PHSO - Labyrinth of Bureaucracy

Follow-up report to the November 2014 Patients Association report on the Parliamentary and Health Service Ombudsman, "The 'Peoples' Ombudsman – How it Failed us"

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Forward and Introduction

On 18th November, 2014 the Patients Association released a report on the failings of the Parliamentary and Health Service Ombudsman (PHSO) http://www.patients-association.com/news/peoples-ombudsman-howitfailedus/ . The findings and recommendations from that report can be found on pages 21-23 and the recommendations still stand. The report was written because of the high number of people who were contacting the helpline distraught, frustrated and angered by their experience of the PHSO. Having been let down by the PHSO, patients and families wanted to share their experience with the Patients Association in the hope that we could offer some help or support.

In that report we stated that the PHSO reportedly costs the public £40 million pounds a year. However we felt that the real cost was far greater than that because prolonged investigations often meant patients or their families had to give up employment to deal with the demands and inadequacies of the PHSO. We concluded that the impact of the inadequate, untimely and unacceptably flawed investigations by the PHSO simply couldn't be measured in financial terms alone. Patients' experience of the PHSO only served to exacerbate their grief, stress and ill health.

In the days and weeks after the report was released we were inundated by calls, emails and letters from patients, families and representatives and to date we have been contacted by over 200 people. They are all at different stages of the process, some completing the initial paperwork, some left only with an option to apply for a judicial review. **All of them agreed with our report and all of them described their experiences of the PHSO as being negative.**

On the PSHO's own website they recognise the common complaints raised about their own service but from what we hear, nothing seems to have improved and lessons do not appear to have been learnt. People describe "battling the PHSO" and that they have "no intention to give in without a fight" which we believe must be the opposite of what people should have to do when engaging with the so called last resort of complaints. **We continue to hear similar feedback from patients on a weekly basis.**

Progress

On 10th December, 2014, Katherine Murphy, Chief Executive of the Patients Association, wrote to Jeremy Hunt, MP, Secretary of State for Health reiterating what we had asked in the report, namely that both Government and the Public Administration Select Committee read our patients' stories, **consider our recommendations and hold the PHSO to account for its actions**. We asked, "If the PHSO was a school or a hospital, evidently failing so demonstrably, special measures would be introduced as a matter of urgency to stop the rot and prevent the situation from deteriorating further. Why is equivalent action not being taken in relation to the PHSO?"

On 16th December, 2014 the Public Administration Select Committee (PASC) launched an enquiry into how incidents of clinical failure in the NHS are investigated and how subsequent complaints are handled. Among other aspects they wanted to hear views on the current capacity of the PHSO to manage and investigate complaints relating to clinical incidents, and their ability to analyse and assess medical evidence. Katherine Murphy provided written and oral evidence on 10th February, 2015 and Jeremy Hunt MP, Secretary of State for Health, provided oral evidence on 25th February.

On 21st January, 2015 the House of Commons Health Committee published its report, "Complaints and Raising Concerns,' which concluded that the current system for complaints handling remains variable. Too many complaints are mishandled with people encountering poor communication or, at worst, a defensive and complicated system which results in a complete breakdown in trust and a failure to improve patient safety.

The Role of the PHSO

The PHSO was set up to investigate complaints where individuals have been treated unfairly or have received poor service from government departments, other public organisations and the NHS. They state that they are the final step of the complaints system, giving people an independent and last resort to have their complaint looked at.

The PHSO state on their website:

- They will investigate complaints fairly
- They won't take sides
- The process will be straightforward
- The process will be thorough
- That complaining will make a difference
- They put the people who use their services at the heart of everything they do.

The PHSO are aware of the public's criticisms and declare they are changing the way they work and are creating a service charter: a set of promises so the public know what they can expect. Unfortunately for all of those who had cause to write to us prior to the publication of our original report on the PHSO and for those 200 who have contacted us since, this charter is too late.

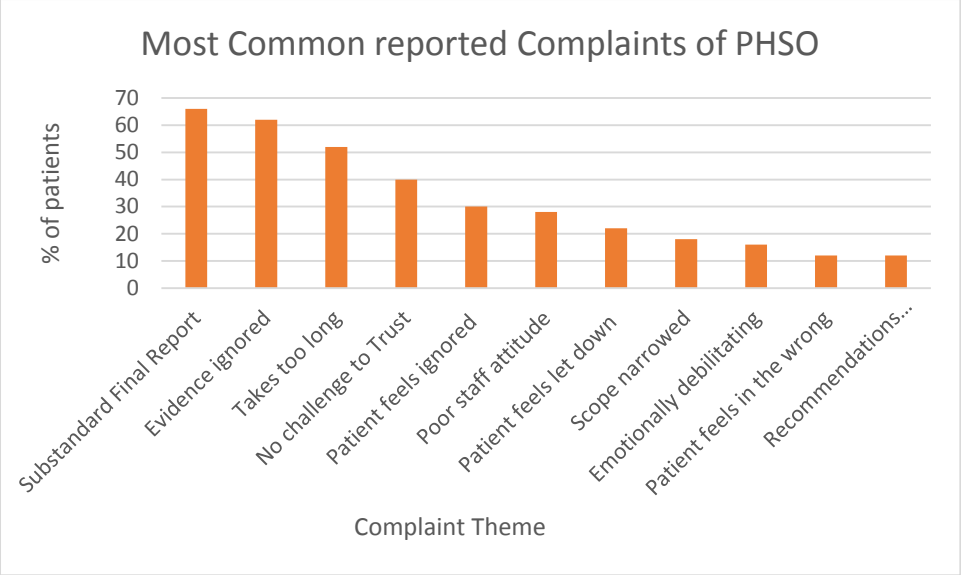
The Patients Association has collated the responses which evidence that the PHSO:

