



listening to patients  
speaking up for change

**Follow-up report to the March 2015 Patients Association  
publication on the Parliamentary and Health Service  
Ombudsman**

**December 2016**

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## 1 Foreword

It is now two years since the Patients Association issued its initial report setting out the failings of the Parliamentary and Health Services Ombudsman (PHSO) in dealing with complaints raised by patients and their relatives about their experience of NHS services (Patients Association: 2014). The Association felt compelled to raise its concerns in response to the high volume of calls to the helpline from people who were distraught, frustrated and angered by their experience of the PHSO.

In March 2015, a further report '*PHSO – Labyrinth of Bureaucracy*' was published by the Patients Association cataloguing the many calls, emails and letters received from patients and their families and representatives echoing and emphasising the continuing, negative experiences people had in their dealings with the PHSO.

Even though the Patients Association has been campaigning for the last two years for improvements in patients' experience with the PHSO, the number of calls that the helpline receives about the Ombudsman remains high with nearly 300 separate calls received between May and October 2016 raising concerns. 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. People contacting us 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 echoed concerns raised in our reports and all of them described their experiences of the PHSO as being negative.

Now two years on from the first report we find ourselves in a similar position. Instead of a decrease in complaints, an increase is being observed, for example in June 2016 there were 68 separate cases of individuals raising concerns.

It is important to note that the aim of this report is not to discredit those who work in the field of dealing with concerns about the NHS. There is an enormous amount of positive work carried out by the NHS complaints service. In its role as advocate, the Patients Association liaises with Patient Advice and Liaison Services (PALS) and Complaints staff who generally do everything they can to get it right for the patient. We would acknowledge that there are many patients who go through the NHS and Local Government Ombudsman 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.

On the Parliamentary Health Service Ombudsman (PHSO) website they recognise the common complaints raised about the service but from the contacts we have received, nothing seems to have improved and lessons do not appear to have been learned. Some people describe that they feel they are "battling the PHSO" and although they are quite determined they are feeling worn down and exhausted by the whole process of raising concerns and trying to have these answered. The Patients Association believes that people who have complained deserve to be treated with more respect and compassion when engaging with the PHSO - "the last resort" in NHS complaints handling. We call upon Government once again to address the long-standing issues in the PHSO and provide a service which is fit for purpose.



**Katherine Murphy, Chief Executive of the Patients Association**

## 2 Introduction

The Parliamentary Health Service Ombudsman (PHSO) was set up by Parliament to provide an independent complaint handling service. They are described as ‘the final stage for complaints about the NHS in England and public services delivered by the UK Government’ (<http://www.ombudsman.org.uk/about-us/who-we-are>).

The organisation is accountable to Parliament and its work is scrutinised by the Public Administration and Constitutional Affairs Committee (PACAC). There is no right of appeal against decisions of the Ombudsman and, as the Office is independent of Government and Parliament, decisions on cases cannot be overruled by a government minister or parliamentary committee. Decisions of the Ombudsman are, however, subject to judicial review.

In November 2014, the Patients Association published its first report into contacts it had received from patients and their families and other representatives regarding the Parliamentary and Health Service Ombudsman (PHSO). The report arose from the direct experiences patients and their families had in working with the PHSO. Many of the cases referred to the PHSO had not been investigated and when they were, the investigations were inadequate. The report called upon Parliament to listen to the concerns of patients and hold the PHSO to account for its actions. Whilst highlighting the failure of the PHSO to thoroughly investigate concerns raised about flawed, partial and inadequate internal complaint investigations within the NHS, the report also highlighted the unclear jurisdiction of the PHSO which left ill-defined boundaries between the Ombudsman and other publicly funded bodies such as the Care Quality Commission.

In December 2014, the Public Administration Select Committee (PASC) launched an Inquiry into investigating clinical incidents in the NHS to review how such incidents are investigated and how subsequent complaints are handled.

