioner may, subject to the provisions of this Act, investigate the alleged failure or other action.

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

(a) the independent provider,

(b) a person employed by the provider,

(c) a person acting on behalf of the provider, or

(d) a person to whom the provider has delegated any functions.

(1E) Where a complaint is duly made to [the Commissioner by or on behalf of a person that the person has sustained injustice or hardship in consequence of maladministration by any person or body in the exercise of any function under section 113 of the Health and Social Care (Community Health and Standards) Act 2003 (complaints about health care), the Commissioner may, subject to the provisions of this Act, investigate the alleged maladministration.

54. “Maladministration” as a concept is a broad one. It encompasses things like poor administration, including poor complaints handling, rudeness, misleading advice, refusal to provide information to which an individual is entitled, or clerical error. Summarising the powers in the Parliamentary Commissioner Act 1967, Andrews J in *R (Rapp) v PHSO* [2015] EWHC 1344 (Admin) said about the meaning of “maladministration”:

‘Maladministration’ is not defined in the 1967 Act. It will cover ‘bias, neglect, delay, incompetence, ineptitude, perversity, turpitude, arbitrariness and so on’. The list is open-ended, but the type of behaviour that qualifies concerns the manner in which a decision is reached or a discretion is exercised, rather than the merits of that decision or of the discretion itself: R v Local Commissioner ex p. Liverpool CC [2001] 1 All ER 262

per Henry LJ at [3], adopting a passage in the judgment of Lord Denning MR in R v Local Commissioner for Administration for the North and East Area of England ex p. Bradford Metropolitan CC [1979] QB 287 at 311-312.

Which bodies or persons can the PHSO investigate?

55. The health service bodies subject to the PHSO's investigatory powers are set out in section 2 of the 1993 Act and are as follows:

- a. Special health authorities (if they have been designated as ones to which the 1993 Act is applicable);
- b. National Health Service trusts managing a hospital, or other establishment or facility, in England;
- c. NHS Foundation Trusts;
- d. NHS England; and
- e. CCGs.

56. A "family health service provider" subject to the PHSO's investigatory powers is, broadly speaking, a reference to a primary care provider, and is defined in section 2A:

(a) persons (whether individuals or bodies) providing services under a contract entered into by them with the National Health Service Commissioning Board under section 84, 100 or 117 of the National Health Service Act 2006;

(b) persons (whether individuals or bodies) undertaking to provide in England pharmaceutical services under that Act;

(c) individuals performing in England primary medical services or primary dental services in accordance with arrangements made under section 92 or 107 of that Act (except as employees of, or otherwise on behalf of, a health service body or an independent provider); or

(d) individuals providing in England local pharmaceutical services in accordance with arrangements made under a pilot scheme established under section 134 of the

National Health Service Act 2006 (except as employees of, or otherwise on behalf of, a health service body or an independent provider).

57. An “independent provider” subject to the PHSO’s investigatory powers is defined in section 2B as follows (importantly, it extends to providers providing direct payments services, where patients arrange for and pay for their own care services out of a payment or budget allotted to them¹⁰):

(1) Persons are subject to investigation by the Commissioner if—
(a) they are or were at the time of the action complained of persons (whether individuals or bodies) providing services in England under arrangements with health service bodies or family health service providers, and
(b) they are not or were not at the time of the action complained of themselves health service bodies or family health service providers.

(1A) Persons are subject to investigation by the Commissioner if—
(a) they are, or were at the time of the action complained of, providing direct payment services, and
(b) they are not, or were not at the time of the action complained of, health service bodies.

The PHSO’s decision to investigate

58. Before the PHSO investigates a complaint, he will first come to an in-principle decision to “propose” to investigate a complaint. This decision involves a consideration of matters set out in the statute, which might preclude an investigation, such as whether a complaint has been properly made, whether there is an alternative remedy, and whether the complaint is in time, but also discretionary factors such as whether there are indications of unremedied injustice sustained such that the PHSO should investigate. The PHSO’s guidance on “Deciding whether to investigate” explains that he will consider the following matters:

¹⁰ See Chapter XX on Direct Payments.

- *Who brought the complaint - whether you have suffered personally or been affected in some other way because of what happened, or whether you are making the complaint for someone else.*
- *Timings - when you first became aware of the problem.*
- *Whether legal action is open to you.*
- *Whether there is another organisation that is better placed to deal with your complaint.*
- *What led you to complain: what did the organisation do wrong, what happened because of this, and what has been done to respond to your concerns.¹¹*

59. The discretion as to whether to treat a complaint to the PHSO as “duly made” and whether to initiate, continue or discontinue an investigation under the 1993 Act are matters for the PHSO, subject only to review by the courts on public law grounds. The relevant sections 3(2) and (3) provide:

(2) In determining whether to initiate, continue or discontinue an investigation under this Act, the Commissioner shall act in accordance with his own discretion.