- **Does not investigate complaints fairly** - Evidence is ignored.
- **Takes sides with the organisation they are supposed to be investigating** - Even when there is clear evidence to do the contrary.
- **Does not make the process straightforward** – They ask many questions that the complainant has already answered or cannot answer. They change case worker/investigator without informing the complainant. They take weeks to respond and then ask a question which could be answered by looking in the submitted paperwork.
- **Produces reports that aren't thorough or the product of comprehensive investigation** - Final reports are full of inaccuracies despite the inaccuracies being highlighted by the complainant when the report is in draft format.
- **Fails to make a difference through the complaints process** - Trusts aren't asked for assurance that recommendations are acted upon and so change is not implemented and improvements are not made.
- **Does not put patients central to process** - Patients are made to feel like they are a nuisance for complaining, that they are wasting the PHSO's time and that there are others worse off.

The Patients Association strongly believes that the complaint process can and must improve and it is important to note that this report is not collated to discredit those who work in this field because there is an enormous of amount of positive work done. In its role as advocate, the Patients Association liaises with Patient Advice and Liaison Services (PALS) and Complaints staff who do everything that they can to get it right for the patient. There are patients who go through NHS, Local Government Ombudsman, and PHSO complaints processes and are satisfied with the outcome. Unfortunately these are not the patients we tend to hear from and **it is for the patients who have contacted us with their stories that we dedicate this report**.

Below are a table and graph showing the themes of complaints about the PHSO.

Complaint Themes	% of patients who reported the theme
Final report factually incorrect, inconsistent or substandard level of investigation (weak justification for the PHSO decision); Queries about the investigator's competency.	66
Even if there is evidence that contradicts what the Trust has said, the PHSO appear to overlook or ignore the evidence. Apparent siding with the Trust.	62
All communication takes too long or communication only occurs if the complainant contacts the PHSO.	52
PHSO seems unwilling to challenge information that the Trust supplies or to independently investigate any other topic which may be relevant but hasn't specifically been identified by the complainant. Possible cover-up or misdirection - Apparent siding with Trust.	40
Not engaging with or listening to the complainant/ complainant feels ignored / Feel like they are not believed.	30
Attitude of case handler, not open minded, rude, dismissive or insensitive and the decision predetermined.	28
Patient feels completely let down.	22
Complaints amended so the scope is narrowed and/or sections arbitrarily dismissed (therefore parts not investigated and questions not answered.)	18
Large amount of time and energy spent is emotionally debilitating. Feel that the PHSO is relying on the complainant giving up	16
Patient feels as if they are in the wrong for complaining.	12
Doesn't know if the PHSO recommendations were put in place. PHSO recommendations were too weak to affect any positive change.	12
Draft report issues, given a very short time to comment and even then the draft doesn't change.	12
Information/evidence/case file is lost by the PHSO.	12
PHSO told complainants they were out of time despite their extenuating circumstances.	8
National Institute for Health and Care Excellence (NICE) Guidance or NHS/Trust policies quoted which weren't in date at the time circumstances occurred.	8
Complainants with learning disabilities felt that the PHSO did not accommodate their needs. **(Reported by 100% of complainants who identified themselves as having learning disabilities.)**	4



Sub-Standard Final Report

66% of people who contacted the Patients Association regarding the PHSO complained about the level of investigation and the standard of the final report. People reported that the final report was sub-standard citing that the report was **inconsistent**, **factually incorrect** or the **reasoning was weak.** Investigators were criticised as not having the necessary skills because the **level of investigation was extremely poor**. Brian Bonsall took his complaint to the PHSO regarding the fact that his late wife Avril had to wait 94 days for her surgery which was in breach of the 62 day maximum target. *"I then hoped for an independent and thorough investigation by qualified, knowledgeable and competent staff (at the Ombudsman.) This was not the experience I had, I regret to say. There was no knowledge shown of the cancer waiting time targets or the guidelines accompanying them. There was no sign of cross referencing, analysis, or judgement by the investigator."*


Avril Bonsall

The draft investigation report ignored any reference to cancer targets. So Mr Bonsall showed the investigator the paragraphs in the guidelines where the targets and surrounding advice was to be found. The investigator did not appear to know about the targets despite that being one of the key aspects of the complaint. What exactly had been investigated? Unbelievably the final report was published without any discussion of targets and Mr Bonsall had to ask for a review.

Complainants go to the PHSO expecting that the investigator will systematically examine the details in an attempt to learn the facts and with all those facts to come to a logical and reasonable decision. They expect this because the PHSO promises a thorough and fair investigation. However patients complain that despite **waiting nearly a year for the final report** it simply regurgitates what the NHS organisation had concluded without any evidence to demonstrate that a new, independent and thorough investigation had taken place.

