Parliamentary and Health Service Ombudsman

Memorandum to the Public Administration and Constitutional Affairs Committee (PACAC) by the Parliamentary and Health Service Ombudsman (PHSO)

November 2017

Our vision is to be an exemplary public services ombudsman by providing an independent, impartial and fair complaints resolution service, whilst using our casework to help raise standards and improve public services.

This Memorandum summarises our progress against our five year strategic plan, which is due to be replaced in April 2018. We also attach (Annex A) the draft strategic objectives that we recently shared with PACAC members and published for consultation with service users and our key stakeholders.

Introduction

1. The original office of the Parliamentary Ombudsman was established by Parliament in 1967 and we celebrate our 50th anniversary this year. We make final decisions on complaints that have not been resolved by the NHS in England, UK government departments and some other UK public organisations. We do this independently and impartially, and our service is free for everyone.

2. Our role is to help people resolve their complaints when there has been an injustice or a hardship because an organisation has not acted properly or fairly or has failed to put things right. We use our casework to shine a light on failures where services fall short and share this insight to help others improve public services and the complaints system overall. In 2016-17 88% of our investigations were about the NHS in England and 12% were about UK government departments and the other UK public organisations in our jurisdiction.

3. Like most organisations delivering a public service, we must change and evolve to rise to a combination of internal and external challenges. These pressures include developing public expectations, the need to resolve complaints more quickly and to restore trust and confidence in our decisions. We are also responding to the need to live within our reduced public funding allocation and to demonstrate more clearly our impact and value for money. We have committed to delivering 24% savings by 2019-20. Our ambition is to become an exemplary Ombudsman service.

4. In many ways, we had already begun elements of this transformation under our previous strategy. Rob Behrens took up post as Ombudsman in April 2017. We are now developing a new three-year corporate strategy that will build on the progress we have made so far, but also set out our ambitions for the future.

Transforming our service

Casework performance

5. We continued to transform our service in 2016-17 to make sure we can meet current and future demand, whilst also demonstrating value for money. We completed 4,239 formal investigations, up from 3,861 in 2015-16 and fully or partly upheld 1,531 complaints or 36% of the complaints we investigated.

6. Overall, the average time to close an investigation reduced in-year from 255 days in 2015-16 to 234 days in 2016-17. We reduced waiting times at each stage of our process including at assessment, the stage of our process where we decide whether or not to launch a formal investigation, which reduced from 47 days in 2015-16 to just 10 days in 2016-17. Waiting times for an investigation also reduced from 63 to 54 days over the same period. We continued to address the backlog of longstanding complaints. Between 1 April 2016 and 31 March 2017 we reduced the number of cases that are taking us more than 12 months to complete from 136 to 104, although significant work is still needed in this area.

7. In the complaints we upheld, 99% of the organisation we investigated agreed to act on our recommendations. This meant we were able to put things right for people through:

    - more than 1,200 apologies;
    - over 800 payments to make up either for a financial loss that had been suffered or to recognise the impact of a public bodies mistake (totalling £605,760 from NHS organisations and £188,300 by UK government departments and other UK public organisations);
    - more than 870 service improvements, such as changing internal procedures or putting in place additional training for relevant staff; and
    - more than 340 other actions to put things right, such as through a government department reviewing a decision or a GP practice correcting errors in a patient's medical record.

Our new operating model

8. Building on the changes we made in 2016-17, we are in the process of introducing a new operating model for our casework, with the aim of providing a faster, more flexible and more consistent service to complainants and the organisations we investigate.

9. Alongside the introduction of the new operating model, we are implementing a comprehensive development programme for all operational staff. In the short-term we are anticipating that these changes will have an impact on our productivity, but we expect to recover ground and improve the quality of service once the training programme is complete. To help us manage this impact, we are recruiting additional fixed term staff and managers to be based in our casework teams.

Service quality

10. A Quality Committee led by non-executive members of our Board helps provide additional oversight of the quality our casework, ensuring that we have in place the appropriate arrangements to assess the quality of our work and drive improvement. In addition, the Ombudsman, Chief Executive and other senior staff are involved regularly in casework discussions and decisions, particularly complex cases.

11. We launched our sector-innovative Service Charter in July 2016 following public consultation and extensive engagement with; past and future complainants; our staff; organisations we investigate; and advocacy groups. The Service Charter makes commitments about the service we provide and focuses on what complainants have told us is most important to them. Sitting at the centre of our approach to quality, the Service Charter commits us to keep people informed, to follow an open and fair process, to provide a good service and to live up to our commitments.