The Health Select Committee (HSC) subsequently published a report *Complaints and Raising Concerns* in January 2015. In reporting on the evidence gathered for its report the HSC quoted written evidence supplied by Which?, highlighting the issue of several ombudsmen and other bodies operating in the “same space”, increasing the risk that “systemic problems are overlooked or fall through the gaps” (2015: 18). The Health Select Committee noted that progress had been made in addressing its concerns about the PHSO including a lowering of the threshold used for acceptance of complaints (ibid: 25) and accepting more complaints for investigation than before with a fourfold increase in investigations. However, the Health Select Committee noted that despite the progress made, “significant concerns remain about the Ombudsman’s own performance in assisting complainants to achieve redress” (ibid: 26). Referring to the evidence cited in the Patients Association report, the Committee observed that the experiences of families made for “sobering reading” and noted that any progress made 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” (ibid: 28). The Committee went on to recommend that an external audit mechanism be established to benchmark and assure the quality of the Ombudsman investigations and for the Ombudsman to “set out how her organisation is seeking to address problems with its processes, and a timetable for improvements” (ibid: 29).

A follow-up report *PHSO – Labyrinth of Bureaucracy* was published by the Patients Association in March 2015.

In March 2015, the Public Administration Select Committee (PASC) published its report into investigating clinical incidents in the NHS following the launch of its enquiry in 2014 (Public

Administration Select Committee: 2015). The report built on previous evidence compiled by the Committee (Public Administration Select Committee 2014) drawing attention to the need for reform of the PHSO if it was to deliver a more effective, responsive and proactive service. The Committee noted that most of the written evidence they received which discussed the Ombudsman was critical. Amongst the points covered in their report the Committee drew attention to “increasing concern that some of (the PHSO’s) adjudications have not been based on reliable evidence, and that this reflects an inadequate capacity for investigating and reporting on clinical incident investigations across the whole of the NHS” [Public Administration Select Committee (2015): p5]. Written evidence to the Committee from the Department of Health indicated that in future it “would expect to see demonstrable improvements in the PHSO; particularly in relation to its pace and responsiveness to handling complaints and increased patient and public confidence in its work” (Ibid: p27). The Committee noted that the Ombudsman’s office was “under considerable strain” and “fundamental reform of the Ombudsman system is needed” (ibid p32). Drawing attention to poor adjudications based on inadequate evidence, the Committee stated that its expectation was that the PHSO should concentrate on making its internal change programme its main effort describing this as “essential and urgent” (ibid p33). The Committee also stipulated an expectation that in future the Public Administration Select Committee should “examine PHSO’s internal change programme and make recommendations about how to reinforce and accelerate much needed change in the behaviour, attitudes and competence of PHSO staff” (ibid p33). A key element in any such scrutiny is the PHSO’s competence in respect of evidence, investigation and legal interpretation.

The Government through the Cabinet Office published a response in December 2015 to a previous report of Public Administration Select Committee, *Time for a People’s Ombudsman Service*, published in April 2014 (Public Administration Select Committee 2014) and a review conducted by Robert Gordon on behalf of the Government considering proposals to “restructure, reform, renew and reinvigorate public services ombudsmen” (Gordon 2014: 1). Gordon’s report set out the case for reform and recommended the creation of a new Public Service Ombudsman. The consultation phase on Gordon’s proposals concluded in December 2015 and the Government’s response has signalled that it intends to proceed with the creation of a Public Service Ombudsman which will bring together the role of the PHSO and the Local Government Ombudsman. As well as primary legislation to create the new body the Government has acknowledged that further work will need to be undertaken on the role, structure, governance and accountability of the service. The response has also advised that the new service will “continue to act as the final tier of redress for complainants” (Cabinet Office 2015: p13).

The PHSO staff have stated their intention to make changes to the way they work. These were included in a strategic plan issued by the PHSO in 2015 covering the period 2015 to 2018. Such changes have included creating a service charter: a set of promises so the public know what they can expect. The service charter was published by the PHSO in July 2016.

Amongst the commitments made by the PHSO they state:

- “(We will) gather all the information we need, including from you and the organisation you have complained about, before we make our decision;
- (We will) evaluate the information we’ve gathered and make an impartial decision on your complaint;
- (We will) keep you regularly updated on our progress with your complaint”.

In the following sections, we will review patients’ experience of raising concerns with the PHSO and the extent to which these commitments are being met.

### 3 Experience of Patients as reported to the Patients Association

Since November 2014, the Patients Association has continued to receive a high number of calls from patients outlining problems in the service provided by the PHSO. Their experience is that the PHSO:

- **Does not investigate complaints fairly** - Evidence is ignored.
- **Takes sides with the organisation they are supposed to be investigating** – Failing to meet the commitment to make decisions impartially.
- **Does not make the process straightforward** – They ask many questions that the person complaining has already answered or cannot answer. They change case worker/investigator without informing the complainant, take weeks to respond to queries from complainants and often raise queries which could be answered by looking in the paperwork submitted by complainants.
- **Produces reports that are neither thorough nor 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 use the complaints process to ensure that lessons are learned at local level**- Trusts are not 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 the process** - Patients are made to feel like they are a nuisance for complaining and that they are wasting the PHSO's time.