The family of Ronald James Coker complained about the nursing care Mr Coker received and presented their complaint at the 'listening events' which formed part of Sir Bruce Keogh's 2013 review. The family took the complaint to the PHSO and wrote, "*We hoped that the PHSO would start a new, full and honest review of the whole complaint but sadly they work on the same basis as the Trust - to Deny, Delay, Defend and Deceive*. *No reference in the report is made to the photos, videos and CD we provided with clear evidence of our complaint. 27 days of our father's inpatient notes are still missing and yet they (the PHSO) have categorically stated the notes were used to complete the investigation.* ***As far as we are concerned if they did not have this information (which we believe is the case) then how could they carry out an investigation at all?"***


Ronald James Coker

<u>Patients Feel Completely Let Down</u>

There are many reasons that people are dissatisfied with the PSHO. From the fact that judgements are made with reference to policies or NICE guidance that weren't in use at the time of the complaint, to records and reports being lost with no explanation. All 200 people who contacted the Patients Association regarding the PHSO in the last two months reported negative experiences. 22% of them felt completely let down.

We don't know how many other patients have had negative experiences of the PHSO and not contacted us. Nor will we know the number of patients who didn't contact the PHSO even though they had due cause to. **Patients may have had no confidence in the PHSO or may not have had the strength to initiate the PHSO process after they had had such a negative experience of the complaints procedure within the NHS.** One patient wrote, *"I was physically and emotionally drained*

(due to the NHS complaints investigation) and had to give up for the sake of my own physical and mental health. ***The file became so large and complicated by what I considered to be procrastination, prevarication and obfuscation that the task became overwhelming****. To prepare a file for the Ombudsman was a daunting prospect… I reluctantly concluded that I couldn't continue even though I desperately wanted to for the sake of my late (relative) and other patients, something that in itself leaves me with a feeling of guilt… I would add that my career before retirement involved in depth investigations and the preparation of detailed and complicated reports so, apart from the emotional involvement, I was well equipped for the task. My heart goes out to those who are not."*

PHSO Overlook or Ignore Evidence

62% of patients reported that the PHSO appeared to overlook or even ignore evidence that contradicted what the Trust had said which made them feel that **the investigation was never going to be fair and was skewed to favour the NHS organisation from the start**. One patient was turned away from their GP practice by the receptionist who deemed the patient's condition wasn't bad enough for an appointment that day in the busy GP practice. The patient was admitted to hospital later that day. "*There were points where the practice's view and mine differed significantly in a factual and verifiable way that were not checked. There were issues which I only briefly outlined, which anyone rigorously examining the complaints would have picked up as a service requirement, and examined in greater detail with the practice, such as the presence or absence of medical staff, which a patient would not be able to obtain."* The Patients Association has also been contacted by members of the public from Scotland who say that the Scottish Public Services Ombudsman (SPSO) has let them down. One family informed us that both the Trust and the SPSO denied existence of video footage which proved the basis of the family's complaint. Despite the family then providing the video footage the SPSO still refused to investigate.

Max Boulton

Max Boulton was a patient at Great Ormond Street Hospital (GOSH) but it was surgeons in France who are responsible for the surgery that has prevented Max from having seizures that were controlling his life. GOSH had agreed to monitor Max but did not have a bed available for four months. Max's seizures occurred up to 20 times a day and the family state they were not supported during this time and that all through his treatment they were having to fight before any progress was made. The hospital agreed that Max shouldn't have remained under the care of the Rapid Assessment Neurological Unit for so long but assigned to a Consultant in the hospital, that he wasn't treated in a way GOSH intended and

that there should have been a review of his initial diagnosis but even with all these admissions the Boultons' complaint with the PHSO did not pass the assessment stage. Their complaint was not investigated as the PSHO assessor concluded that there was a consistent programme of treatment at GOSH and no sign of any failures in communication. In fact there were four months with no treatment and documented evidence regarding the communication. The assessor was categorically wrong and Mr Boulton wrote, *"He (the investigator) refused to answer our questions about demonstrably factually incorrect fundamental assertions he had made.* ***The problem is with the investigators who have little understanding of the process of investigation and, more acutely, with medical assessors who themselves are under no scrutiny."*** It appears that PHSO investigators are frequently making decisions that disregard evidence and ignore facts.

PHSO investigators must be able, allowed and encouraged to investigate all institutions. The GOSH clinicians are world renowned experts but they should be subject to the same standards and checks as everyone else. However, it appears that PHSO investigators and clinical experts do not always have the necessary knowledge or skills to question clinicians involved in the complaints. **How much does professional courtesy, collegiate loyalty or consultant fellowship inhibit critical investigation or professional challenge when it is obviously warranted?** Due to Max's suggestion and persistence the French doctors went on to be given the Légion d'Honneur, France's highest honour. The research minister, Geneviève Fioraso, praised the doctors' work to identify and safely remove epilepsy-causing brain tissue saying, "It is not only science and technology that you advance but hope that you restore to people." In this case it was hope that the doctors in the U.K. had taken away and that the PHSO did nothing to re-instil.

Patients complained that **final reports are inconsistent in their reasoning**. In one complaint the PHSO responded that evidence must be from an independent source and that is why they hadn't accepted a statement from a family member eye witness. In the same complaint, evidence was acknowledged and accepted from another clinician, present at the time of the incident. **Why was it that a clinician's colleague was considered to be independent and yet the family member wasn't?** Both parties could be considered to support as family/colleague yet it is the clinician who is trusted. Is it any wonder that complainants feel that the PHSO sides with the NHS whenever possible, trusting the clinicians automatically and treating the complainant as 'guilty until proven innocent'? These experiences reinforce the perception that the PHSO sides with the NHS organisation by default.

