Memorandum to the Public Administration and Constitutional Affairs Committee by the Parliamentary and Health Service Ombudsman

December 2015

In this Memorandum we set out the progress we have made in delivering more impact for more people and transforming the service we offer our users in 2014-15 and over the first half of 2015-16.

Introduction

1 The Parliamentary and Health Service Ombudsman was established by Parliament. We make final decisions on complaints that have not been resolved by the NHS in England, UK government departments and some UK public organisations. We are impartial, independent and free for everyone.

2 Our role is to help people with their complaints when there has been an injustice or a hardship because an organisation has not acted properly or put things right. We then use our casework to shine a light on failures where services fall short and share this insight to help others improve services and complaint handling.

3 Our vision is for everyone, whoever they are, to be confident that complaining is straightforward, fair and can make a difference.

4 Two years ago we started consulting people about our service and they told us there were many more people who wanted access to justice than were getting it. They also said that people weren't complaining because they weren't convinced it would make a difference nor have an impact on the service they received. We began a process to build the foundations for change, transform our organisation and fully realise a modern ombudsman service.

Building the foundations for change

5 2014-15 saw us successfully complete the first 'building' phase of our modernisation programme. In this phase we increased our capacity, and used the insight we gained from handling more complaints to support Parliament in holding organisations to account. We became more transparent about our operations and conducted a major listening exercise to help fundamentally re-shape our service.

6 People told us that they wanted to be able to see the results of our work. We now publish selected summaries from our casework portfolio. In 2014-15 we published 613 summaries, searchable on-line by topic, locality or organisation.

7 People also told us that they wanted more real-time information about how we were performing, so we began publishing monthly performance statistics on our website.

8 Part of our journey to a modern ombudsman service is the development of a service charter. We worked with people who have brought their complaints to us, groups who have a special interest in our work, and organisations we receive complaints about. This helped us to develop a series of draft commitments that people can expect us to deliver when they use our service.

9 We are successfully realising tangible benefits through working closely with the Local Government Ombudsman (LGO). We established a joint team to carry out investigations that span health and social care. Cross-membership between our boards is helping both organisations prepare for a public ombudsman service.

10 Providing answers for people who complain is the foundation of our work. We are doing this at a time when there is significant pressure on public finances so we must also deliver value for the taxpayer. Our total costs have been broadly flat for five years while we have delivered more impact for more people. In 2014-15 we:

- **Completed ten times more investigations than before we began our modernisation programme.** To deliver more impact for more people we lowered the threshold to be reached before we would carry out an investigation, completing 4,159 in 2014-15 compared with 384 in 2012-13.

- **Took less than half the time from allocating a case to an investigator to completing the investigation than we did before we began our modernisation programme.** Investigations took an average of 117 days in 2014-15 compared with 305 days in 2012-13.

- **Achieved high levels of independently-surveyed customer satisfaction.** Satisfaction ratings are naturally influenced by whether we uphold a complaint. In 2014-15 88% were satisfied or very satisfied with our service if we fully upheld their complaint, and 49% were satisfied or very satisfied if we did not uphold.

11 We have delivered this by moving resources from corporate services to what people value – investigations and final decisions. More efficient working and operational improvements in productivity saw our cost per case investigated reduce by 6% in 2014-15. We also invested in our capacity to deliver impact beyond our work on individual complaints by investing in our capacity to investigate systemic issues across the public sector. This has begun to deliver impact by helping Parliament hold services to account though the type of reports we describe later in this memorandum.

Transforming our organisation

12 In 2015-16 we have moved into the second of the three phases of our modernisation programme - transforming what we do and how we do it.

13 Our service charter will provide a benchmark for our new ways of working and make sure people know what to expect from us. Following extensive development work, the draft service charter is the subject of a formal public consultation which will end on 13 January 2016. We will assess the feedback we receive and finalise the

charter. We will embed internal changes to make sure we can meet the promises and then spend a period of time testing our performance against the commitments in our charter. By summer 2016 we expect to be able to show how we are delivering against our charter.

14 We continue to change the way in which we conduct investigations so that they are more efficient and transparent. We're investing in new technology so that people can complain much more easily over the phone and online. New technology will also help us track our performance and quality to ensure we deliver on our service charter. This will enable us to focus further service improvements on those areas which are most meaningful for our users. Our on line performance reporting will be expanded to give a wider view of our performance against the service charter commitments.

15 These changes require a continuing cultural shift in our organisation. We are realistic that it will take some time to get everything right, but we are committed to doing so and to being open and honest about our progress. In the first two quarters of 2015-16 we:

- **Completed 1,912 investigations.** This is in line with the 1,910 investigations completed in the first two quarters of 2014-15.

