Parliamentary and Health Service Ombudsman

Health and Social Care Committee inquiry

Integration and Innovation: working together to improve health and social care for all White Paper - Written submission from the Parliamentary and Health Service Ombudsman

23 March 2021

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 When we look into complaints about the NHS in England, we do so under powers granted under the Health Service Commissioner Act (HSCA) 1993, which allows a member of the public to bring a complaint to PHSO directly, if they are not satisfied with the final response they receive from the organisation they are complaining about. When we look into complaints about Government departments and their agencies, we do so under powers granted under the Parliamentary Commissioner Act (PSC) 1967, which requires complaints to be referred by an MP.

2. Introduction

2.1 PHSO welcomes the opportunity to contribute to the Health and Social Care Committee's inquiry into the *Integration and Innovation: working together to improve health and social care for all* White Paper. The proposals in the White Paper offer an opportunity to strengthen the patient safety, learning and improvement system and we look forward to working with the Committee to consider these opportunities over the coming months.

2.2 This written submission focuses on the White Paper's proposal to put the Healthcare Safety Investigation Branch (HSIB) on a statutory footing, incorporating provisions in the former Health Service Safety Investigations Bill.

2.3 As PHSO previously raised in its evidence to Parliament when similar proposals were brought forward by the Government in 2019, we welcome the overarching aim to strengthen the patient safety system by formalising HSIB's role in statute. We also welcome the role of 'safe space' in helping to create a just culture where staff, patients and families feel safe to speak up when things go wrong. However, we remain seriously concerned about the unprecedented restrictions on PHSO's constitutional role and function that will result from the proposals as they stand. The reasons for these concerns are set out below.

3. Safe space provisions in the White Paper

3.1 The White Paper proposes that access to information held by HSSIB will be prohibited in order to create a 'safe space' within its investigations. This will enable clinicians and others to take part in, and provide information to, these investigations without the fear that this will be disclosed or used for disciplinary purposes.

3.2 The White Paper also proposes that the Secretary of State will have the power to determine when the prohibition on disclosure will not apply.

4. Why PHSO needs access to information held by HSSIB in safe space

4.1 The independence and autonomy of the Ombudsman are founding principles of the Ombudsman institution. This was recently reiterated in a resolution adopted by the United Nations, which was co-sponsored by the UK. This resolution made clear that National Public Service Ombudsman Institutions must have *'a broad mandate across all public services, the powers necessary to ensure that they have the tools they need to select issues, resolve maladministration, investigate thoroughly and communicate results, and all other appropriate means, in order to ensure the efficient and independent exercise of their mandate and to strengthen the legitimacy and credibility of their actions'*.[1]

4.2 Currently, if we require access to any information held by a body within our jurisdiction for the purpose of an investigation, we can use statutory powers under section 8 of the Parliamentary Commissioner Act and section 12 of the Health Service Commissioners Act to compel them to provide this evidence. Proposals set out in the White Paper would change this arrangement for a public body, HSSIB, for the first time since the Ombudsman was established more than 50 years ago.

4.3 There are two distinct situations in which PHSO may require access to HSSIB's safe space:

i. When PHSO receives complaints about HSSIB itself

[1] https://undocs.org/en/A/RES/75/186

ii. When PHSO is investigating complaints about the NHS and requires information held by HSSIB to carry out a full and effective investigation

4.4 Firstly, it could prove impossible to investigate a complaint about HSSIB's handling of an investigation without accessing the information that the complaint is about if that information is held in safe space. The powers granted to us by Parliament are equivalent to those of the High Court.[2] The proposal would significantly impede PHSO from accessing information that could be pivotal in investigations about HSSIB or care provided in a situation HSSIB has investigated.

4.5 In cases where PHSO receives a complaint about a matter investigated by HSSIB, there is a risk that we will not be able to carry out full and effective investigations if we do not have access to information held by HSSIB in safe space and it has not separately been provided to us in our call for evidence. This will have significant consequences for citizens by limiting access to justice for those who have suffered harm as a result of safety failings in the NHS, as well as prohibiting PHSO from using our investigations to drive learning and improvement in the safety of care. As a result, this could undermine public trust in the integrity of the NHS and its ability to learn from when things go wrong.

4.6 There is a danger that a patient or their family member, when pursuing a complaint about failings in treatment, could find that a contradictory account had been given by a witness – one to HSSIB in safe space that is not seen by the Ombudsman and another to the Ombudsman about what happened and why. This could lead to the Ombudsman making incorrect or incomplete recommendations for either individual or systemic remedy.

4.7 We are committed to working closely with HSSIB to ensure that any information we access in the course of an investigation is handled and used appropriately as is the case for the thousands of sensitive cases and information we already consider each year.

5. Applying to the High Court or requesting the Secretary of State to disclose information held by HSSIB in safe space

5.1 Previous proposals brought forward by Government through the Health Service Safety Investigations Bill indicated that applications to the High Court could be made to seek disclosure of information held in HSSIB's safe space. Parliament has provided for its Ombudsman to be able to access a wide range of highly sensitive information from all Government Departments and the NHS, with a statutory requirement to also investigate in private.

[2] Under Section 12 of the Health Commissioner Act 1993 and Section 8 of the Parliamentary Commissioner Act, PHSO has the power to require individuals and organisations to produce information and provide documents relevant to an investigation.

5.2 While PHSO could in principle apply to the High Court to obtain this information, our legislation for all other public bodies, including those handling the most sensitive information in central government, provides us direct access to the information we require. Putting in such provisions just for the new HSSIB would therefore come at significant extra cost to the taxpayer for handling complaints solely about this organisation and could undermine confidence in the quality of scrutiny applied to it as a public body. Moreover, it would divert funds from the core complaints-handling service that PHSO provides to citizens.

5.3 The White Paper also sets out that the Secretary of State will have power to determine when prohibition of information held in safe space will not apply. The principle of the Ombudsman is that it must be functionally and practically independent of Government and the Executive if it is to scrutinise public services effectively, impartially, and thoroughly. This independence must be preserved and unfettered. It is not for the Secretary of State to determine the circumstances under which the Ombudsman can have access to information held in safe space. This would be a clear breach of the principles established in the UN Resolution about the role of Ombudsman services that the UK itself recently co-sponsored.

6. Conclusion

6.1 We welcome the proposals set out in the *Innovation and Integration* White Paper to create a safe space for information held by the Health Service Safety Investigation Body and the intention to create a just culture where staff, patients and families feel safe to speak up when things go wrong.

6.2 However, the unique constitutional role of the Ombudsman demands that PHSO has access to the information held within safe space for the specific purposes of examining failings, to preserve the Ombudsman's independence, autonomy and ability to undertake fair and thorough investigations.

6.3 There are significant implications for the PHSO throughout the White Paper, as well as opportunities to strengthen and modernise the Ombudsman's role in driving improvements in patient safety and the NHS more generally. We would welcome the opportunity to work with the Committee to explore this in more detail over the coming weeks and months.