IFF Research

Parliamentary and Health Service Ombudsman

Report on seminar with PHSO the Facts

Contents

Introduction from the Parliamentary and Health Service Ombudsman

We are modernising, so that we can better meet the needs of the people who need our service.

To help us with this, in the summer we asked an independent research agency to facilitate a seminar with members of the voluntary pressure group, PHSO the Facts (www.phsothefacts.com). The aim was to find out what they thought needs to change in our organisation. We were pleased to get such honest and frank feedback. The comments and experiences that members of the Group shared with us have shone a light on some areas where we genuinely need to learn and improve. They also reflect past experiences of our service that we had recognised needed to change, and that we have taken steps to address.

The last year has seen us building the foundations for a major transformation of our service. We have already made some significant changes. Some of the personal experiences of members of PHSO the Facts, expressed in this report, pre-date these changes. For example, we now have different criteria for accepting complaints for investigation. So instead of hundreds of statutory investigations a year, we now conduct thousands. We are now giving so many more people the kind of closure that sometimes only a final, statutory adjudication by us can bring.

We are now ready for the next stage in our modernisation plans. This will cover every aspect of what we do. Our aim is to put users of our service at the heart of our work, giving them the best service at every stage of their journey with us– from the first point of contact through to our decision-making and investigation methods.

Over the coming months we will invite more feedback from past, existing and future users, consumer and advocacy groups, and the government and health service organisations we investigate. Their views will help us develop a new Service Charter, which will describe the service people can expect from us in future.

We are extremely grateful to PHSO the Facts for their full and open participation in the seminar. A report, produced by the research agency IFF Research, follows this introduction. We have also highlighted throughout the report changes we have made, and others that we are planning, which are relevant to points raised by members of PHSO the Facts.

Myself and my colleagues are meeting each of the participants in the seminar individually. There may be further learning from their personal experiences that can help us shape our service for our future service users. I am confident that we are listening and learning from feedback, and changing and modernising our service.

Mick Martin
Managing Director

December 2014

Acknowledgements

The report that follows was prepared by the independent research agency, IFF Research, on a seminar held with the pressure group, PHSO the Facts (www.phsothefacts.com).

IFF Research is an independent research agency that specialises in researching public policy issues, and has considerable experience of undertaking research concerning the work of the Ombudsman and the views of their users and stakeholders.

Introduction and context

Introduction

IFF Research was commissioned by the Parliamentary and Health Service Ombudsman (PHSO) to facilitate a seminar between PHSO and PHSO the Facts as part of the wider work PHSO are doing to seek feedback and learning from customers, organisations in jurisdiction and stakeholders. The seminar was held on Thursday 26th June 2014.

About PHSO

The Parliamentary and Health Service Ombudsman (PHSO) combines the two statutory roles of Parliamentary Commissioner for Administration (the Parliamentary Ombudsman) and Health Service Commissioner for England (Health Service Ombudsman). Its role is to investigate complaints that individuals have been treated unfairly or have received poor service from government departments, other public organisations and the NHS in England.

About PHSO the Facts

The PHSO the Facts website[1] states that the aim of the group is to demonstrate to the Public Administration Select Committee (PASC) that the PHSO is 'not fit for purpose' and should be 'totally' reformed.

The pressure group has two objectives: to improve the service for all those who follow, so that each receives a fair and unbiased investigation, remedy and closure; and to compel the Ombudsman to thoroughly investigate historic cases where they perceive them to have had no satisfactory resolution.

1 www.phsothefacts.com/join-pressure-group

About IFF Research

IFF Research is an independent research agency that specialises in researching public policy issues, and has considerable experience of undertaking research concerning the work of PHSO and the views of PHSO customers and stakeholders[2].

Structure of the seminar

The seminar was attended by 20 members of PHSO the Facts, senior members of staff from PHSO and three members of staff from IFF Research (in a facilitation role).

The seminar included introductions, a workshop session gathering feedback on the customer experience from PHSO the Facts members and a discussion on the key themes to emerge from the seminar.

The rest of the report sets out the broad themes to emerge from the workshop discussions, captures the views of participants reflected in the feedback and discussion session.

The seminar represented an opportunity for senior individuals at the PHSO to reflect upon the comments from the pressure group and consider those activities and strategies that the PHSO is currently delivering or planning to deliver, which are relevant to the feedback gathered. The report highlights these activities in the 'Learning and improvements' sections throughout the report. These are presented on separate pages in order to differentiate this information from that provided by the group.

This report reflects the views of members of PHSO the Facts raised at the seminar. It is not intended to be representative. It does not reflect the views of IFF Research.

2 IFF Research previously conducted the 2009 PHSO Stakeholder and Impact Studies; post-Francis research among NHS Trusts' Chief Executives, Board Chairs, and Non-Executive Directors regarding their complaints practices; evaluation research examining the PHSO website; and the ongoing PHSO Customer Satisfaction Survey and qualitative follow-up work to map out PHSO customer journeys.