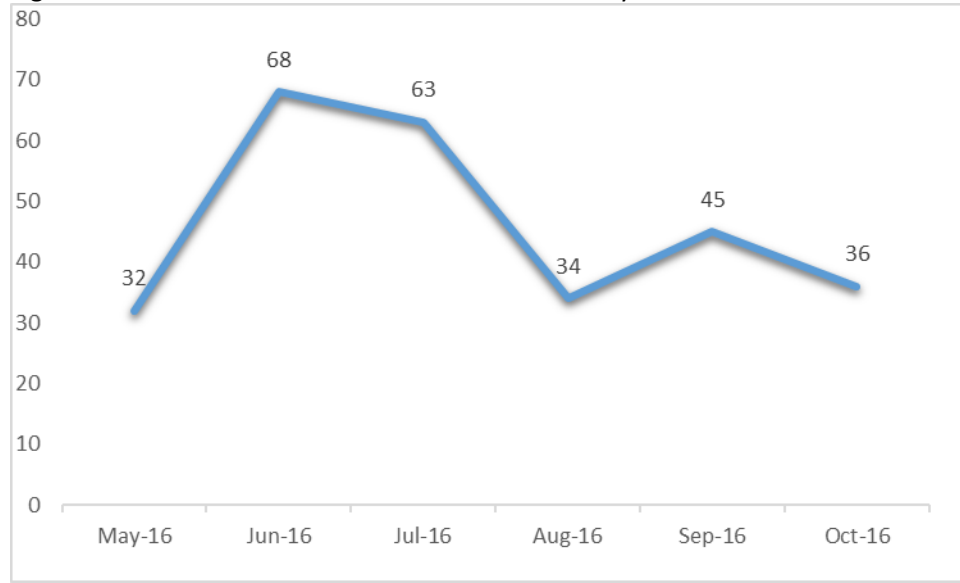
In response to the many criticisms, the PHSO has adopted a policy of increasing the number of cases it investigates. However, unless the quality of investigations undertaken improves this will be of little reassurance to patients and their families.

We endorse the opinion expressed in the Gordon review into proposals to bring forward a unified public ombudsman service (2014) that the role of Ombudsman requires a body which has “a commitment to excel in understanding the customer’s perspective, demonstrating a responsive and empathetic service, building trust in the final tier of the complaints handling service, and in turn actively demonstrating the benefits of doing so” (2014: 17). Regrettably from the evidence we frequently receive from patients and their representatives the PHSO fails to live up to such ideals. We share the hope that the new role of Public Ombudsman will live up to the service standards envisaged for it. However, for the immediate future it remains important that the PHSO makes the necessary changes to ensure the provision of a service which is fit for purpose and strives to undertake robust and balanced investigations into concerns raised by patients and their families.

Recent experience of patients and their representatives in dealing with the PHSO has suggested an organisation that continues to experience profound difficulties including regular resignations of case handlers and investigators. This is leading to a lack of continuity in dealing with outstanding complaints with significant delays in their resolution and continued frustration and disappointment for complainants.

