

Parliamentary  
and Health Service  
Ombudsman

# RESOLVE

*News from the Ombudsman Service*

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### Parliament and our work



*Julie Mellor talks about the relationship between Parliament and the Parliamentary and Health Service Ombudsman.*

Insight from our casework allows us to support MPs in holding organisations to account for the way they deliver public services. The Public Administration and Constitutional Affairs Committee (PACAC) uses our reports to help them hold public services to account for how they learn from mistakes, and how they use that learning to improve public services for all.

In September 2015 PACAC held an evidence session on '[Dying without Dignity](#)', our report on end-of-life care. Later this month the Committee will hold similar sessions on our [report into a complaint about HS2 Ltd](#) and our [review of the quality of NHS investigations](#). Individual MPs can also look on our searchable database of individual case summaries to see what cases relate to their area. You don't have to be an MP to take advantage of this function – just click [here](#).

PACAC also looks at how we do our work. Last month, along with Managing Director Mick Martin, I attended a formal [scrutiny session](#). During the session, we discussed progress towards our goal of delivering more impact for more people who have experienced hardship or injustice as a result of mistakes made by public service providers.

We've completed the first phase of our five-year strategy and are now meeting demand for our service. We acknowledged that while we have been adjusting to a higher volume of cases, some people have had to wait too long for our service. We have put in place temporary resources to eliminate those queues and people coming to us are now having decisions on their cases made more quickly.

The second phase of our strategy sees us focussing on the quality and consistency of our service. Our quality standards have been designed with people and organisations that use our service and we will soon start publishing information on how we are performing against those standards.

I believe that even more can be done to make public ombudsman services more accessible, better able to hold organisations to account, and better value for money. PACAC has played a key role in promoting ombudsman reform, including provisions to make sure ombudsman services are accessible to those who are unable to make a complaint, or fear the consequences of complaining. They have recommended, for example, that ombudsman services are able to investigate a potential service failure causing hardship or injustice to people without a complaint being made. This would help those least able to complain themselves. I am pleased that the Government intends to publish draft legislation on ombudsman reform before the end of the current Parliamentary session.

Julie Mellor  
Parliamentary and Health Service Ombudsman

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## More News

### Using feedback to transform our service - an update on our Service Charter



*The consultation on our draft service charter has come to an end and has provided us with invaluable input from a wide range of people and organisations.*

Our consultation on our [draft service charter](#) closed on 13 January 2016, marking the final wave of a comprehensive year-long dialogue to create a clear set of promises to everyone who uses our service.

Over the past year we have consulted past and potential complainants, our critics, the range of organisations we investigate, our staff, and the consumer advocacy community on what they can expect from our investigations and our service.

Between November 2015 and January 2016, 179 people fed back on the draft service charter and over 2,000 people engaged throughout the year. If you took part, thank you; your input has been invaluable.

The finalised service charter will be our public statement of the changes we are making so that we are wholly transparent with the public and the organisations we investigate. But it is more than just a document; the feedback from all we have heard has helped us to evaluate everything we do and how we do it; from the way we explain our role to people and what they can expect from our service, to how we carry out our investigations and communicate our decisions.

Our new service model is based on things we learned during engagement on the charter. The service model describes our casework process and sets out in detail how we expect our staff to work so that everyone receives a consistent service and has a clear understanding of how we do things. It has already changed working practices and processes for delivering sound decisions and good service experiences.

Our focus now is on getting our service right and being consistent in how we work. Engaging the organisations we investigate on our service model is now underway and we will continue to draw on the feedback we have received to inform our learning and make adjustments to our service as appropriate.

Our analysis of the feedback we received for the consultation, along with our response and the finalised charter, will be shared via Resolve in the coming months.

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## Why are older people afraid to complain?



*Many older people are afraid to raise the alarm when something goes wrong in their care and worry about what will happen to them if they do.*

Older people are some of the most regular and vulnerable users of health and social care services, but when it comes to complaining about poor services they received, many are reluctant or afraid to complain. Fear of the consequences of complaining means many older people are suffering in silence whilst opportunities to rectify issues and improve services are being missed.

On 30 December 2015, we published our report [Breaking down the barriers](#), which looked at why older people are afraid or reluctant to complain about the NHS despite accessing its services more than other groups of people.

The report revealed that people over the age of 75 often lack the knowledge and confidence to complain, and worry about the impact complaining might have on their future care and treatment; many fearing that complaining will simply make matters worse for them.

Through a combination of personal testimonies from focus groups with older people,

information from a national survey we conducted, and evidence from our own casework, our report highlights the significant barriers that older people can face when looking to complain about their care.

The report found that:

- Over half (56%) of those aged 65 and over who had experienced a problem but not complained, were worried about the impact that complaining might have on their future treatment.
- Nearly one in five (18%) people over the age of 75 did not know how to raise a complaint about the NHS or a social care provider
- Among those over the age of 65 who were unhappy with a service, but who didn't complain, over a third (32%) felt that complaining would not make a difference
- Less than a third of the older people surveyed could recall being offered support to make a complaint.

