Written evidence from the Parliamentary and Health Service Ombudsman to the Joint Committee on Human Rights' inquiry on Protecting Human Rights in Care Settings

14 April 2022

About the Parliamentary and Health Service Ombudsman

The Parliamentary and Health Service Ombudsman (PHSO) makes final decisions on complaints that have not been resolved by UK Government departments, the NHS in England, and some other UK public organisations. We do this impartially and independently of Government, holding public bodies to account. PHSO is not part of Government, the NHS in England, or a regulator. We are neither a consumer champion nor an advocacy service. We hold public bodies to account and speak truth to power.

1. How PHSO deals with complaints

1.1. PHSO considers complaints where an individual or group believes there has been injustice or hardship because an organisation has not acted properly or fairly or has provided a poor service and not put things right. We expect people to complain to the NHS organisation or Government agency first, so it has a chance to put things right. If an individual still believes there is a dispute about the complaint after an organisation has responded, PHSO can then be asked to consider it. We also share the learning from complaints so that public services can improve.

1.2. We look at complaints independently and impartially, carefully weighing up evidence from both parties and drawing on expert advice, such as input from clinicians, where relevant. Where we find unresolved failings, we made recommendations so the organisation can put things right.

2. How PHSO works with other bodies

2.1. We work with other organisations to make the complaints system better and to improve public services.

2.2. *Joint Working Team with the Local Government and Social Care Ombudsman* - we work in close partnership with the Local Government and Social Care Ombudsman (LGSCO), with whom we have established a Joint Working Team to investigate the most complex joint health and social care complaints. The complaints investigated by the team demonstrate that many of the problems experienced have been caused by the complex way in which health and social care is provided at a local level. This is evidence of the need for a less fragmented system. We have also been collaborating with LGSCO on the recently published Joint Section 117 Aftercare guidance, which is a cross-cutting health, social care and local authority issue.

2.3. *Health and Social Care Regulators Forum* – we have an established, formal mechanism for sharing learning, insight and concerns and helping to join up the regulatory and oversight system in health and social care. The Health and Social Care Regulators Forum brings together health and social care leaders from across the sector for this purpose. Common topics include joining up learning around COVID-19, contributions to patient safety reviews, and the emerging concerns protocol.

2.4. *Emerging concerns protocol* – PHSO is signed up to the emerging concerns protocol which provides a process for health and social care regulators to share information that may indicate risks to people using services, their carers, families or professionals. The protocol strengthens existing arrangements, providing a clear mechanism for raising concerns and ensuring a collaborative approach to proposed actions.

3. PHSO's cases in relation to human rights

3.1. Our role is enshrined under Article 2 of the Human Rights Act in the state's obligation to carry out an investigation in some circumstances when a death takes place which involves the state. This crucially allows us to shine a light on failures of the state in relation to breaches in fundamental human rights when we find that investigations have not been carried out.

3.2. We are also embedding in our work the Venice Principles on the Protection and Promotion of the Ombudsman Institute (as endorsed by the United Nations General Assembly). As part of this we will identify and call out flagrant breaches of fundamental human rights.

3.3. In the complaints PHSO investigates about healthcare, we have found a number of instances where people have not been treated with dignity and respect, where people's safety has not been protected and where people's rights have not been upheld.

3.4. In 2019 we published and laid a report, Missed Opportunities, which included two very similar cases we had investigated of failings in mental health care and treatment on the same ward of the same Trust. Two young men died avoidably because of this.

3.5. We found failings including not appropriately monitoring physical health and nutrition, not using de-escalation techniques where appropriate or prescribing the right mediation and not adequately managing environmental risks including ligature points in their rooms. In one of the cases, staff took no steps to investigate rape allegations made by the patient.

3.6. It took numerous investigations, inspections and inquests before the Trust started making measurable improvements, and this began only after it was merged with another Trust under new leadership. We found the Trust failed to investigate one of the deaths adequately, and this was a breach of human rights. This tells a story of the complex and difficult journey the families had to endure to get answers about what happened to their loved ones.

3.7. As a result of this report, an independent inquiry has been launched into all inpatient deaths in Essex from 2000 to 2020. The inquiry is now gathering evidence.

3.8. Our 2020 report, Continuing Healthcare: Getting it right first time, which looked at failings in NHS-funded care for people with ongoing health needs, highlighted that failings in the provision of NHS Continuing Healthcare have devastating consequences for those affected and "constitute an abrogation of basic rights".

3.9. The report showed how failings in the planning process can leave people without adequate care and in situations where they may be unsafe. These failings may also force family members to act as unpaid carers despite being eligible for NHS-funded care, and negatively impact their sense of dignity. In addition, failings in the review process in relation to previously unassessed periods of care often show a lack of compassion and respect for those affected. This needlessly compounds the already challenging emotional and financial burdens of ongoing health problems.

4. The complaints system is complex and confusing

4.1. The complaints system as currently constructed is excessively complex and can be confusing for members of the public to navigate. As the Committee heard in oral evidence from LGSCO and the Care Quality Commission, this can make it hard for individuals to know where to turn when they have been let down by health and care services, and the NHS has not provided a satisfactory resolution to their concerns. This includes when individuals' rights have been infringed. This may be particularly true for people who complain if they are in circumstances that make them vulnerable, such as people who are living in a long-term inpatient care setting with autism, a learning disability or mental health condition.

4.2. Professional regulators such as the General Medical Council and Nursing and Midwifery Council can act on concerns about the professional and clinical conduct of individual doctors, nurses and midwives, but they cannot look at complaints about services or organisations.

4.3. The system regulator, the Care Quality Commission, actively encourages members of the public to share concerns about the quality of services they use, but it cannot look at the experiences of any one individual or investigate or resolve any complaint they raise. Only PHSO and LGSCO can investigate individual complaints about services and organisations. Ombudsman services are unique in this respect.

4.4. The creation of a single Public Service Ombudsman would mean the LGSCO and PHSO would be replaced with one single public services Ombudsman for the UK, with an integrated jurisdiction across health and social care, local and national government. This would make it easier for people to know where to go when they have been let down by a public service.

4.5. We are working in partnership with a number of organisations to pilot and deliver the NHS and Government Complaint Standards. The NHS Complaint Standards set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care.

4.6. The Standards aim to support organisations in providing a quicker, simpler, and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. This will make it easier for members of the public to make complaints when they have been let down by a public service. The Standards also place a strong emphasis on regular review by senior leaders on what learning can be taken from complaints, and how this learning should be used to improve services.

5. Access to justice must be improved

5.1. Access to justice must be improved for everyone who uses health and care services.

5.2. As part of our new Corporate Strategy 2022-2025 we are improving access to justice by focusing on improving awareness of and access to our service. This will especially benefit those from marginalised communities. As part of this we will:

- remove barriers to our service,
- improve public awareness of what we do and provide clarity about our role so service users can make informed choices and,
- focus our resources to make sure we make the right decision at the right time.

5.3. We could better support people who use public services if we had the powers of own initiative. This would mean we could investigate a known issue without receiving a complaint about it, in line with Ombuds services in the devolved nations. In turn we could support public services to improve in a timely way by launching systemic investigations and making recommendations at the appropriate time.

5.4. This will particularly benefit people from marginalised and excluded groups who may be at greater risk of their rights being infringed, and who may be less likely to bring a complaint. This includes people with autism, learning disabilities or a mental health condition living in long-term inpatient care; people living with dementia, and those from other marginalised and excluded communities.

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