12. We use these commitments to measure how well service users consider we are delivering our service and understand where we need to improve. Since April 2017, we have reported quarterly on the progress we have made against these commitments. Our quarterly reports draw on two separate sources of feedback on our service that show us quite different things:

    - For the first, a dedicated, in-house casework process assurance (CPA) team routinely carries out a random sampling of cases. Each review examines if there is evidence that the caseworker followed internal processes correctly, in line with our Service Model. The team aims to sample around 800 cases each quarter.

    - Separately, we also then use an independent, external research company to undertake telephone interviews and get feedback from complainants at different stages of our process. This provides us with complainant feedback (CF) scores that offer insight into their experience of our service. Each question is aligned with a distinct Service Charter commitment. Our independent research company aims to speak to around 600 of the complainants each quarter.

13. The scores we publish on similar issues can often be quite different.. This is because complainant feedback is based on questions regarding the complainant's experience of our service, while the CPA data assesses whether we have followed the correct approach in reaching our decision.

14. The most recent complainant feedback data from the Service Charter covers the period April to June 2017. This shows that 89% of the complainants we surveyed felt that we had treated them with courtesy and respect and 84% agreed that we had explained clearly the specific concerns that we would look into. In those cases where we were unable to help, 81% of those surveyed said that we had directed them to someone who could help.

15. The complainant feedback data also makes clear, however, where we need to improve. Only 52% of complainants we surveyed agreed that we had gathered all the information we needed before we made our decision, whilst only 59% felt that

we had explained our decision and recommendations and how we had reached them. Some 60% agreed that we had given them our final decision on their complaint in a timely manner.

16. The feedback shows that we need to get better at explaining our decisions to complainants, so we are introducing new staff training improve how we communicate our decisions and write reports. We are also changing the way we work so complainants get answers more quickly, although it will take time to see substantial improvements in this area as we embed our new operating model and implement the new training.

<u>Final decisions</u>

17. Since starting in post in April, the Ombudsman has met with a significant number of complainants, both individually and including a recent roundtable discussion with over 23 members of PHSO the Facts, many of whom have been pursuing cases with us for a number of years. These conversations have been invaluable in helping us to consider how we interact with complainants, as well as being useful for informing the development of our new strategy. A theme raised in some of these discussions, however, has been the possibility of additional independent reviews of both historic and some recently closed Ombudsman cases.

18. Our position is that this would not be appropriate. The purpose of the Ombudsman is to be the independent complaint handler of last resort for issues that have already been considered by complaint teams within public organisations. To add a further tier of review beyond that would significantly degrade the position of the Ombudsman in the system.

19. This does not mean that we are blind to the argument that we do not get every decision right. That is why we have an established Customer Care Team that not only receives feedback from complainants on our service at any stage of our process, but that also supports complainants who want us to reconsider a decision. We do conduct such reconsideration where it can be shown that:

- we made our decision based on inaccurate facts that could change our decision;
- there is new and relevant information that was not previously available and which might change our decision; or
- we overlooked or misunderstood parts of a complaint or did not take account of relevant information, which could change our decision.

20. Where these reviews take place, they are completed by staff who had no direct involvement in the original case, providing a second opportunity for us to consider whether we did get our original decision right. But we must be clear that this is not an opportunity simply to revisit a decision that is not accepted or agreed with. We only review cases where the above criteria are met.

21. Complainants are of course able to seek a judicial review of our decisions if they think we have got it wrong. We accept that this is a high bar to cross, but for the reasons outlined, we are of the view that this is right, if the Ombudsman is properly going to fulfil his role as the complaint handler of last resort. It is also

open to Ministers to set up independent reviews into particular cases where they deem this appropriate, as the Health Secretary has done in the case of Elizabeth Dixon, the terms of reference for which include examining our role in that case. We will fully cooperate with this process.

22. Ultimately, there has to be a final stage for complainants to reach. Our view is that it is right that the Ombudsman, with the internal review processes we already have in place for exceptional cases, is this point. We do understand that for some complainants, the matters they are seeking redress for can be serious and often traumatic. That is why we remain committed to listening to our complainants through our service charter engagement, individual casework conversations, our Customer Care Team and by launching regular open meetings to understand how we can continually improve what we do and how we do it.