Laurence Poulton took his complaint regarding the cancer care provided to his late wife, Christine Poulton, to the PHSO and wrote the following about the final report, *"facts were wrongly stated, wrongly interpreted (and) in addition other relevant facts were not considered at all."* His complaint was centred on the fact that much of the discussion about treatment was frequently prefaced with the phrase, "nothing will work" and there was a persistent reluctance by the Oncologist to try anything seemingly because the cancer wasn't curable which left his wife feeling utterly hopeless. Neither he nor his wife were under any illusion that treatment would be curative but to act in such a pessimistic manner had devastating consequences on their ability to cope or develop any sense of control.


Christine Poulton

The PHSO report included factually incorrect statements to back up their decision and didn't mention the fact that the Poultons had to ask for chemotherapy from a different hospital because they had been told there were no options. Decisions were based on incorrect dates and assertions made of the value of a cancer marker which is internationally debated. The final report was also inconsistent citing that no oncologist could offer treatment without seeing the patient first but not challenging the fact that two months after seeing his wife and describing her as '*very well*', their Oncologist described her as too frail and decided to offer no further treatment without seeing his wife again. **Where is the quality assurance that medical staff are reviewing medical decisions?**

Communication with the PHSO takes far too long

52% of patients report that all communication with the PHSO takes too long which can cause the **whole process to take over a year or longer**. Patients comment that even the acknowledgment takes over four months and then they have to chase the PHSO for every subsequent response. Having to chase for a response makes people feel ignored, makes them doubt they are doing the right thing by complaining, exacerbates the stress of the experience and makes them feel that their case simply isn't important enough.

The PHSO process can take over a year however patients are given a very short time to comment on the draft report. Brigid Wainwright reported, "*Having gone through the tortuous route of the complaints system I submitted my case to the PHSO in May 2014. In December 2014, 7 months later I received their draft report. They asked me to submit comments within 7 days. Their report was so distressing… did not seem to have reflected my side of the story at all, had several inaccuracies and totally ignored the objectives I was trying to achieve.* ***They portrayed a total lack of compassion****."*


Brigid Wainwright

Complainants may have waited years to get this far and drop everything when the draft report is issued. They want to ensure they scrutinise every point made so that the PHSO investigator can have all the details to make a fair decision. However one in ten complainants found that the final report was an exact copy of the draft report, with all of their comments completely ignored.

Many complainants find the fact that the draft report is to be treated as confidential confusing and the threat of criminal prosecution if they give any information to a third party very intimidating. They don't feel qualified to know whether the PHSO investigator has been thorough enough, looked into every aspect and not just taken the NHS organisation's word for it. Only being able to share it with a family member, who may be equally unaware of correct medical or nursing practice, or having to pay money for a professional adviser, seems to be heavily weighted in the NHS's favour.

Patients are also put off going to the PHSO if they think there is any potential they might go through the legal system. The PHSO form reads, "We may not be able to look at your complaint if you are already pursuing legal action or are planning to take legal action or if we consider that there is a course of legal action open to you that it is reasonable for you to pursue.**"** The complaints process is complicated, emotionally draining and exhausting and not everyone has made their mind up about seeking legal redress at the beginning.

Dismissive or Insensitive attitude of PHSO Assessor/Investigator

Patients might not feel ignored and feel that their case was important if the PHSO staff simply acknowledged the patients frustration at the length of time it all takes. However 28% of those who contacted us complained about the attitude of the staff, citing that the staff **were "rude", "dismissive" or "insensitive."** Nicola Watson wrote, *"The (specialist) who they consulted as their expert was clearly uninformed about the condition under discussion, her tone was very frosty … I also found some of her comments quite insulting and completely lacking in empathy for my difficult situation."* Further to this investigations are often delayed when the investigators write to obtain evidence that they were already sent, which doesn't instil much confidence.

Ronald James Coker's family received a letter saying their draft report was being shared with Cumbria Partnership NHS Foundation Trust despite the fact that Mr Coker had never been a patient there. Again this doesn't make complainants feel that the PHSO has given their complaint their full attention.

Patients Feel Emotionally Debilitated

The total length of time that the process takes and the unexplained periods of time between communication also has a negative effect on complainants who are mostly already in the middle of an extremely stressful time. 16% of patients reported that the time and energy spent engaged with the PHSO is emotionally debilitating and some considered that the PHSO worked like this on purpose in the hope that they would give up.

Sally Hooper wrote, *"When I wrote to complain (about the length of time between communications), I received acknowledgement that there had been periods of inactivity that had no explanation and that their communication with me was "not what they would wish" and generally apologising. Overall I found my interaction with the PHSO intensified my terrible experience, not only of the death of my*

(relative) but the effort taken to complain about the poor care she received and the terrible way I was treated during the complaint process. The PHSO eventually declined to consider my complaint to them because they decided it was out of time, working from the date of (the relative's) death and not when the complaint process had finished... I decided I would never complain again nor recommend anyone else did so as the psychological impact can be too great."

PHSO don't challenge NHS organisations

40% of patients reported that they thought the PHSO seems unwilling or unable to challenge a Trust's stance on a complaint unless the patient specifically identifies an issue to look into. Patients go to the PHSO assuming that the PHSO already have a good understanding of NHS policies, procedures, practices, behaviours and what is expected. Patients assume this because the PHSO say their aim is, "to provide an independent, high quality complaint handling service that rights individual wrongs, drives improvements in public services and informs public policy." **Patients however feel that they have to do a lot of the research and investigation themselves.**


Lynda May

Lynda May commented that, "*The whole process relies heavily on the complainant being able to formulate and present complaints to almost evidential standards. There appears to be no recognition that most complainants are laymen*." Some patients commented that if they hadn't kept comprehensive notes, become an expert in their disease and treatment and behaved as project manager for their complaint they wouldn't have got past the first stage. Not only does the PHSO not challenge Trusts but they don't ask for evidence if it is not forthcoming, as one patient wrote, "*Ombudsman's officers must base decisions on evidence. Not even requesting the relevant documents from the Trust shows the decision was foregone conclusion."*

Patient not listened to or not believed

30% of patients who contacted the Patients Association said that they felt that that weren't listened to or that they weren't believed. This was even when they provided extensive evidence. The PHSO is the last resort, the ultimate judgement and to not listen to the patient who will, in most cases, know more about the complaint than anyone else seems counterproductive.