(3) Any question whether a complaint is duly made to the Commissioner shall be determined by him.

60. In terms of whether a complaint is duly made, section 8(1) of the 1993 Act provides that “a complaint may be made by an individual or a body of persons, whether incorporated or not, other than a public authority”. Section 9 of the 1993 Act sets out the requirements that must be followed:

(2) A complaint must be made in writing.

(3) The complaint shall not be entertained unless it is made—

(a) by the person aggrieved, or

¹¹ https://www.ombudsman.org.uk/sites/default/files/PHSO_Step_Two_Info_leaflet_1.pdf

(b) where the person by whom a complaint might have been made has died or is for any reason unable to act for himself, by—

(i) his personal representative,

(ii) a member of his family, or

(iii) some body or individual suitable to represent him.

(4) The Commissioner shall not entertain the complaint if it is made more than a year after the day on which the person aggrieved first had notice of the matters alleged in the complaint, unless he considers it reasonable to do so.

(4A) In the case of a complaint against a person who is no longer of a description set out in section 2A(1), but was of such a description at the time of the action complained of, the Commissioner shall not entertain the complaint if it is made more than three years after the last day on which the person was a family health service provider.

(4B) In the case of a complaint against a person falling within section 2B(1) in relation to whom there are no longer any such arrangements as are mentioned there, the Commissioner shall not entertain the complaint if it is made more than three years after the last day on which the person was an independent provider.

61. Section 10 of the 1993 Act gives a health service body the power to refer to the PHSO a complain made to it that a person has, in consequence of a failure or maladministration for which that body is responsible, sustained injustice or hardship as mention in section 3(1).
62. Sections 9(4) creates a statutory bar to the Ombudsman investigating a complaint if it is made more than a year after the day on which the person aggrieved (i.e. who alleges to have sustained injustice) first had notice of the matters alleged. However, he may investigate nonetheless if he considers it reasonable to do so (although see above for the decision in *Newman* about the applicability of the general case law on the breadth of the Ombudsman's discretions). It is worth pointing out here that both the NHS complaints procedure and PHSO legislation create a prima facie one-year time limitation period. They technically run concurrently and complainants at the NHS stage may want to consider this if they think they

will refer their complaint onto the PHSO. However, exhaustion of the local resolution process will be a highly relevant factor to the PHSO's decision as to whether it is reasonable to investigate after a year has passed. This decision is inherently fact-specific. The personal circumstances of the complainant, the reasons for any delay, and potentially the impact on the person or body being complained about, will be relevant. For family health service providers and independent providers there is a long-stop period of three years after the person has ceased to act in that capacity, after which the PHSO has no discretion to extend time and investigate.

63. It is the practice of the PHSO, once he has received a complaint, to liaise with the complainant to ascertain the exact scope of their complaint and the scope of the investigation they wish for him to conduct if the complaint is accepted for investigation. This is proper; however, it was held by the Court of Appeal in *Cavanagh v Health Service Commissioner* [2005] EWCA Civ 1578 that the PHSO's functions were limited to an investigation of the complaint and he had no power of investigation at large. In addition, the statutory discretions that he possessed neither enabled him to expand the ambit of a complaint beyond what it contained, nor his investigation of it beyond what the complaint warranted.
64. Another matter that the PHSO must consider under section 4 of the 1993 Act before he can decide to investigate the complaint is whether a complainant has an alternative remedy. As described in *Miller*, section 4 "*provides a qualified prohibition which guards against conflict and inconsistency where judicial or quasi-judicial remedies are otherwise reasonably available giving them a priority over the ombudsman*". It provides:

(1) The Commissioner shall not conduct an investigation in respect of action in relation to which the person aggrieved has or had—

(a) a right of appeal, reference or review to or before a tribunal constituted by or under any enactment or by virtue of Her Majesty's prerogative, or

(b) a remedy by way of proceedings in any court of law,

unless the Commissioner is satisfied that in the particular circumstances it is not reasonable to expect that person to resort or have resorted to it.

(2) The Commissioner shall not conduct an investigation in respect of action which has been, or is, the subject of an inquiry under section 84 of the National Health Service Act 1977 or section 76 of the National Health Service (Scotland) Act 1978 (general powers to hold inquiries).