Sharing our insight

23. Our statutory role includes sharing the unique insight from our casework with Parliament to help hold the NHS in England, UK government departments and other UK public organisations to account for the services they provide. We also share this insight more widely, with the organisations we investigate, regulators and policy makers to help them improve complaint handling and public service delivery.

24. Our insight helped to bring about real and lasting change in 2016-17. Our report on Learning from Mistakes from July 2016 informed PACAC's follow-up inquiry Will the NHS never learn? and the Government's approach to improving local NHS investigations of potential avoidable harm or death.

25. Our October 2016 report Driven to despair highlighted failings in the way the Driver and Vehicle Licensing Agency (DVLA) made decisions about whether people with certain medical conditions are safe to drive. DVLA accepted our recommendations and reversed its decisions in six cases, granting complainants the driving licences they had applied for and the Department for Transport agreed to take steps to put right some of the wider problems we identified in our report.

26. In 2016-17 we saw government taking action in response to some of our earlier work and that of others. Following the recommendations in our Time to Act report on sepsis in September 2013 and PACAC's own follow-up hearing in July 2016, the National Institute for Health and Care Excellence (NICE) published a guideline to help NHS staff recognise and treat sepsis more quickly. Public Health England and the UK Sepsis Trust launched a national sepsis awareness campaign to help parents and carers of young children recognise the symptoms and NICE issued a new draft Quality Standard in March 2017, setting out priorities for treating cases of sepsis.

27. Following our report on Midwifery supervision and regulation in December 2013 which recommended that supervision and regulation should be separated and that the Nursing and Midwifery Council should be in direct control of regulating midwives, new legislation implementing our recommendations came into effect on 31 March 2017. This change in law will help make sure that lessons are learnt when mistakes are made and improve the safety of mothers and babies across the country.

28. In September 2017 we started 'Radio Ombudsman', a new podcast series, which will help us to share and discuss our insight and engage with our stakeholders, including complainants, in new and innovative ways. The first podcast was with Scott Morrish, whose son Sam died in December 2010 of severe sepsis, aged just three years old and the next will be with Sarah Barclay from the Medical Mediation Foundation.

29. On 30 November we will host our first Open meeting in Manchester with complainants, complaint managers and other stakeholders and more such events will follow in the future. On 4 December, in partnership with the LSE, we will launch an annual Ombudsman lecture series, which will provide an opportunity to highlight themes and issues emerging from the sector, the first of which will focus on the legacy of 50 years of the Ombudsman and what the future may hold.

Financial controls

30. In 2016-17 we consolidated the improvements we had made to our financial management, accounting and controls following the qualification of our accounts in 2014-15. This has enabled us to return this year to laying our Annual Report and Accounts before Parliament in July, rather than in November as we did in 2016. The National Audit Office certified our 2016-17 accounts with an unqualified audit opinion, without modification.

Ombudsman reform

31. The Cabinet Office published the Draft Public Service Ombudsman Bill in December 2016. We responded jointly with the Local Government and Social Care Ombudsman (LGSCO) to welcome the proposals and to make a small number of suggestions on how the draft legislation could be strengthened further, most importantly from our perspective including the provision of the own-initiative investigation powers that the vast majority of our international counterparts have.

32. We are aware that the pressures of Brexit on parliamentary time make legislation in this session highly unlikely and we therefore continue to work closely with the LGSCO. We have already created a joint investigation team that investigated 352 organisations in 2016-17 in areas where our respective jurisdictions overlap, such as hospital discharge, adult mental health and care of older people in nursing homes. We are also working closely with LGSCO on the development of our new strategy as they develop their own, so we can maximise the opportunities for aligning our services where it makes sense to do so.

Annex – The Parliamentary and Health Service Ombudsman's new draft three year strategy

Objective 1: To deliver an independent, impartial and fair Ombudsman service

Our aim is to deliver a consistent, high quality ombudsman service that uses the right tools, at the right time, to make fair, final decisions for both complainants and the bodies in jurisdiction.

People who bring their complaints to us expect to have their complaints taken seriously, to be listened to and treated with respect, and to be dealt with fairly and in a timely fashion. We will hold ourselves to these standards by implementing a new operating model that is more people-centred, one that streamlines our processes, helps us manage the demand for our service, improves communication and transforms how we approach our casework. Learning from good practice in the wider ombudsman sector, we will pilot the use of early dispute resolution methods, adding these tools to our casework toolbox. In addition, we will review how and when we draw upon clinical advice when resolving complaints.

We will create a culture supportive of continuous improvement that encourages staff to live our values.