Lynne Noble commented, "*I had kept extensive notes of my experience as it was happening – part of my professional background kicking in. Heaven help people without a health care background who haven't made extensive notes of their experience.*


Lynne Noble

The PHSO will just consider the patient's experience as never having happened. Should we have to write up notes every time we interact with people? How sad that it has come to this in society!"

Patients made to feel they were in the wrong for complaining

12% of patients that contacted the Patients Association wrote that they came away feeling that somehow they were in the wrong for complaining and some stated they were even told they had wasted the PHSO's time and the Government's money. Together with the fact that so many patients felt that the investigation was skewed to favour the NHS organisation from the start this **casts doubt on the PHSO's ability to deliver a fair service and not take sides**.

One patient wrote, "*I have never wanted to cause a fuss or cause more work for anyone as I know that nurses and doctors do everything they can. I thought hospital was the one place he would be safe but my husband wasn't cared for properly and died in pain and I couldn't let that go. I complained for my husband and so that it wouldn't happen to anyone else. The response to my complaint seemed to suggest that my husband's many illnesses were to blame, that we were asking too much of the hospital and the PHSO. I realised that he needed a lot of care towards the end and I felt sorry for the other patients who may have had to wait for attention because of my husband's needs. I felt guilty for having complained about a system that is free and that we are lucky to get."*

Scope of the Complaint Narrowed

18% of patients who contacted us reported that the scope of their complaint was narrowed, sections were arbitrarily dismissed or parts simply weren't investigated and questions were therefore not answered. **This contributed to making them feel the investigation was not fair or thorough**. Nicola Watson continued, *"Having whittled my complaint down to a very small and essentially meaningless component, the Ombudsman then 'investigated' in such a way that they seemed to have decided in advance that the consultant was right, without actually taking the trouble to look fully at my concerns."* This all correlates with the issues raised about the standard of the final report and how patients have complained about the inconsistencies.

Lynda May went on to say, "*The draft final report completely omitted any reference to a very significant (but very clear) element of my complaint. The final report remedied this by upholding my complaint, and making a recommendation. The Ombudsman apologised for the omission. However their final report significantly changed an earlier (draft) decision about another element of my complaint and … they have given me very little reason for the change."*

Sally Hooper added, *"Although I was disappointed by the outcome I was also distressed by errors in the response which included getting my (relatives) name wrong, poor spelling and grammar, missing whole sections of my complaint and therefore not responding to these areas and more."*


Sally Hooper

Recommendations are Ineffective

The recommendations are a crucial part of the PHSO's role. We hear that people aren't looking for financial recompense, they simply want a sincere apology and to ensure that it doesn't happen to anyone else. The PHSO make recommendations to put things right and to prevent the same problems from happening again however the same problems do happen again.

12% of patients felt that the recommendations were too weak to affect any positive change or were never able to find out if the recommendations were put in place. Complainants wait for months for the PSHO to come to the recommendations but without the guarantee that changes will be made it often feels like a hollow victory. If the PHSO required that the Trust Board had to demonstrate that it had gained assurance, not simply reassurance, that their organisation had implemented the PHSO recommendations, or had good reason why the recommendations couldn't be implemented, then it follows that the circumstances leading to complaints would reduce. Without obtaining assurance the cycle of complaints is unlikely to end.

What influence or power, if any, does the PHSO have?

Patients report that NHS organisations seem apathetic regarding the fact that their patients take complaints to the PHSO. The PHSO does not have the gravitas or influence to implement change or improvement and many organisations do not have the governance infrastructure to self-regulate or thoroughly assure quality. Ralph Boulton concluded, *"(the PHSO) encourages a complacency in institutions, discouraging change and reform. It is not enough for them to say they are soliciting feedback. I was approached for feedback but what use is this if during the actual investigative process they refuse outright to listen? Promises of change are not enough. They must be brought to account for serious misconduct of their affairs."*

The Future for Health and Social Care Complaints Handling?

It is important to note that everyone, the public, NHS, Local Government Ombudsman, PHSO and the Government, all seem to agree that complaints handling is not what it could or should be. There have been many, many reviews and recommendations to improve it: so why is it still not working? Everyone agrees that services should be honest and open but we still hear from patients who find it impossible to find anyone who will talk to them and when they do they feel that they are lied to. The Health

Committee report, 'Complaints and Raising Concerns,' concluded that most of those who complain about NHS services do not seek financial redress but wish for understanding, acknowledgment, lessons learned to create improved services and a sincere and timely apology. As Peter Ashcroft wrote, "I received (an) apology on the last day of the time period set by PHSO for response…if I had received such an apology in the first place, I would have had no reason to take things further." When it is clear that an apology is what people want, why is an apology so often not provided?

The PHSO produces reports with recommendations which may or may not be implemented. Commissioners must start to hold organisations to account and insist on receiving assurance that changes have been made. Additionally commissioners should hold organisations to account for implementing recommendations from serious incident investigations.

