Parliamentary and Health Service Ombudsman

Public Administration and Constitutional Affairs Committee

‘Responding to COVID-19 and the Coronavirus Act 2020’: Written submission from the Parliamentary and Health Service Ombudsman

13 July 2020

1. About the Parliamentary and Health Service Ombudsman

1.1 The Parliamentary and Health Service Ombudsman (PHSO) provides an independent and impartial complaint handling service for complaints that have not been resolved by the NHS in England and UK Government departments.

1.2 We look into complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right. We share findings from our casework to help Parliament scrutinise public services, and to help drive improvements in public services and complaint handling. We investigate complaints fairly and independently, and our service is free to use.

1.3 PHSO temporarily paused work on NHS complaints and acceptance of new health complaints on 26 March 2020, in order to help the NHS focus on tackling the COVID-19 pandemic. Over that period our phone lines remained open and we continued to process Parliamentary casework. After careful consideration, we decided to restart accepting health complaints from 1 July 2020. We continued to accept complaints about UK Government departments and their agencies throughout the pandemic period.

2. The need for an independent lessons-learned review

2.1 PHSO welcomes the expansion of the Committee’s inquiry to look at this issue and the role it can play in seeking clarity on the nature and scope of any lessons-learned inquiry from Government.

2.2 The NHS, social care and countless other public services across the UK have made a heroic effort during the COVID-19 pandemic. Staff working in these essential services have made an extraordinary contribution during one of the most challenging periods in recent history.

2.3 We have rightly applauded the work of dedicated public servants by clapping for carers and key workers and remembering those who have lost their lives to COVID-19.

2.4 As well as demonstrating this continued appreciation, we must also support NHS organisations, Government departments and other public services to learn. Learning and improvement are essential if public services are to

strengthen their response to future pandemics and emergencies. This is important as COVID-19 is expected to have an ongoing impact over the next period, with public services adapting to local and regional outbreaks and any future 'second wave' of the pandemic nationally.

2.5 To do this, PHSO has, over the last few months, been calling on the UK Government to provide greater clarity about its plans for a robust and independent lessons-learned exercise into the handling of the COVID-19 pandemic.

2.6 To learn the lessons of public services' response to the pandemic, it is essential that any inquiry is fully independent, open and transparent.

2.7 On 19 May 2020, the Ombudsman wrote to the Chancellor of the Duchy of Lancaster asking for clarity on this issue. We are yet to receive a response to this letter, and we urge Government to explain what progress has been made in setting out plans for a lessons-learned inquiry.

2.8 If we had been able to speak to Ministers about this issue in a timely fashion, as requested, our initial suggestion would have been to establish the scope and format for any inquiry process quickly. This could have been based on a phased approach with Part One looking at the experience to handling the initial outbreak, and Part Two addressing issues as the crisis moved through to conclusion.

2.9 If the Government is to take a holistic approach, it should look at the actions taken across public services, not just in the NHS. For example, the inquiry should look at coordination between the NHS and Social Care agencies, learning for the Foreign and Commonwealth Office (FCO) from the experience of citizens seeking repatriation at the start of the pandemic and learning for the Department for Work and Pensions on the rapid rise in applications for Universal Credit.

2.10 It is important to be clear about the extent to which the inquiry will be based on UK-wide analysis. On key issues, such as the handling of the COVID-19 pandemic, it will be necessary to examine ***coordination*** between the UK Government and the devolved nations, but the extent to which any inquiry looks at devolved issues beyond this, must of course be agreed with each of the devolved administrations. Early clarity on this would be welcome.

2.11 An understanding of the Government's plans on these issues would help PHSO establish where we can best place our resources to prioritise certain types of complaint and the resultant learning useful to a public inquiry.

3. The vital role of complaints in learning lessons

3.1 Complaints have a unique and vital role to play in supporting learning and shaping improvement. Any inquiry into public services' response to the COVID-

19 pandemic should recognise the value of complaints and draw on this rich source of evidence.

3.2 Complaints reflect the individual experiences of those who used public services, including the NHS, during the pandemic. They shine a light on the human stories of how the pandemic affected – and continues to affect – people who have faced injustice or hardship as a result of failings in public services. Complaints can also illuminate wider systemic issues, as even a single complaint can sometimes expose learning for a whole service, system or pathway.

3.3 PHSO is especially well-placed – alongside the Local Government and Social Care Ombudsman (LGSCO) – to support the Government, Parliament and public services to learn from complaints. We not only resolve individual complaints and achieve justice for those who have suffered hardship or injustice, but also share the wider learning from the complaints we see to inform improvement in the NHS and Government departments.

3.4 We invite the Committee, and urge the Government, to ensure learning from complaints will inform any national lessons-learned exercise, and to involve PHSO (and, depending on the scope of any inquiry, our colleagues from across the four nations), so that we have the opportunity to share the learning from the complaints we see.