Key themes from the seminar

In this chapter we summarise the key themes to emerge from participant feedback throughout the seminar. The key themes have been separated into two distinct areas: Those themes relating to the overarching public complaints environment and the Ombudsman's relationship with Parliament, and those relating to the investigation process.

Ombudsman reform and improving the independence, accountability and transparency of public complaints systems

Improving the public complaints system

Participants discussed having been involved in the complaints system for a number of years, attempting to have their complaint dealt with appropriately for their needs. They described having to negotiate several different routes to resolve their complaints (e.g. various NHS systems, PHSO and legal routes).

"*It* [the complaints system] *seems designed not to work*".

Participants felt that the complaints landscape can be complicated and confusing, and that they had 'slipped through the gaps' between different complaints processes, with no one addressing their complaint appropriately.

"*Each institution has just allowed me to slip through the cracks*".

In many cases their complaint had spanned a period of time in which there had been significant changes at the PHSO (including different Ombudsmen and investigations staff). Participants had approached PHSO with the belief that they would be there as a final opportunity to have their complaint dealt with appropriately. However, they all felt that their experience of complaining to the PHSO had been negative, with no resolution of their complaint.

This led many to feel that there is no 'safety net' anymore. In their opinion the last point of recourse, i.e. PHSO, had let them down, in the same way that all previous complaints processes had.

Participants described the negative impacts that being in the complaints system for so long can have, including the negative impact on their own physical and mental health and the sheer time and effort involved in having to battle for recognition of their complaint for some time.

Participants told us that the length of time that it takes to go through the complaints process of an NHS organisation in England or a parliamentary body, then the PHSO complaints process, has a significant impact on their ability to bring a legal case if they do not get the outcome they wish for from PHSO[3]. Consequently, participants felt that 'the clock is ticking' on the timescale of their complaint as soon as it is made.

> *"You've already been through the NHS process, that's taken a year perhaps, go through the Ombudsman, that's another year, what time have you got left for legal action?"*

There was a concern that public bodies can drag out the complaints process in order to reduce the likelihood of a legal proceeding at a later stage. Participants questioned why there is any time limit placed on cases.

Ombudsman oversight and accountability

Participants in the seminar felt that PHSO can lack the level of independence required in order to perform the function of holding public bodies to account. They also felt that Parliamentary scrutiny of PHSO is not sufficient, resulting in a perceived lack of accountability for PHSO's performance.

Participants suggested that the Ombudsman has not acted on recommendations from the House of Commons Public Administration Select Committee (PASC) for an overhaul of the Ombudsman.

Participants felt that the Ombudsman does not always apply the principles that they themselves set out as good practice, does not always provide redress and justice to the public, and is not capable of getting a resolution because of the boundaries of the legal remit that surrounds it.

3 For example, there is a three year limit for clinical negligence claims – www.nhsla.com/claims/pages/advice.aspx.

Learning and improvements

Our service

Time bar for bringing complaint to us

The legislation that governs our work says that users should bring complaints to us within 12 months (or to a Member of Parliament to refer on to us if the complaint is not about the NHS in England).

We recognise how long it can take sometimes to go through the local NHS complaints process. That is why we have always been able to use our discretion to take on complaints even if people come to us after a year.

Now we are going further. For serious complaints about the NHS in England, if there is enough evidence to make an investigation viable we will, as a general rule, investigate – even if the complaint is several years old.

Helping service providers improve complaint handling

We know that pursuing a complaint through local resolution and then escalation processes can take time and determination.

We want to do more to help service providers improve the way they handle complaints – resolving complaints at service level, quickly and effectively, is better for the user and their ongoing relationship with the service provider. That's why, for the first time, in collaboration with Healthwatch England and the Local Government Ombudsman, we have defined what good complaint handling looks like. The document, *'My expectations for raising concerns and complaints'*, looks at complaint handling from the complainant's perspective and is a set of statements that people might say if they had had a positive experience of making a complaint. Service providers will be able to measure their complaint handling against the statements, to see how well they are doing and where they may need to improve the way they deal with complaints. We are pleased that leaders in the health care system are already committing to using *'My expectations for raising concerns and complaints'*.

One Public Ombudsman service for England and UK reserved matters

Complaining about public services can mean negotiating a confusing maze of organisation and systems. It needs to be simpler. We are calling for there to be one ombudsman service covering all public services, local and national, in England and all non-devolved services. A unified Public Ombudsman Service would be designed around the needs of people and would aim to make it quicker and easier for users to make a complaint. It would provide a common approach to investigations, so it would be easier and fairer for service providers, and would make it easier to detect big and repeated service failures.