Complaints and incident management are intrinsically linked and both depend heavily on self-regulation, professional accountability and organisational culture and policy. Everyone makes mistakes but are there some professionals more likely or willing to learn lessons than others? Many are familiar with Sir Liam Donaldson's 2004 quote, "To err is human, to cover up is unforgivable, and to fail to learn is inexcusable."[1] However there is an apparent widespread failure to learn as the same problems continue to be reported: pressure ulcers, medication errors, poor communication, failed discharges, 'never events', hospital acquired infections and the list continues.

Sir Robert Francis calls for a 'just culture' instead of 'no blame' but this can only be created if everyone who makes up that culture is held accountable to the same standards. These organisations have multiple professional groups working in them, all of whom are essential to provide an effective service. However are members of all professional groups affected equally by a complaint made against them or an incident they may be involved in? Are some staff able to defend or explain away a complaint because they consider themselves above patient judgement and too valuable to the organisation? Everyone, however busy or senior they are, has a responsibility to ensure that incidents and complaints are properly investigated and learnt from. From what we hear this isn't what happens.

The number of people who take their complaints to the PSHO shows that the complaints system needs to be improved. The number of complaints about the PSHO show that that institution also has a long way to go. Health and social care organisations do so much good for so many people, it is such a shame to fail so dramatically when it goes wrong. The Patients Association strongly believes that the complaint process can and must improve.

[1] (Sir Liam Donaldson speaking at the launch of the World Alliance for Patient Safety in Washington DC on 27 October 2004. Calling to mind, and adding to the comments made by Susan Sheridan (the wife and mother of victims of medical error) some years earlier, Sir Liam Donaldson summed up the challenges of patient safety in this way.
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/aboutus/ministersanddepartmentleaders/chiefmedicalofficer/cmopublications/quoteunquote/dh_4102570

Other quotes from complaints about the PHSO received by the Patients Association following the publication of its report, 'The Peoples' Ombudsman – How it Failed us.'

- "I have no intention of giving in without a fight."

- Frank Plowright wrote, "Your report highlighted how **the Health Service Ombudsman is letting down patients.** I'm glad this has been spotlighted as I feel my (relative) was very poorly served in 2011, and after long and fruitless dealings with the hospital concerned I was astounded when the ombudsman found no case to answer." Mr Plowright's response to the PHSO, "I've waited a few days before replying **in the hope that time would diminish the bitter disappointment** of it, but this hasn't proved to be the case. Before I began the complaint procedure my (relative) told me I was wasting my time as there would be cover-up, delay and no change. They are an optimistic, fair-minded individual, yet that was their expectation of the complaints process, and 18 months later they've been proved exactly right. To you it's perfectly acceptable that the only people to have apologised to my relative, via me, are two people with nothing to apologise for, not those who endangered my relative's life… **Given the recent revelation of long-standing patient neglect, skewed administrative priorities and the astonishing situation whereby a health minister actually had to issue guidance compelling hospital staff to a duty of honesty, your response is all the more disappointing."**

- Miriam Pryke wrote, the PHSO were, "**slow, secretive, defensive, non-transparent**, lacking appropriate skills and understanding, resistant to absorbing facts unfavourable to aspects of health care and unable to respond to them, insulting, and **added to my already great distress**."

- Peter Ashcroft wrote, "The final report agreed with the draft report and that was that! I nearly gave up but decided to ask for the evidence they used from the hospital which was readily provided. **It then transpired that the PHSO and their EXPERT had used an internal report from the hospital referring to a different elderly lady!"**

- Ann Scull wrote "I have just read your recent November report entitled 'The People's Ombudsman - How it failed us' with great interest, since it is now nearly two years since my daughter, Laura's death in care… The CQC are currently doing a 'desktop review' into my daughter's death and I have sent all the necessary forms and supporting documentation to the PHSO. **I now have no faith in either organisation reaching an impartial decision**. So much of what was written in your report rings true from my own experience. I would welcome any comments or advice you can give me to end this continuing frustration and total despair, from being forced to go over the same ground and complete long-winded, intrusive forms to different departments, with still no end in sight. **We deserve some resolution to be able to try and move forward."**

- Tracy Cox writes, "The whole case has been lies, lies and more lies **we only wanted them to admit the truth initially but as each step we felt more and more let down**,"
    - There are too many assumptions made about the care and its impact to our father. This is not acceptable when we have remained factual on our accounts.
    - **If we hadn't complained and brought the failings to light, what would have happened?** Would the code of practice continued as is?
    - We have a lot of family and friends behind us on this complaint because many have their own bad experiences but not the strength and determination it takes to bring their complaint to light.

  What the PHSO have done is deny us the right to grieve, left us mentally exhausted and totally untrusting of any complaints process."

- "The worst thing of all is that I am not being believed."

- "If a complainant misses something (because most of them are probably not trained doctors) then the real problem is not identified and **the hospital continues making the same mistakes**."

- "What is alarming is the issue of the numbers of people who don't go to the PHSO as they feel that this will, "**simply prolong their suffering and won't make any difference anyway**." This despondency has been caused by the attitude and actions of the NHS complaints process as well as the PHSO."