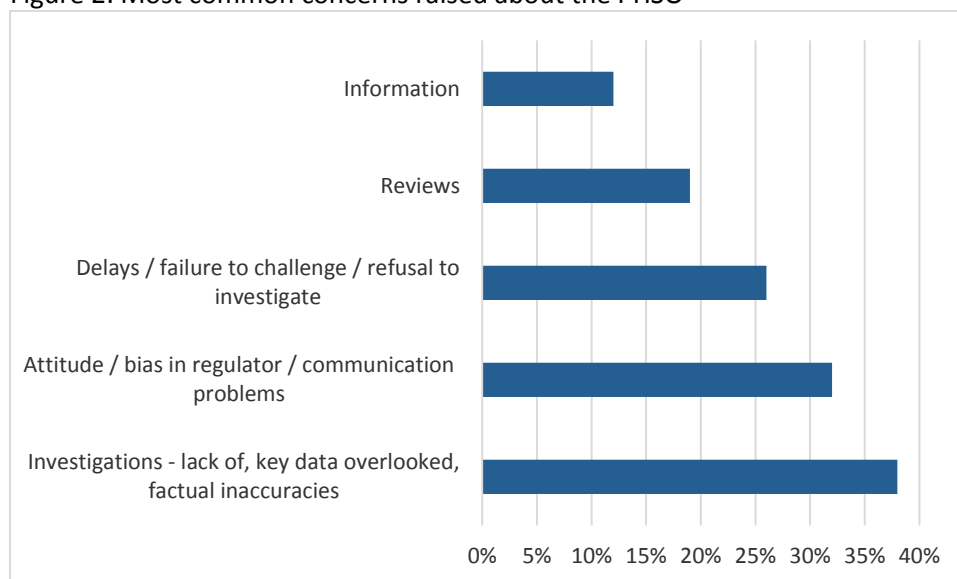
A graph illustrating contacts received by the Patients Association is set out below. This shows the continuing high volume of calls received highlighting concerns with the PHSO.

Figure 1: Problems raised about the PHSO from May 2016 – November 2016



There were 278 problems reported to the Patients Association between May 2016 and October 2016. The most common categories of complaints are highlighted in figure 2 below:

Figure 2: Most common concerns raised about the PHSO



#### 4 Investigation- lack of/ key data overlooked/ factual inaccuracies

Between May and October 2016 106 people raised concerns regarding the quality of investigations undertaken by the PHSO. The concerns covered in this category included failure to undertake an investigation, overlooking evidence in the investigation, as well as factual inaccuracies within the investigation report. The final report was frequently described as sub-standard with callers citing examples which were inconsistent, factually incorrect or where the reasoning was weak.

Investigators were criticised as not having the necessary skills because the level of investigation was extremely poor and often lacked rigour. The expectation of callers was that investigators would systematically examine the details of a complaint in an attempt to understand the facts and thereafter come to a logical and reasonable decision. This expectation is based on the PHSO promise

of a thorough and fair investigation. However, patients complained that despite waiting for extended periods (sometimes a year or more for a final report) the report frequently repeated what the NHS organisation had concluded without any evidence to demonstrate that a new, independent and thorough investigation had taken place.

In identifying problems with the burden of evidence, one correspondent stated that it was difficult to challenge the NHS if you were not medically trained due to the need to supply detailed evidence to enable the PHSO to take up your concerns.

Describing factual inaccuracies in his report one caller in February 2016 referred to key details being wrong, for example referring to a hip replacement when an operation was actually for a knee replacement. Another correspondent observed: "Although I was disappointed by the outcome I was also distressed by errors in the response which included getting my (relative's) name wrong, poor spelling and grammar, missing whole sections of my complaint and therefore not responding to these areas and more." A further correspondent raised concerns in June 2016 about a report prepared following the investigation of a complaint she had raised about the care of her mother. There were three places in the report where the name of the patient was wrong and although the PHSO apologised for the "typographical error" it raised concerns in the mind of the caller about whether the investigator had looked at the correct records.

Other patients raised similar concerns about the focus of the PHSO failing to reflect the concerns which had been raised in the complaint. For example, one person said "The problem is that little of the draft report directly related to my complaint."

The poor quality of investigations was often cited by complainants. For example, one person wrote:

"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."

Many people complained that final reports from the PHSO were 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. It is reasonable to question why the clinician's colleague was considered to be independent and yet the family member wasn't. This reinforces a concern expressed by complainants that the PHSO fails to act in an impartial manner, trusting the clinicians by default and appearing to treat the complainant as 'guilty until proven innocent'. These experiences reinforce the perception that the PHSO has an inherent bias when reviewing complaints.

50 people who contacted us in the last six months 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. For example, one person wrote, "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.”

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

## 5 Reviews

53 people who contacted the Patients Association in the last six months complained about PHSO reviews, citing evidence of the reviews being limited in nature and not challenging evidence supplied in pursuance of the investigation. For example, one correspondent made the following observation, “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.”

Amongst the issues raised about reviews, one correspondent In October 2016 raised concerns about the PHSO being unwilling to release details of the clinical advisor used to review details of their complaint.