While our vision for one Public Ombudsman Service may be some way into the future, we are already paving the way for it by working with the Local Government Ombudsman to bring our processes and procedures into line with each other.

Accountability

Openness and transparency

We now post information about our performance on our website on a monthly basis and every quarter we publish hundreds of summaries of cases we've resolved, so people can see the kinds of complaints we deal with and the decisions we have made.

But we know we need to share more information about our processes and how we make decisions on cases.

We have started work on a new Service Charter. This will be a major step forward in describing our service and explaining how we work. It will cover everything from how we make decisions about whether to investigate a complaint, how we deal with cases where someone could, or is, seeking alternative legal remedy, and how we share facts and findings with the parties to the complaint.

Accountability to Parliament

Our role is to shine a light on public service failings, so that public service providers can be held to account for the services they provide. Our own performance is currently scrutinised by the Public Administration Select Committee (PASC).

In our view there is a tension between PASC's role in scrutinising our performance and its role in championing our work in Parliament to bring about change and improvement in public service provision.

We are pleased that PASC has recommended that the Public Accounts Commission, or a similar body, should take over primary responsibility for scrutinising our performance. This would allow PASC to focus on using the insight we share through our reports to hold public services to account for acting on our recommendations.

Investigation process at the PHSO

Gathering evidence and engaging with bodies in jurisdiction

Participants in the seminar often mentioned how they felt the relationship between the PHSO and those bodies being complained about was too close. This included a perception that the PHSO was more likely to take the word of bodies in jurisdiction at face value compared to the word of complainants themselves and that, on occasion, not all of the appropriate evidence from the body under investigation is gathered. Participants felt the victim should be believed first and foremost.

This perceived imbalance in power also extended to the provision of evidence, where participants felt that despite having no expertise, complainants are expected to provide evidence to prove their case, in addition to assessing evidence submitted by those bodies in jurisdiction.

Other specific concerns regarding the investigation process and collation of evidence included:

- The criteria used to decide what complaints to investigate, and how and why PHSO uses 'discretion' to decide that a case is not worth investigating;
- On occasion PHSO fails to investigate a complaint due to a lack of evidence – participants felt this should not prevent PHSO opening an investigation;
- PHSO accepts evidence submitted by the organisation under investigation at 'face-value', and does not scrutinise their version of events appropriately;
- PHSO takes the word of professionals from the NHS/Parliamentary Bodies over complainants, and ignores complainants when they try to point out inaccuracies or missing evidence;
- Complainants do not have appropriate opportunities to scrutinise the evidence submitted by the organisation under investigation, and the evidence for the case overall;

- There is no opportunity for the complainant to discuss with PHSO where evidence is missing, inaccurate or false, whereas the organisation under investigation has the opportunity to discuss the case with PHSO in an informal way;
- Bodies continue to discuss a complaint with PHSO, even when a complainant has been told that the case has been closed; and
- Participants were concerned that, in old cases, PHSO does not accept new evidence as reason to re-examine a case.

Various experiences relating to these issues had led many participants to feel that there is an element of collusion (some claimed corruption) between PHSO and Bodies in Jurisdiction. For example, one participant stated that they felt the PHSO had allowed 'manipulation and tactical misdiagnoses' of evidence submitted by an NHS Trust, while another stated that PHSO had accepted 'manufactured statements' from medical professionals.

Clinical Advisers

Another issue raised by participants was the independence and expertise of the clinical experts used by PHSO to assess medical cases. Specific issues mentioned included:

- Concern that clinical advisers may collude in 'cover-ups' regarding medical notes submitted by NHS staff;
- Concern that PHSO sometimes uses clinical advisers who are not qualified, from the wrong discipline, also employed by the NHS (therefore not independent) or retired, and a perception that PHSO provides confidentiality to clinical advisors, meaning that complainants have no opportunity to check their professional expertise, independence and credentials;
- A sense that clinical advisers just tell PHSO 'what they want to hear';
- Concern that clinical advisers, as experts in how to write a report, can turn evidence against the complainant (some participants felt clinical advisors were complicit with PHSO in trying to find against complainants); and
- A belief that the balance of power is in favour of the assessment/report of the clinical advisor, rather than the complainant, as they are a medical expert. Consequently if a complainant disagrees with an assessment, or how it has been arrived at, PHSO will back their clinical adviser over the complainant.

Communicating with complainants and final reports

Participants were frustrated about what they felt were inappropriate investigations and reports.

> *"Your complaint will be about the ceiling, but you'll get an answer about the walls or the floors – they don't answer the exact question you are asking."*

Examples of their concerns included:

- Investigations and reports perceived to focus too much on the small details, rather than the big picture, potentially picking out minor points in a case and, in participants' opinion, using these to dismiss the whole complaint;
- Reports not believed to fully answer the issue or concern raised;
- Report conclusions lacking clear logic;
- A perception among participants that PHSO merges separate complaints (e.g. one of maladministration and one of negligence) into the same complaint investigation and report; and
- How the issue of recompense is discussed and decided with bodies under investigation; and the influence of these bodies in shaping reports.