These are barriers which can dissuade or prevent anyone from making a complaint regardless of age. However, for older people there are often many additional factors - such as ongoing reliance on NHS care or living alone - which can make these barriers even harder to overcome.

In order to overcome these barriers, change needs to happen. Our report makes a number of recommendations to improve older people's experience of the complaints system. The report recommends all NHS and social care providers should:

- make older people aware of how to complain;
- point them to the support that is available to them;
- make it absolutely clear that their future care will not be compromised if they complain;
- use the framework contained in '[My expectations for raising concerns and complaints](#)', which sets out what good complaint-handling looks like from the perspective of patients and service users, and which can be used to measure how effectively complaints are being handled.

Implementing the recommendations will allow older people to be more confident in speaking up and complaining when things go wrong and not suffering in silence. It will also allow service providers to handle complaints more effectively, allowing complaints to act as opportunities for improving services and preventing mistakes from being repeated.

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## Government responds to consultation on a Public Service Ombudsman



*The Government has set out its view on what organisations and people said about its proposed approach to Ombudsman reform.*

On 17 December 2015, the Government published its [response](#) to the consultation on a Public Service Ombudsman. This follows the publication of a consultation paper '[A Public Service Ombudsman](#)' that was published earlier in 2015. The paper asked users of services and other interested parties to reflect and comment on the proposals to reform the current public service ombudsmen sector and create a new Public Service Ombudsman.

The consultation ran for 12 weeks and received 158 responses from a broad range of organisations and individuals, including ombudsmen, charities, local authorities, housing associations, professional bodies, academics and individuals with direct experience of the current system.

The paper had 10 questions in total and included questions on the principles that should underpin reform of the Ombudsman service and the creation of a single Public

Service Ombudsman. The majority of respondents to these questions welcomed the suggestions made within the paper. You can read our response [here](#).

The government will now continue to work with interested parties to clarify further the role, structure, governance, and accountability of the new service. Following this, the government will publish a draft legislation that sets out the detail of the proposals for further consideration before the end of the current Parliamentary session.

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## A new National Guardian to support whistleblowers



*The first National Guardian has been appointed to support whistleblowers and improve reporting culture within the NHS.*

On 7 January 2016, the Care Quality Commission (CQC) appointed Dame Eileen Sills DBE - the Chief Nurse at Guy's and St Thomas' NHS Foundation Trust - as the first

National Guardian for speaking up safely within the NHS.

The National Guardian is a new role created as a result of recommendations made by Sir Robert Francis in his 'Freedom to Speak Up' review in February 2015. The review found that patients could be put at risk of harm because vital information about mistakes and concerns was not being routinely raised by NHS staff. This was either due to reporting systems being insufficient or not used, or because healthcare professionals did not feel able to speak up. This new role aims to remedy that by supporting whistleblowers in the NHS and improving reporting culture.

The work of the National Guardian will involve leading, advising, and supporting a network of individuals working within NHS trusts, appointed as local 'freedom to speak up guardians'. These individuals will be responsible for developing a culture of openness at a trust level. The National Guardian will also share good practice, report on national or common themes, and identify barriers to having a truly safe and open culture within the NHS.

Dame Eileen will take up the post as National Guardian from 1 April 2016 and will work in partnership with the CQC, NHS England and NHS Improvement, but will work independently in her role.

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## Our work in pictures



*Watch and share our newly-produced animations explaining the work we do and how we help with complaints*

In December 2015 we released a series of short animations to explain who we are and how we deal with complaints that are brought to us.

Currently there are three animations that explain how we can help with complaints, what happens when we receive them, and what steps we take once we have decided to investigate a complaint. If you haven't had a chance to watch the videos yet, you can find them on our [website](#).

Please feel free to share the animations with your network through your website, newsletters, and social media channels.

## The role of clinical advisors in handling cases brought to us



*We explore how our caseworkers can draw on expert clinical advice to help them in their work*

Clinical Advisors play a very important role in the way we consider complaints that are brought to us. Coming from a wide range of professional backgrounds, they provide our caseworkers with expert advice on clinical matters.

The role of the Clinical Advisor is to help enhance the understanding of caseworkers on any clinical issues raised in a complaint, and on whether the clinical care and treatment provided was in line with established good practice and recognised standards.

Specific templates and guidelines are used to ensure clear and impartial advice is provided in a structured and systematic manner. When answering questions from caseworkers, clinical advisors will provide rationale to support what they have said. When relevant to a case, they will also support their advice with reference to recognisable and relevant professional standards. Where no such professional standards exist (or existed), they will outline what would have been considered to be 'established good practice'. Clinical advice is regularly quality assured and peer reviewed.

Our Clinical Advisors come from a wide range of professional backgrounds which include GPs, physicians, surgeons, dentists, as well as specialists in gynaecology and obstetrics, care of elderly physicians, ophthalmology, emergency care, orthopaedics, radiology, mental health, nursing, and paramedics. All of our Clinical Advisors are in current clinical practice in the NHS.

For more insight into the work of our clinical advisors, you can have a read of this interview that was published last year in *GP Life*: ['GP Dr Uzma Qureshi interview: The GP ombudsman'](#)