- "I have been given complete run-around by the ombudsman to the point where I have no confidence in their ability to do or change anything with regards to my complaint… I feel **I am at the end of my tether and am extremely angry about the sheer cowardice I have been confronted with."**

- "(The) PHSO is failing in its remit to challenge manifestly duplicitous and flawed NHS process and application of criteria, compounding this by not engaging with specific criticism in my communications, not engaging with identified factual errors or information pertaining to misunderstanding, overlooking evidence and in denial about how a proper reading of the case should change its decision. **In responding to challenge, PHSO is sidestepping real issues and preferring to reply with weak justifications of flawed consideration (and) repeatedly demonstrating misunderstanding."**

- "(After commenting on the draft report I) received a Finalised report almost immediately; this would not have given her enough time to investigate my concerns. I emailed her stating this but **she simply rebuffed my concerns and ended the investigation**."

- "I complained to the hospital and they referred me to the Ombudsman. I made it quite clear that I had no intention taking any legal action. The Ombudsman were friendly but entirely ineffectual. It was clear that they wanted to protect the hospital at all costs, even

though their errors were blindingly obvious. **'Not fit for purpose' couldn't have been a more appropriate phrase."**

- "I have just read an article in a newspaper where you are highlighting the inefficiency of the N.H.S. Ombudsman. I was delighted to read that you had identified the poor quality of their work... **Their response was a disgrace**."

- "I complained to the PHSO but **they were hopeless**. They let the Trust involved get away with murder regarding timescales to respond and then threw my case out because time had run out."

- "**Because I was putting so much time into the PHSO I lost precious moments with a relative now no longer with us**"

- "I have held off contacting you because my claim and complaint originated from the Parliamentary section of the Ombudsman's work and not through a medical failure. However so much of what you have highlighted in your report is identical to my experience. The Ombudsman is not fit for purpose regardless of which hat it is wearing…**The report I received was completely inadequate, quite frankly it wouldn't pass muster for GCSE level work much less Parliamentary. The report failed to cite a single source…** "I don't know who to complain to about the Ombudsman. They are the worst organisation I feel I have ever dealt with. **They ignore evidence and it seems that among them is a group dedicated to trying to cover up wrongdoing and hide transgressions."**

- "The problem is that **little of the draft report directly related to my complaint**."

- "**The investigator in effect ignored (the) evidence that I brought to her attention** together with most of the comments I provided relating to the Draft Report."

- "Seems a little unfair that the trust and PHSO took over two years to complete their investigations and the public are allowed three months to take to court**. I am exhausted from the whole process."**

- **Over 3 years after the complaint was submitted to the PHSO** "(the draft report) was factually inaccurate, misleading and matters claimed would be investigated had not been. The final draft was presented but the issues raised and factually inaccuracies had not been dealt with. A further complaint was made and for 6 months we were informed a report on the complaint was waiting consideration by the Ombudsman or one her deputies. It transpired no report had been completed nor had the complaint been investigated. We had been misled. We complained and were informed that a review would be carried out as a matter of urgency." **19 months later, after some communication but no investigation, the following was received from Dame Julie Mellor, "***I am very sorry that you have not received the level of service you should expect from us. However, we are seeking to put that right by extending the scope of our current investigation.* **3 months later the final report was received.** "It was factually inaccurate, misleading and many matters which it had previously claimed would be

dealt with had not been." **6 months later** I was contacted by (someone from the PHSO) wh**o** informed me she was reviewing a number of complaints and was seeking my views. We are currently awaiting the result of the review."

- "**We are left shocked and dismayed by the quality of the investigation with little rationale or explanation of findings in stark comparison to the significant detail provided by ourselves.** The report appeared more about opinion than looking at the detail of the evidence provided…**We feel shattered and are incredibly let down** by the Ombudsman's 'investigation however we are going to submit a request for a review despite little confidence. We are given some comfort and reassurance by the concerns you are raising nationally and as an affected family thank you very much for your work."

- "I was left with the conclusion that the investigation had been nothing but a whitewash and that **the Ombudsman exists to protect the interests of NHS Trusts rather than those of patients.** For me that was the end of the line. No financial compensation would have helped but I did expect that the Trust would learn from what had occurred."

- "The flippant way they are dealing with us**, does not encourage much confidence**"

- "As a patient **currently experiencing frustration and utter dismay at the way the PHSO is handling my case**, which is almost into its second year now, the interview and the full report by Katherine Murphy has inspired me to pursue my case with vigour and not to give up, something I suspect many patients tend to do. "

- "The Ombudsman only took hospital reports as truth, ignoring our own notes written at the time (my sister and I stayed in hospital for 5 days and night.) **The Ombudsman did not even obtain all the hospital notes, so had no information about the period we were questioning, but failed to notice the omission.** The Ombudsman ignores any correspondence it chooses and does not even give a reason. The Hospital Trust knew it would be 'let off' by Ombudsman. **The Trust sent 'apology' when forced by Ombudsman but *apologised for the wrong thing*, which was very distressing and hurtful.**

- "We went several times to try and contact the PHSO but were told that we had to follow an extremely lengthy process of complaints, before they would consider our case. This is clearly because they want to put people off from complaining. **Eventually patients become fed up with the complaints process and give up."**

- "May I say how pleased I was to read your (report) that clearly stated that **the Health Ombudsman service is unfit for purpose and does a disservice to grieving families** who witness gross errors being made within the NHS that never get brought to justice."