(3) A Commissioner shall not conduct an investigation in respect of action [by a health service body other than the Mental Welfare Commission for Scotland if it is action in relation to which the protective functions of the Mental Welfare Commission for Scotland have been, are being or may be exercised under the Mental Health (Scotland) Act 1984.

(4) Subsection (5) applies where—

- (a) action by reference to which a complaint is made under section 3(1), (1A) or (1C) is action by reference to which a complaint can be made under section 113(1) or (2) of the Health and Social Care (Community Health and Standards) Act 2003 or under a procedure operated by a health service body, a family health service provider or an independent provider, and*
- (b) subsection (1), (2) or (3) does not apply as regards the action.*

(5) In such a case the Commissioner shall not conduct an investigation in respect of the action unless he is satisfied that—

- (a) the other procedure has been invoked and exhausted, or*
- (b) in the particular circumstances it is not reasonable to expect that procedure to be invoked or (as the case may be) exhausted.*

(6) Section 1(2) of the Hospital Complaints Procedure Act 1985 (which provides that no right of appeal etc. conferred under section 1 of that Act is to preclude an investigation under this Act) shall have effect subject to subsection (5) above.

65. The effect of this section is that if, when a complaint is made to the PHSO, there are already existing or contemplated proceedings, for example by way of judicial review, a claim for negligence, or proceedings before the GMC, the PHSO cannot investigate until those proceedings have been concluded. Where they are concluded or no longer contemplated, the PHSO has to be satisfied that it was not reasonable for the complainant to have resorted to

those alternative remedies. In addition, for health complaints, section 4(4) and (5) provide that the Ombudsman shall not conduct an investigation where a complaint could be made under the NHS complaints procedure set out above, unless that procedure has been invoked and exhausted or it is not reasonable to expect that procedure to be invoked or exhausted. Complainants should be aware that if they bypass the NHS complaints procedure under the Complaints Regulations and go straight to the PHSO, or refuse a reasonable offer of mediation or local conciliation from the NHS body or provider, then the PHSO may well refer them back to complete the local resolution process.

66. As explained in *Miller* at [87], “Ultimately, two questions need to be answered under section 4 of the 1993 Act: (1) is there a legal remedy? (2) is the ombudsman satisfied that in the particular circumstances it is not reasonable to expect that person to resort to it?”

67. And at [88]:

The question of reasonableness is one for the ombudsman, and this court can only interfere if the ombudsman's approach discloses an error of law or the conclusion is irrational. The following principles appear to be clear:

(1) The presence of an alternative legal remedy does not preclude the ombudsman from investigating. Any other conclusion would defeat the purpose of the provision in section 4 questioning whether it is reasonable to expect the other person to resort to it.

(2) The decision is a matter of weighing several factors. If the complainant is primarily seeking financial redress, that points to the legal remedy being appropriate. If the person is primarily seeking an apology or wider systemic change, that points to the legal remedy being inappropriate. Neither factor is, however, conclusive. It is a sliding scale, and all the circumstances of the person, including their financial circumstances should be considered.

68. It is important that the decision-maker clearly records all the possible alternative routes of address, then records and weighs up the relevant factors, coming to a specific conclusion on

the presence of an alternative legal remedy and whether the complaint should be investigated nonetheless.

The PHSO's investigation procedure

69. Section 11 governs the procedure the PHSO must adopt in respect of investigations. The first point is that under section 11(1)-(1C), when the Ombudsman “proposes” to conduct an investigation of a complaint, before he actually proceeds with the investigation, he must give the body complained about the chance to comment on any of the allegations in the complaint. As a matter of fairness, the allegations must be disclosed with sufficient particularity to allow the person complained about to have a meaningful opportunity to comment (see *Miller*). At this stage, the PHSO has not exercised his discretion to decide to investigate formally so the comments of a body complained about could change an in-principle decision that a complaint is suitable for investigation. For example, a body or person complained about may highlight that there are parallel proceedings in front of a court or the GMC or that a complaint was not made under the Complaints Regulations.

70. Section 11(2) provides that an investigation shall be conducted in private.

71. Otherwise section 11(3) gives the PHSO a broad discretion to conduct the investigation in a way that he considers “appropriate”, however it must be a fair process, which will depend on the individual circumstances of the complaint. Section 11(3) provides:

(3) In other respects, the procedure for conducting an investigation shall be such as the Commissioner considers appropriate in the circumstances of the case, and in particular—

(a) he may obtain information from such persons and in such manner, and make such inquiries, as he thinks fit, and

(b) he may determine whether any person may be represented, by counsel or solicitor or otherwise, in the investigation.