- **Took an average of 120 days to carry out an investigation.** We continue to fine-tune our ways of working to accommodate the larger numbers of cases we are handling. The time we took to carry out actual investigations remained in line with the first two quarters of 2014-15 (118), but there have been some bottlenecks earlier in our processes which have caused delays. We have taken on more staff to sort out these delays.

- **Achieved customer satisfaction ratings of 89% in cases where we fully upheld a case and 40% where we did not uphold a case.** The rating for fully upheld is marginally higher than the 88% achieved in the first half of 2014-15. However, the satisfaction rating for not upheld shows a drop from 52% in the first half of 2014-15. We received these figures shortly before the submission of this memorandum and are carrying out further analysis to understand and address underlying issues which may have led to this result.

16 Our people are our most important resource. Our 2015 staff survey showed a staff engagement rating of 54%. Our 2013 staff survey gave a rating of 48%. We want to ensure that staff engagement continues to improve. Following the 2015 survey we identified a number of key themes for development that sit across the whole organisation, where improvement should have a positive impact for all staff:

- Leadership
- Change and involvement
- Feeling valued
- Job satisfaction and development

17 Project teams are bringing staff together from across the organisation to identify the actions we can take that will lead to improvements in each of these areas. Once this is done, those actions will be shared with the whole organisation and a senior member of staff will be given responsibility for implementing actions in each area. Our next full staff survey will be in 2016.

18 We have committed as part of the Government's Comprehensive Spending Review to reduce our costs by 24% over the next four years. We have already made investments in new casework management, telephony and finance systems that will improve productivity as they are brought into operation as well as improve our ability to serve people well and provide more insight to Parliament. We have made these investments in consultation with the LGO, so that we can continue to converge our services in expectation of legislation which will bring our services together.

Supporting Parliament in holding services to account

2014-15

19 The Public Administration Select Committee (PASC) held an evidence session to scrutinise the Government's progress on implementing recommendations made in our reports, *Time to Act, Severe Sepsis: rapid diagnosis and treatment saves lives* and *Midwifery supervision and regulation: recommendations for change*.

20 PASC acknowledged the seriousness with which the Government was addressing issues around sepsis. PASC was less encouraged by progress to remove the conflict of interest in midwifery supervision, which we identified. It urged the Government to take substantive legislative action before the General Election. In July 2015 *Learning not blaming* confirmed the Government's intention 'to act as swiftly as possible … by introducing an Order in Council made under section 60 of the Health Act 1999', but without setting a timetable for this.

21 We presented evidence from our casework to the Health Select Committee demonstrating the poor care and treatment experienced by too many people at the end of their lives. We also presented evidence to PASC on our initial findings from a review of 150 cases where there was an allegation of avoidable harm or death. This evidence underpinned the PASC report *Investigating clinical incidents in the NHS*.

April 2015 to date

22 Our report *Dying without Dignity* highlighted cases where people's suffering could have been avoided or lessened with the right care or treatment, as they approached the end of their lives. The Public Administration and Constitutional Affairs Committee used the report as the basis for an evidence session on how services could be improved for up to 355,000 people in England who could benefit from end-of-life care. The Committee's report on the issue invited the Government to set out how it will make sure necessary improvements are made, and highlighted the need to ensure that progress can be objectively assessed.

23 Our publication *Complaints about UK government departments and agencies, and some UK public organisations 2014-15* highlighted that last year we upheld more than two thirds of the 158 complaints we investigated about the Home Office and its immigration agencies, Border Force, UK Visas and Immigration and Immigration Enforcement. This is more than double the average rate of upheld cases for public sector organisations. This information was used by the Home Affairs Select Committee during a scrutiny session with the Home Office's Permanent Secretary.

24 In our *Report of the results of an investigation into a complaint about High Speed 2 Ltd (HS2 Ltd)* we outlined how the organisation had dealt with six families, whose small community faced break-up under plans for the new high speed rail network. The families wanted HS2 Ltd to help them relocate their community together to a new site. HS2 Ltd failed to respond fully and promptly, causing the families worry, distress and frustration. We laid this report before Parliament so that it can hold HS2 Ltd to account for learning from this case and to encourage other public organisations to take note of our findings about engagement and consultation.

25 Our *Review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged* cast a question mark over the current ability of NHS organisations in England to conduct effective investigations where it is alleged that someone may have been harmed, or died, avoidably. Trusts are not always identifying patient safety incidents and are sometimes failing to recognise serious incidents. When investigations do happen, the quality is inconsistent, often failing to get to the heart of what has gone wrong and to ensure lessons are learned.