## 6 Attitudes, Bias in Regulator & Communication Problems

### Attitudes

There are many reasons why people are dissatisfied with the PSHO. These range from judgements being 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. Everyone who contacted the Patients Association regarding the PHSO reported negative experiences. 62 people described themselves as feeling let down and 20 complained about the attitude they had encountered in their dealings with the PHSO. Patients told us that they felt ignored and that their case did not seem important to the PHSO staff. This could be improved if PHSO staff actively acknowledged the patients' frustration at the length of time the process can take. Callers described PHSO staff as “rude”, “dismissive” or “insensitive.”

The process of concluding reports also often left people feeling frustrated. For example, one correspondent wrote in March 2016 “after commenting on the draft report I received a finalised report almost immediately; this would not have given [the investigator] enough time to investigate my concerns. I emailed her stating this but she simply rebuffed my concerns and ended the investigation.”

Another caller in February 2016 raised concerns about changes of caseworker or Manager with no explanation about why there had been a change of personnel. The new manager appointed for their case refused to look at evidence she supplied including contradictory emails. The caller's MP had written to the PHSO seeking reassurance that the investigation would be based on the evidence supplied but this letter was not responded to.

### **Bias in regulator**

31 callers who contacted us in the last six months expressed concerns about an apparent bias on the part of the PHSO, who often appeared not to give due weight to the concerns they raised.

Describing a lack of even handedness one correspondent wrote:

“I complained to the hospital and they referred me to the Ombudsman. I made it quite clear that I had no intention of taking any legal action. The Ombudsman’s staff were friendly but entirely ineffectual. It was clear to me that they wanted to protect the hospital at all costs ...”

Many complainants described being motivated by the desire to prevent other people encountering the same problems that they had experienced. They state that they have no intention of achieving any personal benefit. They felt it compounded their frustration when they encountered a perceived bias on the part of the PHSO. For example, one person said;

“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.”

Referring to the lack of even handedness encountered with the PHSO one correspondent in October 2016 wrote:

“Last year I passed a complaint to the PHSO, regarding problems I was experiencing whilst registered at a GP practice. I found the investigation to be lacking very much, and I received a draft report that was incorrect and one sided. I decided to immediately cancel and discontinue the complaint, not least because it was stressful and one-sided. I understand I have the absolute right to cancel a complaint if I want. I was informed it was discontinued. However, roughly 10 months later I discovered by chance the GP practice had a final report sent to them very many months after the complaint was discontinued. This seems very strange. I have recently asked the PHSO why this was done, and they have merely said and admitted fully that I did ask for my complaint to be discontinued at draft stage, but that they wanted to be fair to the other side and so disregarded my request as the complainant to cancel my own complaint, and they openly admit to also not sending me a copy of the final report.”

### **Communication problems**

40 patients reported that all communication with the PHSO takes too long, which can cause the whole process to take a year or longer. The lack of communication is frustrating and the communication is one way. It relies on the complainant consistently chasing the PHSO due to the lack of updates on the progress of their case. Some patients commented that even the acknowledgment can take over four months and then they have to chase the PHSO for every subsequent response. Having to chase for a response exacerbates the stress of the experience and makes patients feel that their case simply isn’t viewed as important enough. An example was one caller who contacted the Patients Association in November 2016 to discuss delays in having their complaint concluded. Their complaint has been under investigation for over two years.

Despite the PHSO process taking over a year and sometimes much longer, patients complained that they were given a very short time to comment on the draft report. A concern of complainants is that they want to ensure they scrutinise every point made so that the PHSO investigator can have all the relevant details to make a fair decision. However, frequently complainants found that the final report was an exact copy of the draft report, with all of their comments completely ignored. For example, in July 2016 a caller contacted the Patients Association to advise that they had received a draft report of 110 pages from the PHSO and were asked to supply comments in 10 days. He provided detailed comments on the draft but they refused to make any amendments.

Many complainants drew attention to a PHSO stipulation that the draft report is to be treated as confidential with the implied threat of legal action if they give any information to a third party. Callers described the experience as intimidating. Others described the importance of seeking further advice because they didn't feel qualified to know whether the PHSO investigator has been thorough enough in looking into every aspect and had not just taken the NHS organisation's perspective. 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 against the patient and their family, often with limited resources compared to the NHS Trust they are complaining about.

Complainants are also put off going to the PHSO if they think that they may need to take their case 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.

## 7 Information

23 callers expressed frustration with the level of information requested by the PHSO and the bureaucratic approach that was often adopted.