72. In terms of the standard of review adopted by the PHSO in determining whether there has been a service failure or maladministration, Burnett J in *R (Attwood) v Health Service Commissioner [2008] EWHC 2315 (Admin)*, confirmed in *Miller*, held as follows at [27]:

The purpose of the Health Service Commissioner ... is to adjudicate over complaints and provide redress by making findings and recommendations. It is, in my judgment, clear that Parliament was not seeking to create a parallel jurisdiction to courts and tribunals, which jurisdiction should apply the same principles by reading over established legal concepts into the language of various Acts governing the jurisdiction of the ombudsmen.

The Judge explained the key issue and concluded at [27] saying:

As a matter of principle, it is for the ombudsman to decide and explain what standard she applies before making a finding of a failure in a service. That standard as defined will not be interfered with by a reviewing court unless it reflects an unreasonable approach.

73. The PHSO's adopted standard must therefore be a rational one and that standard ought to be clearly communicated to the public and those involved in the complaint. The PHSO's current literature explains in relation to its adopted approach:

To help us understand what should have happened, we look at how the organisation was expected to act at the time of the events. We look at any standards, legislation or established good practice that was in place at the time, and we use advice we have gathered from experts. We also refer to our Principles of Good Administration and Principles of Good Complaint Handling. These set out what we expect from organisations when they carry out their work and how they should reply when things go wrong. You can find them on our website¹².

74. The PHSO has long had a practice of producing a draft report of his findings, along with a draft decision as to whether the complaint will be upheld, partially upheld or not upheld, and if upheld what remedies he suggests are appropriate. It is possible at this stage for a complainant or person or body complained about to provide further comment and/or evidence. The PHSO may also commission further specialist advice at this stage from his

¹² At the time of writing, it does not appear that this wording has been reconsidered since the judgment in *Miller*. Readers should check whether there have been any changes since publication of this book.

clinical advisors. The decision-maker should be careful to ensure he or she acts fairly. Any comments on the draft report or further information obtained should be carefully considered and taken into account in any final decision. To avoid pre-determination, the decision-maker should keep an open mind to the new information changing the conclusions and outcome of the complaint, even if he or she has reached a provisional view.

75. Under section 12 of the 1993 Act, the PHSO has the same powers in relation to evidence as the High Court and may require disclosure by those bodies and persons he is investigating.

The PHSO's Final Report

76. Under Section 14(1) of the 1993 Act, the PHSO is obliged to send a report of the results of his investigation to the following people:

- (a) to the person who made the complaint,*
- (b) to any member of the House of Commons who to the Commissioner's knowledge assisted in the making of the complaint (or if he is no longer a member to such other member as the Commissioner thinks appropriate),*
- (c) to the health service body who at the time the report is made provides the service, or has the function, in relation to which the complaint was made, and*
- (d) to any person who is alleged in the complaint to have taken or authorised the action complained of.*

77. In the case of an investigation into the actions of a primary care provider or an independent provider, there is also a requirement to send the report to the relevant commissioning body or the health service body or primary care provider with whom any independent provider made the arrangement to provide the services concerned. If the complaint was about complaints handling within the NHS, then the report must be sent to the complaints handler and any other provider about whom the complaint was originally made. An example would be if a complaint was made to NHS England, about a GP, then the complaint about NHS England's complaint handling was made to the PHSO. The PHSO would have to send the report to the GP too under section 14(2E).

78. Section 14 does not state what the report must contain, or define what “the results” of an investigation should be. The PHSO therefore has a broad discretion as to what that report will contain and what remedies he will suggest are appropriate to remedy the injustice he has found the complainant has sustained. The PHSO’s guidance explains that the final report will mean that the complainant will:

- *know our final decision on your complaint,*
- *have a clear understanding of how we made our decision, what information we used, and how we took into account any feedback we received on our draft report,*
- *know what action we may have asked the organisation to take and by when,*
- *know how you can give us feedback.*

79. It says: “*If we have made recommendations for the organisation to carry out, our report will clearly explain what action we expect and by when. We will check to make sure the organisation does what we have asked, and we will keep you updated about this.*”¹³

80. In terms of remedy, the PHSO’s guidance makes clear that the remedy could include an organisation or person complained about:

- *acknowledging its mistakes,*
- *apologising to you,*
- *making a payment to you - for example, to pay you back if you have been left out of pocket because of its errors, or to acknowledge distress it has caused you,*
- *taking action to prevent the same mistakes happening to someone else, and to make services better for everyone.*

81. If the PHSO decides not to investigate, under section 14(2) he must send a statement or reasons to the person who made the complaint and to any MP who he knows assisted in making the complaint.