- "I was immeasurably reassured to hear (your report), because I have had a torrid and horrid experience with the PHSO myself…The PHSO responses from their ombudsmen have been nothing short of pathetic. Wholly lacking in any investigation, delayed, quite off hand and complicated. They have insisted in breaking my complaint in to two, narrowing the scope so

that there could be very little recompense or penalty or anything required, and they are massively biased in my opinion in favour of those they are 'investigating'. **I have to say they appear an extension of a very mistake-denying NHS. I love the NHS. I also know how complex and inefficient and ineffective it can be…The PHSO looks to my mind, so far, to be totally ineffectual and worse, people being paid to do something, and not doing it.** That makes me feel quite angry. I'd rather they close and the money went to recruit more nurses, or fund more social care, but not to people doing nothing to investigate what is being laid out clearly to them."

- "I have made the decision to withdraw from the Ombudsman investigation in protest of how they have handled my issues, you are right they are not fit for purpose. I am ringing them today to confirm this…you are right I have my health and wellbeing to consider which is more important.
  I have waited five months for this investigation. As you know I have twenty five years' experience in the police service**, if I conducted myself in an investigation like this I would have been in trouble and probably out of a job.** Sensitive complaints and investigations must be handled in a sensitive accurate manner and install confidence that it will be dealt with right. My case is a classic example how it has been mishandled from the outset."

Excerpt from the Health Committee report, "Complaints and Raising Concerns."[2]

The experiences of the families quoted in the Patients Association report make for sobering reading. For a major patient advocacy charity to no longer support the second stage of the complaints system is a worrying development, and must result in a thorough examination of the criticisms it has made. The progress that is being made in increasing the numbers of investigations and in modelling a better complaints system will count for nothing if the public perception of the PHSO is that its investigations take too long, require too much of those who are complaining and do not provide appropriate redress at the end of the process.

[2] http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/350/35002.htm

The Patients Association Findings from the November 2014 Report

1. The jurisdiction of the PHSO is unclear, leaving ill-defined boundaries between the organisation and other public funded bodies such as the CQC.

2. The PHSO hides its failings behind legislation.

3. Individual cases take far too long to be assigned to an investigator and subsequently, the investigations are far too lengthy.

4. The current process relies heavily on families providing the burden of evidence. If evidence is not presented by the families, the PHSO does not look further to find it.

5. There are too many gaps involving clinical decisions that the PHSO refuse to investigate, therefore families fall into a bureaucratic no man's land, for example, cases under the Mental Health Act or where there is a case of Do Not Attempt Resuscitation (DNAR).

6. The right people, with the right skills, are not always assigned to cases and as a consequence, can negatively impact on the outcome of an investigation.

7. Investigations are not diligent, robust or thorough.

8. The PHSO investigators fail to appropriately consult medical and clinical advisors who might be available to them.

9. Complainants are refused the chance to meet with the person investigating their case, in order to explain their concerns, agree the remit and terms of reference of the investigation, timelines and communication pathways.

10. The PHSO fails to acknowledge that many relatives have intimate knowledge of the care received by their loved ones and detailed facts relating to their particular case.

11. The PHSO also declines requests from families for additional crucial information and evidence to be submitted, once a written complaint has been made and an investigation has begun – they frequently ignore evidence from families and carers.

12. Linked to this, there is little evidence that PHSO investigation conclusions are entirely evidence based. Crucial mistakes in investigations result in flawed decisions and recommendations.

13. As a consequence, the PHSO continually make errors of judgement and mistakes, which ultimately leads to re-investigations, which then result in additional cost to the public purse and considerable further distress to the families.

14. The PHSO compound their errors by frequently re-assigning the same investigators to re-investigations. As a consequence, mistakes made the first time round remain unchallenged and are even, on some occasions, repeated. The investigators are in effect re-investigating themselves.

15. If and when the PHSO appeal process agrees to a re-investigation and despite their possession of the papers from the initial investigation, the families are expected to submit all the relevant papers all over again and are only afforded two weeks in which to do so.

16. The PHSO requires families to keep the outcomes of draft reports confidential under dubious application of the law, effectively gagging the families concerned.

17. Families are not consulted prior to finalisation of reports and as a consequence, have no influence or say regarding the final recommendations.

18. Even when recommendations are made, there is little evidence that they are followed up, reviewed or the Trusts held to account for failing to implement any recommendations.

19. Throughout the whole PHSO process, families are left distressed, exhausted and distraught by the failings of the body to carry out their public function in an efficient, effective and caring manner.

20. In real terms, the total cost to society and families of the PHSO far exceeds the £40 million funding the body receives.

21. The PHSO appears to be both unaccountable and untouchable.

Recommendations from the November 2014 Report

1. It is time for an independent review of the role and accountability of the Ombudsman.
2. A more publically accountable PHSO.
3. Legislation applied to the PHSO should be reviewed.
4. The statutory duty for NHS Trusts to adhere to the principles of *being open* should be extended to the PHSO handling of complaints.
5. Clearly defined organisational boundaries and jurisdiction must be established.
6. A review of case by case costings by the National Audit Office.
7. PHSO's paper-based procedures need to be completely overhauled.
8. An independent appeals process for PHSO investigations.
9. A code of practice for investigators.
10. Terms of reference for each investigation must be agreed with the families at the commencement of an investigation.
11. A review of time lines for the completion of investigations.
12. Face to face meeting with the complainant/s at the commencement of an investigation.
13. Agreed regular face to face meetings with complainants at each stage of the investigation.
14. Independent advocacy support available for all complainants.
15. Time lines for submissions of appeals must be extended.
16. It should not be under the remit of the PHSO to recommend monetary settlements to complainants.
17. To ensure learning the PHSO must influence change and ensure Trusts adhere to recommendations following appropriate investigations.