As referred to earlier, concerns were also raised that information supplied by complainants was often not cited or used in reports into investigations. This meant that the resulting reports could lack nuance and/or evidence that the complainant's concerns had been given sufficient weight in the conclusions reached by the PHSO. For example, one person in May 2016 said: "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."

## 8 Failure to challenge & Refusal to investigate

### Failure to challenge

In the last six months 28 correspondents expressed frustration with the PHSO's apparent inability to adequately challenge the services complained about. At times this suggested the PHSO was insufficiently robust to take on the Trust concerned or investigators lacked the curiosity to challenge the defensiveness displayed by different Trusts. This comment received from one of the callers to the helpline this year is typical of the frustration experienced by complainants.

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

Describing the impact of the lack of challenge demonstrated by the PHSO one caller in February 2016 drew attention to the case of his mother who had died due to acute urine retention. The hospital, in responding to the investigation by the PHSO, claimed that there were no notes, no records. The ultimate report drafted by the PHSO stated that they couldn't comment on the lack of records.

Many correspondents who saw referral to the PHSO as their final opportunity to challenge poor practice and act effectively in the public interest, felt that the PHSO did not live up to the standards they would expect from an independent adjudicator. This was expressed by one correspondent in the following way:

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

### **Refusal to investigate**

This was referred to by 25 people who contacted the Patients Association in the last six months. Describing the problems associated with the PHSO failing to investigate concerns, some correspondents highlighted the frustration this engendered, leading to cynicism and feeling generally ‘ground down’ by the process of making complaints or raising concerns.

One example quoted by a correspondent in September 2016 was of his mother being given a bed bath against her will. This was raised with the PHSO but they took the decision not to investigate the matter further.

## **9 Delays**

20 callers expressed concerns or frustration with the delays encountered when working with the PHSO. Typical was one correspondent who wrote to us in September 2016 “I have had to go through (my complaint) with four different people at the Ombudsman's office so far putting me under enormous pressure. By June 2016 I was getting nowhere so had to get my MP and his aide involved.”

People who contact us on the national helpline continue to tell us that they feel NHS Trusts are given greater latitude in responding to the PHSO.

In describing delays encountered some correspondents described how they felt worn down by the process. For example, one correspondent said:

“(It) 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 (it) to court. I am exhausted from the whole process.”

Some of the delays encountered by correspondents were extreme. A particularly bad example involved a draft report which was received in 2016 over three years after the complaint had been raised with the PHSO. The correspondent described their experience in the following way:

“(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 factual 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 of 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 in 2015 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) who informed me she was reviewing a number of complaints and was seeking my views. We are currently awaiting the result of the review.”

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. Many patients reported that the time and energy spent engaged with the PHSO is emotionally debilitating. One correspondent in August 2016 expressed his frustration in the following way:

“People are not expected to persist with their complaints. The idea is to exhaust the complainant at every stage of the complaints process.”

## 10 Case Studies

### **Case study 1: Sally Elizabeth Mays – new story**



This is a new case study and has been compiled by Angela Mays, Sally's mother.

Sally Elizabeth Mays died on 25 July 2014 aged 22 years, whilst in the care of Humber NHS Foundation Trust. Sally's death was a direct result of clinical negligence on the part of the Trust and Yorkshire Ambulance Service (Inquest – Hull Coroner's Court, 14 – 23 October 2015). It was also found that Sally's Human Rights had been breached under Article 2 of the Human Rights Act 1998, The Right to Life.

On the afternoon of 22 July 2014, three days before Sally's death, Sally told her mother that she had been asked by her senior *Community Psychiatric Nurse (CPN)*, if she would be prepared to "act as if in crisis" in order to test a student's skills in a telephone call that was to be set up that afternoon between herself and a student nurse.

Sally was also told by the CPN that the student was not to know that she was pretending to be in crisis and not actually experiencing that level of distress at that time.

Sally's parents were immediately concerned about the ethical nature of this so-called "student learning experience" and were considering reporting it to the Trust, but were overtaken by events as Sally died three days later.

The student involved, subsequently learned from a peer that the telephone call she believed to be a current/ immediate crisis situation was "set-up" by her mentor to test her skills.

She immediately reported this to the University of Hull, who in turn reported the issue to Humber Trust. This report formed the basis of an initial HR/fact finding investigation carried out by the Trust.