For participants this was compounded by what they saw as a defensive or adversarial approach to communications, together with a lack of responsiveness from staff.

Also mentioned was the inappropriate use of the phrase 'no worthwhile outcome', in the past, to explain why PHSO had decided not to investigate a complaint[4].

4 This term was formally removed from PHSO's processes in late March 2012, in response to customer feedback.

The review process

Participants discussed the process of making a complaint about PHSO's service (known as a 'review'). A number of concerns were raised, including:

- A feeling that the review process focuses on procedures rather than the actual case, therefore it is not actually a review of the complaint; and
- A sense that the review process is used to close down a complaint, and that once you are with the review team 'nothing gets you out of there'.

Some participants claimed to have been ignored or insulted by the review team.

Impact of investigation decisions and duty of care

Participants discussed the impact that PHSO's decision not to investigate their complaint, or not to uphold their case, had had on them, in terms of both their physical and mental health. They described the emotional impact of having to relive their trauma over and over again, of feeling abandoned and let down by PHSO and having no redress or closure at the end of the process.

Participants stated that the impact of this had left various people needing serious care to help them deal with the distress it had caused them. One participant stated that they had been suicidal after the PHSO report on their case.

Participants questioned how PHSO handles its duty of care to complainants, and suggested that they did not see sufficient evidence of suitable duty of care in operation.

Retention and disposal policy

Participants questioned what the retention and disposal policy of PHSO is, and suggested that it should be reviewed so that important information is not lost. Participants reported that they believed PHSO had destroyed their case files, within what they viewed as an inappropriate time period[5].

5 PHSO keeps all information about complaints for two years after their last action on the case. At that point PHSO deletes some of the electronic and paper records.

Investigation and upholding of complaints relating to Government policy

Participants perceived that the PHSO deliberately avoids investigating or upholding complaints where their findings may challenge significant policy issues or contentious issues. In their view, PHSO avoids such cases as it is concerned about the embarrassment it may cause the NHS and/or Government and it considers them too complex to deal with. As one participant claimed:

"*They do not want to challenge policy decisions, embarrass policy-driven rationing* [of care] *and decisions made that are unethical* [and designed] *to save money*".

Corruption in the system

Some participants discussed their belief that there is endemic systematic corruption of the State, which extends to PHSO's relationship with the Bodies in its Jurisdiction. One participant suggested that all of the various complaints discussed in the seminar need to be considered under an umbrella of "state controlled fraud".

"*There is endemic systematic corruption in this country right up to the top.*"

Learning and improvements

More investigations, faster outcomes

Some of the concerns raised by participants relate to decisions we had made to not investigate their complaints in the past. These date back to a time when we took a different approach to assessing whether or not to investigate. Some of these complaints may have been handled differently if they were considered now, under our current process, which we changed in 2013.

In 2013, in response to strong feedback from users and Parliament, we made a fundamental change to the way we consider complaints, so that we can help more people. Now, if a complaint meets some essential criteria, we will usually investigate it. As a result, in 2013-14, we investigated six times as many complaints as we did the year before – 2,199 compared to 384. We are upholding more complaints and getting service providers to acknowledge and address the impact their mistakes have had on people's lives. We are bringing more people closure.

We have also shortened the length of time it takes us to investigate complaints. In 2012-13, the average length of an investigation was 317 days. In 2013-14, we concluded 95% of cases within six months.

Other concerns raised by members of the group were about decisions we had made to not uphold their complaints. Our job is to investigate and make final decisions on complaints based on evidence. We are the end of the complaints process, and so we recognise that some people will inevitably feel disappointed and let down if we decide not to uphold their complaint.

Improving our service

We have made other changes to the way we work, to improve people's experience of our service and their confidence in the impartiality of our processes. These include:

- Talking to complainants much more and relying less on emails and letters.
- Speaking to people involved in the case, to gather evidence. In the most serious cases, we interview people.
- Sharing a statement of facts with both the complainant and the organisation complained about at the same time.
- Sharing our draft and final investigation reports with both parties at the same time.

Going further: our new Service Charter

We have explained in this report how we are already using new ways of working, so that we can help more people. What comes next is a more radical transformation of our service. Our new Service Charter, which we have begun to develop, is a set of promises about our service, covering everything from the time we will take to investigate a complaint, to how we approach our investigations and who we will share our findings with. The comments from the seminar with PHSO the Facts will help us to shape the Charter and make clear what users can expect in the future.

---

mailto:service.charter@ombudsman.org.uk

#PHSOservicecharter