It is important for us to continually learn and improve how we deliver our services. Over each year of our strategy we will develop our cadre of professional casework staff so that they have the right skills, knowledge and judgement. In addition to delivering a comprehensive, new, staff training programme we will develop an accreditation scheme and seek to embed ombudsman values into everything that we do.

Improving how we communicate with people who complain to us is at the heart of our development. Building on the standards in our Service Charter we will explain how we work, how our decisions are reached and what they mean in practice. Complainants rightly expect decisions about their cases to be understandable and not obscured by bureaucratic jargon. They also expect our staff to be professional and apply consistent quality standards in case reviews and decisions. We will address these behaviours through continuing professional development and will work towards greater accessibility by publishing clearer guidance and ensuring our online resources are understandable, including by those most vulnerable in our society and those that support them. We will be clear once we have taken a decision that it is final, helping all parties to achieve closure.

Our transformation will also focus on being a well-run and well-led organisation, with leaders and staff at all levels of the organisation having the right tools to do their jobs properly. As part of our strategy, we will undertake a review of our governance, including consideration of different options for ensuring the voice of service users can best be heard.

In 2018-19 we will:

- Complete delivery of our new operating model and initial staff training programme.
- Identify early dispute resolution we can easily introduce.
- Build on our staff training programme by taking steps towards acquiring professional accreditation.
- Develop our Service Charter to broaden how we monitor and measure our performance by introducing a balanced scorecard approach that improves business intelligence, supports decision making and improves accountability.
- Review how we draw upon clinical advice for resolving complaints, adapting our operating model and training as needed.
- Review both our governance and operational policies to ensure we are fit for purpose and how we demonstrate value for money.
- Consider how the voices of service users can be heard at all levels of our organisation and introduce the options we identify to achieve this
- Begin scoping how we will pilot and evaluate mediation.

In 2019-20 we will:

- Pilot the use of mediation and more complex early resolution methods so that we can build up the number of casework tools available to our staff.
- Introduce changes resulting from our governance review. Complete delivery of our 3-year 24% savings target by becoming a more streamlined and efficient organisation.

In 2020-21 we will:

- Begin accreditation of caseworkers.
- Evaluate our mediation and more complex dispute resolution pilots, implementing the most successful as part of our new 'Ombudsman toolbox'.
- Build the approach from our pilots into our training and accreditation programme so our staff are fully equipped to use these methods.

What will be different at the end of the three years?

- We will have introduced new ways of working that resolve cases sooner, improving the quality of our decisions and the overall experience of people making complaints.
- We will have invested in the capability of our staff so that they are fully equipped to deliver a people-centred and professional casework service, transforming our organisational culture in the process.
- We will have worked within our means to deliver an effective and efficient service, improving how we measure our performance and demonstrating value for money.
- We will have improved our governance to ensure we are fit for purpose, and we will have enabled the voices of service users to be heard at all levels within our organisation.

Objective 2: To increase the transparency and impact of our casework

Being an exemplary ombudsman means holding ourselves accountable to the same high standards that we hold others to. For the public to have confidence in us and what we do, we need to become a more open, accessible and transparent service. Improving how we communicate – with the people who complain to us, with public sector organisations we investigate, with our partners and with the general public – underpins each of our planned activities. Better use of digital technology will help us achieve this.

First, we will publish more information about the outcomes of our casework online. This will include where we have made findings against the bodies in jurisdiction and setting out what steps they have taken to comply with our recommended actions. Often, people who make complaints to us have been injured or suffered harm, losing loved ones and experiencing bereavement. Publishing what we have found can help public services learn from what went wrong and help them to restore trust whilst ensuring that future service users do not face similar experiences.

In the short term we will explore how we can publish casework data and make it more useful for public services, regulators, complaints handlers and improvement agencies as well as complainants. Longer term, we plan to publish much more of our casework online so citizens can see more clearly the impact of our work on public services, and complaint handlers can increase their understanding about good practice. As well as making us a more transparent organisation, this will also align us to the current practice of the Local Government and Social Care Ombudsman (LGSCO).

In addition to publishing our casework, we will target our Insight reports so that important lessons from our casework and systemic reviews contribute to raising standards in public services, especially within the NHS. This does not mean setting arbitrary targets, but making sure we make constructive proposals for change when our casework indicates this is needed. We will also continue to explore what more we can do in this area with LGSCO through the insight gathered by our joint working team and emerging issues from the intersection of health and social care.