### **Background**

In January 2016, we submitted a complaint to Humber Trust regarding the events of 22 July 2014. Following the first stage of the investigation, in March 2016, the Trust admitted that the Initial HR/fact finding investigation, completed in October 2014, was neither "rigorous nor accurate". However, the complaint investigation failed to interview two key witnesses and a further complaint investigation took place which was completed in June 2016, which again failed to address our outstanding issues. Subsequently, we were advised by the Trust to submit a complaint to the PHSO which we did in June 2016.

This PHSO complaint relates to:

- the issues of ethical practice, relating to a student mentor, setting up a student learning activity with an exceedingly vulnerable patient (Sally Mays) being asked to act "as if in crisis" in a telephone conversation with a student in order to assess the student's skills as part of her studies. Importantly, Sally was told NOT to tell the student that the telephone call had been set up by the CPN/Student Mentor and that she, Sally, was not actually experiencing acute levels of distress at that time. The student was therefore NOT fully aware of the circumstances of the activity and neither she nor the patient can have given meaningful consent;

- the standard of the Trust's initial HR/fact-finding investigation into what actually happened on 22 July 2014.
- the Trust's two-stage formal complaint investigation process undertaken between January and June 2016 together with the subsequent reports and the Trust's responses to our comments on those reports.

### **Our initial experience of the PHSO - timeline 2016**

We submitted a complaint to the PHSO in June 2016. In July, we received a letter from the PHSO acknowledging our complaint and indicating that our case had been passed to a caseworker to decide whether or not the PHSO would accept the case for investigation. The letter said that we would receive an outcome in three weeks.

In August, in the absence of any response, I contacted PHSO to be told that the case had been approved for investigation on 21 July and a letter had been sent to this effect to the CEO of Humber Trust. I questioned why, I, the complainant, had not received a copy and was told it was an oversight.

After raising this with the PHSO, I received a copy of the original letter, which had previously been sent to Humber Trust, including a synopsis of our complaint, which was inaccurate. I contacted the caseworker at the PHSO and she agreed to draft another synopsis, which was again inaccurate. I drafted a synopsis myself and sent it to her to send to the Trust. Her response was that she would leave it on file and the Case Investigator, when appointed, would deal with it.

At the end of August, having had no further communication from the PHSO I wrote to the caseworker indicating that it was 80 days since I submitted the complaint and 41 days since the complaint was accepted for investigation and that I found the timescale for appointing an investigator extremely disappointing. A response on the same day indicated that an investigator would be appointed in the next two to three weeks.

In mid-September, I wrote to the PHSO indicating that it was now 101 days since our complaint had been submitted and we had still not been allocated an investigator.

In the absence of any acknowledgement of this email, two days later I sent another email asking for acknowledgement of my previous email and a timescale for a response. The reply indicated that my comments had been passed to a manager for response.

On 26 September 2016, I received a response from the Manager indicating that it would take another 4 – 6 weeks for an investigator to be allocated, which in total would mean a wait of 143 days from submission of the complaint to the PHSO and allocation of an investigator.

On 30 September 2016, I wrote to Dame Julie Mellor, Chair and Ombudsman, copying the letter to the Right Honourable Bernard Jenkin MP, Chair, Public Administration and Constitutional Affairs Committee and Katherine Murphy, Chief Executive, The Patients' Association highlighting my dissatisfaction with my experience of the PHSO complaint process to-date.

On 10 October 2016, I received the name of the Case Investigator allocated to our case. I immediately made contact and in the ensuing conversation mentioned that I would like to meet with her before she commenced the investigation. She indicated that this would not be possible and that case investigators do not generally meet with complainants. I indicated a number of reasons why I felt this was important and questioned the possibility of a Skype meeting. She indicated that the

PHSO does not do Skype meetings with complainants and said that she would speak with her manager about the issues.

Four days later, in a further conversation with the Case Investigator she indicated that the case had now been passed to the specialist Mental Health Team and that someone would contact me in due course. At this point it was 17 weeks from the submission of our complaint.

On 21 October 2016, I received the name of a new case investigator. The following week an arrangement was made for us to speak on the phone on 1 November. In the meantime, I sent an email indicating that I was happy to have an initial conversation on 1 November, but that I wanted to actually meet with the investigator to discuss our complaint face to face.