3.5 We have already received a number of enquiries about COVID-19-related concerns. We are seeking to resolve them where we can, but also, we are actively monitoring the nature of complaints that we are receiving to identify recurring themes. Emerging themes from these enquiries in our health jurisdiction (to date) include concerns over cancelled or delayed cancer treatment, patients being given the wrong COVID-19 test results and, most seriously, cases of potential avoidable death.

3.6 While we await the Committee's findings, and further action from the Government to set out its plans for a lessons-learned review, we have encouraged people to give feedback to the NHS and the other public services they use.

3.7 The Government should amplify this message: encouraging people to provide feedback, including complaints, and signposting them to the Ombudsman service where concerns have not been resolved locally by the NHS, Government departments or their agencies.

4. Improving the impact of complaints

4.1 PHSO would be able to achieve an even greater impact if the outdated legislation that underpins our work was reformed. PHSO wants to see the creation of a single Public Service Ombudsman, with an integrated jurisdiction

across health, social care, local government, UK Government departments and other public services.

4.2 There is now an even greater need for an integrated Public Service Ombudsman, given that different public services have needed to collaborate even more during the pandemic, and concerning reports in the media about cross-cutting issues, such as people being transferred from hospital inpatient care into residential social care without adequate testing or personal protective equipment (PPE) in place.

4.3 Currently, complaints about a Government department or agency must be referred to PHSO via the complainant's constituency MP. While MPs play a vital role in supporting their constituents and championing their concerns, the current 'MP filter' is an outdated legal requirement, dating back more than half a century. It is out of line with international standards of good practice in Ombudsman services, as set out in the 'Venice Principles'[1], and lags behind other Ombudsman services in the UK.

4.4 Unlike other national Ombudsman institutions across the world, and including our colleagues in Wales and Northern Ireland, PHSO does not have the power of 'own initiative' to look at the injustice or hardship faced by people who are unable or unwilling to complain. The risk is that we miss out on vital learning from the pandemic by excluding people who find it harder to complain – often those who are vulnerable due to their circumstances - from sharing their experiences and achieving justice.

4.5 Any inquiry should take seriously the need to ensure there are no gaps between the redress mechanisms for health and social care, including in its own recommendations.

5. Learning from previous inquiries on pandemics

5.1 The Government has previously undertaken lessons-learned exercises in response to flu and swine flu pandemics. The independent review into the UK's response to the 2009 influenza pandemic, led by Dame Deirdre Hine (published July 2010), made 28 recommendations for the management of a future pandemic.[2]

5.2 Swine flu was described by the then Chair of the House of Lords Science and Technology Committee as being a real-time test of the UK's preparedness in

[1] The Venice Principles set out key benchmarks to help uphold the independence and effectiveness of Ombudsman offices throughout Europe. They are published in full on the Council of Europe's website: https://www.venice.coe.int/files/Publications/Venice_Principles_eng.pdf

[2] 'Independent review of the UK response to the 2009 influenza pandemic', led by Dame Deirdre Hine (July 2010): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/61252/the2009influenzapandemic-review.pdf.

dealing with a pandemic virus. PHSO would expect those findings and recommendations to provide a useful starting point for informing a COVID-19 lessons-learned inquiry for our health and social care systems, and to be looked at again in detail. To ensure transparency, any inquiry should assess whether those recommendations have been met and maintained, as well as what further recommendations are needed in light of the practical experience of managing a pandemic on the scale we are currently facing.

5.3 In addition, given the scale of the COVID-19 pandemic and its impact, and the fact that coronavirus differs from influenza, we would expect an inquiry into the handling of the response to the recent pandemic to be broader in scale and scope than previous exercises.

6. Ongoing local learning and improvement within public services

6.1 Alongside a national lessons-learned exercise, we encourage NHS services and Government departments to regularly review their learning on an ongoing basis. This will enable iterative improvements to the response to the current pandemic, while we await the outcome of any future national inquiry. It should also be transparent, with findings published and shared with, for example, Select Committee's so that they can monitor improvements at the national level.

6.2 In some cases, there may be a lag-time in the emergence of COVID-19 related issues such as, for example, the impact of delays in elective NHS care. Once such issues are identified, it can then take weeks or even months for people to make a complaint and for it to be considered by the organisation they are complaining about, before they can bring their complaint to PHSO.

6.3 All public services should work to embed a learning culture that allows them to continuously improve the services they provide. This means that any mistakes or errors made in their initial response to the pandemic can be identified and put right at pace. One example of this could be undertaking a rapid review of the approach taken to the first set of local lockdowns, which would change things in a timely enough fashion to improve public services' response to the next local outbreak.

6.4 In the absence of clarity from Government, we welcome the action being taken by some organisations already, such as the Care Quality Commission, to initiate rapid reviews on key topics. Activity like this will enable public services to learn lessons quickly in discrete areas of operation, while we await details of a wider national inquiry.

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