We plan to continue improving how we engage with complainants by further developing the programme of open meetings we commenced in November 2017 and the Radio Ombudsman podcast series launched in September 2017. We will continue the programme of annual Ombudsman lectures we began in December 2017. We will identify new opportunities to get direct feedback from those that use our service, in addition to the quarterly outturns of user feedback related to our service standards.

In 2018-19 we will:

- Start publishing quarterly data about the health complaints we receive.
- Develop an approach to setting out information about our findings and the level of compliance with our recommendations and begin publishing this information.
- Publish a transparent set of principles and case studies about the use of financial remedy.
- Build on our training programme to improve the quality of our investigation reports, by developing the capability of staff to produce publication ready reports.
- Scope a project for publishing the vast majority of our casework online, as well as exploring what other material we should publish proactively.
- Start a review that explores new ways to get feedback from people who complain to our service and begin introducing the most effective methods we identify.

In 2019-20 we will:

- Publish our first annual report on the complaints we receive about the health system, highlighting trends and key insights as we already do for parliamentary cases.
- Deliver an online solution for publishing much more of our casework.
- Begin publishing some of our casework online.

In 2020-21 we will:

- Complete our plans to publish much more of our closed casework decisions online, drawing out insights for the bodies in jurisdiction.

What will be different at the end of the three years?

- We will be publishing much more data and information about our casework online, including about our findings and levels of compliance, enabling complainants and bodies under our jurisdiction to have greater confidence in what we do.
- We will be targeting our Insight reports so that important lessons from our casework and systemic reviews contribute to raising standards in public services, starting with the health service.

Objective 3: Working in partnership to improve front-line complaints handling and public services

Our complaints resolution service is at the end of what can often be, for many people, a traumatic and emotional process navigating the public sector complaint system. Whilst we must be unquestionably independent, we recognise that we are part of a larger constellation of public sector organisations seeking to improve quality and prevent harm in public services, especially in healthcare. Being more externally focused requires us to strengthen our relationships and collaborate with strategic partners to influence how the public sector responds when things go wrong.

We plan to work with a number of strategic partners across the public sector to develop tools that enable frontline complaint handlers to deal with what are often complex and sensitive issues. This might include finding ways to share good practice, developing curriculum materials and offering e-based training. We also want to support leaders at the very top of their organisations to create the culture we know is necessary to make sure their organisations learn from mistakes.

We already work closely with a number of bodies across our jurisdiction to do this. The organisations include NHS England, NHS Resolution, the Health Service Safety Investigation Branch and NHS Improvement. They also include the HMRC chaired Cross-Government Complaints Forum in Whitehall. We want to expand the work we do in this area. Closer working with health service and other government partners will help shape how complaints are initially handled by front-line service deliverers.

The ongoing policy shifts that are bringing health and social care together - such as integration, new care models and joint commissioning - underscore the need to strengthen our existing partnership with the LGSCO. During the next three years we will build on this close working relationship to align further how we resolve complex health and social care complaints and to publish critical insights together.

To stay abreast of ombudsman good practice, we will also contribute to the burgeoning field of ombudsman activity in this area, working with our colleagues throughout Europe to learn from them and share our own expertise.

In 2018-19 we will:

- Build on and strengthen our existing external relationships, whilst developing new strategic partnerships with the shared aim of setting common standards and expectations for resolving complaints, starting with the NHS, as well as identifying tools and training opportunities to help meet these standards.
- Review the challenges to casework posed by changes across the health and social care sectors, working with LGSCO on this as needed.

In 2019-20 we will:

- Develop and publish a number of new tools and training options for consultation with our target audiences, piloting different delivery mechanisms to test what works.
- Begin to roll out tools and training where we think this is most needed.

In 2020-21 we will:

- Complete the roll out of those tools and training approaches we find work best, and re-launch a new version of 'My expectations' to reflect any relevant changes we think are needed as part of this process, ensuring the revised guidance is co-produced with service users.
- Explore how we can share the experiences we have had delivering our strategy with Ombudsmen colleagues and invite them to share their views on what we should include in our next strategy.

What will be different at the end of three years?

- We will have stronger relationships and collaborate regularly with strategic partners to influence how the public sector responds when things go wrong, from sharing good practice to offering training to complaints handlers.
- Drawing insights from our casework, we will be working with our partners to apply these lessons in order to improve the delivery of public services, starting with the NHS.
- We will be engaging actively with other ombudsman services in the UK and internationally to exchange good practice and to improve how we operate further.