¹³ Available here: https://www.ombudsman.org.uk/sites/default/files/PHSO_Step_Three_Info_leaflet_1.pdf

82. Section 14(2I) provides a catch-all provision about report recipients, and states, “*Where the Commissioner is required by this section to send a report or statement of reasons to certain persons, the Commissioner may send the report or statement to such other persons as the Commissioner thinks appropriate.*”
83. Under section 14(2HA), if the PHSO “*has not concluded an investigation before the end of the 12 month period beginning with the date the complaint was received, the Commissioner must send a statement explaining the reason for the delay to the person who made the complaint.*”
84. Moreover, the PHSO has the power to lay reports before the Houses of Parliament in certain circumstances. The first is under section 14(3) if it appears to him that the injustice or hardship sustained by the complainant has not been and will not be remedied. The second is under section 14(4)(a), whereby the PHSO is required to lay an annual report before Parliament providing a general report on the performance of his functions under the 1993 Act. This must include information about: (a) how long investigations that were concluded in the year to which the report relates took to be concluded, (b) how many of those investigations took more than 12 months to be concluded, and (c) the action being taken with a view to all investigations being concluded within 12 months. Finally, the PHSO has the power to lay reports before Parliament “*with respect to those functions as he thinks fit*”. The PHSO relies on this power to publish reports such as the one referenced above about care of patients with eating disorders, where he has amassed a certain amount of evidence and wisdom about potential service failures on a broader scale as a result of his investigation of individual complaints.

Remedies against a decision of the PHSO

85. If a complainant is not happy with the decision of the Ombudsman, it is possible to apply to the High court for permission for judicial review to challenge the lawfulness of a PHSO decision. As explained above, the substantial areas of discretion available to the PHSO mean that it is not straightforward for claimants to prove that various of the Ombudsman’s discretions have been exercised unlawfully.

The parallel jurisdiction of the PHSO and the court

86. A tricky question often arises relating to the parallel jurisdiction of Ombudsmen and the courts where a decision made by an NHS service-provider is one that is both amenable to the review jurisdiction of the courts and is one about which a complaint could be made to the PHSO. Issues arise particularly in the context of the 3-month judicial review time limit under Part 54 of the CPR and what a claimant should do in the circumstances where he or she might want to pursue both forms of redress. This issue was recently considered by Hickinbottom J (as he was) in *R (Zahid) v University of Manchester* [2017] EWHC 188 (Admin), albeit in the context of complaints to the Office of the Independent Adjudicator. He made the following observations about the correct approach at paragraphs 67-68:

67. The early finality of executive and administrative decisions is an important principle, and consequently, as a general principle, prompt resolution of public law claims by the courts is considered to be in the public interest – hence the relatively tight and strict time limit for the issuing of judicial review proceedings. However, the courts have also recognised that that principle may sometimes have to bow in the face of other interests, both public and private. Where there is an available ADR procedure – especially when it is provided by Parliament – the interests of the public body and citizen in having a more attractive procedure and, very importantly, the public interest in resolving claims outside the court system where possible, will be of such weight that the balance of interests will be in favour of giving a proper opportunity for the dispute to be resolved, in whole or in part, by the alternative procedure; even if that may delay the final resolution of the dispute, if recourse to the courts is in the event necessary.

68. Consequently, where there is such a complaints procedure as provided by the 2004 Act through the OIA, the court should be slow to become engaged with issues arising out of the same subject matter, unless and until that procedure has been given reasonable time and opportunity to run to a conclusion; and, where either a claimant or a defendant (or both) wish to progress court proceedings before then, they must provide the court with good reasons for doing so. In my view, both parties and the court should approach the issues raised in the applications such as those before me – and all issues that arise as a result of the relationship between a reference to the OIA and judicial review proceedings – with this uppermost in mind.

87. Against this background, he suggested at paragraph 83 that *“the court is in any event unlikely to refuse a student [a complainant] an extension of time”* for judicial review if they have missed the 3-month time limit mandated by CPR part 54 because they were pursuing an alternative complaints procedure, such as to an ombudsman.
88. However, the safest approach is likely to be that a judicial review claim is issued protectively within the three-month time limit, in conjunction with an application to the court for a stay of proceedings at the earliest reasonably practicable stage. The PHSO’s consent to a stay should also be sought. If a stay is granted, the PHSO can consider the matter before the claimant resorts to judicial review proceedings. This can raise complex issues given section 4 of the 1993 Act, however, so potential claimants/complainants are very much advised to seek legal advice in these circumstances.