On 1 November 2016, I had a telephone conversation with the Case Investigator regarding my request for a meeting. He indicated that the PHSO did not generally meet with complainants. I indicated that I was willing to travel to meet him to lessen PHSO costs. He indicated that he did not believe there was any benefit to be gained from a meeting but that he would speak with his manager. The next day, I spoke with the manager who also indicated that a meeting was not appropriate in terms of “proportionality”. I suggested a Skype meeting, previously discounted, and she said she would consider this and get back to me.

Our interactions with the PHSO have significantly compounded the enormous stress under which we as a family are living. Initially, when we submitted our complaint to the PHSO in June 2016, we were reasonably optimistic that it would be dealt with in a courteous, timely and efficient manner and finally bring external scrutiny to the events of 22 July 2014 concerning our daughter, Sally, and Humber Trust’s investigation into these events.

However, our experience of the PHSO, to-date, has been deeply upsetting and enormously frustrating. Their inability to stick to their own timescales or abide by their own Charter, which purports to put the complainant at the centre of the investigative process, is hard to believe. The fact that they have taken approximately 18 weeks to allocate a Case Investigator to our complaint, the reason cited being that they do not have a sufficient number of suitably trained and experienced Case Investigators, is extremely disconcerting, particularly in the light of the fact that in total, our complaint has previously been exceptionally poorly investigated on five separate occasions. Having been allocated two different Case Investigators recently, the refusal of both to meet with us prior to commencing their investigation, despite the fact that we have offered to travel to save PHSO resources, is inexplicable and in the light of our previous experiences, insensitive in the extreme.

The fact that the PHSO, as the final arbiter, either does not have or does not adhere to the necessary protocols, systems and procedures or have adequate numbers of competent staff to enable them to address their workload effectively, serves to jeopardise any potential confidence we had in the service and leads to the inevitable question as to whether this investigation, when it gets underway, will in fact be any more robust than previous ones.

In summary, I would describe our experience of the PHSO to-date as, inaccessible (standard three day reply timescale if you contact them by ‘phone, regardless of urgency), inefficient (do not adhere to their own timescales or operate as per their Charter), lacking complainant focus (“our way or no way” attitude), inflexible and insensitive (i.e. we do not meet with complainants or communicate by Skype).

We believe that in order to improve our experience of the PHSO’s service (and we have not even got to the investigation stage) the organisation needs to:



- Put the complainant at the centre of the process and remember that they are there to serve the public and investigate on their behalf.
- Bear in mind that those who contact the PHSO with a complaint do so as an absolute last resort, often in extremely traumatic circumstances.
- Show some patience, understanding for their plight.
- Develop a user-friendly service whereby complainants can contact the service by ‘phone or email and receive a prompt response.
- Communicate effectively with the complainant and keep them up to date
- Stick to the timescales the organisation sets and if it fails, contact the complainant, apologise and explain the reasons for the delay.
- Employ sufficiently qualified, knowledgeable and experienced staff to undertake investigations in an appropriate and timely manner.
- Offer those who request the opportunity to meet with the investigator to discuss their complaint.
- Give consideration to the option of Skype interviews where distance/time/cost are issues

### **Case Study 2: Jo Deering update since Nov 2014**

Jo’s case study was originally included in the 2014 report into the PHSO by the Patients Association. This case study updates the material in the light of recent developments as supplied by Jo’s sister Maureen Rickman.



Jo Deering had a history of acute psychotic episodes for a number of years. In May 2011, she was sectioned for treatment under Section 2 of the Mental Health Act and was admitted to hospital for the protection of herself and others. Within 2 weeks of her admission Jo was permitted ‘extended leave’ to live with her vulnerable elderly mother. Her family had acute concerns about her subsequent care by the Trust experiencing indifference and lack of support when concerns were raised. In October 2011, Jo told her psychiatrist she was “feeling very depressed,” but this was

not followed up with action. A few days later, Jo committed suicide. At her inquest, the Coroner stated there was a “significant link” between the decision to grant leave and the “sad conclusion” to Jo’s life. (Fuller background about Jo’s case can be found in the report produced by the Patients Association about the PHSO in 2014.)

Jo’s sister, Maureen, made a written complaint to the Trust involved – Southern Health NHS Foundation Trust – because of the insensitive and unsafe care provided. The Trust’s response was based on interviews with the relevant clinicians, but contained significant errors, omissions, distortions and false claims.

The response to Maureen’s complaint made frequent and repeated references to the extent to which Jo had recovered, and also claimed Jo had recovered sufficiently to be discharged. There was

no evidence to support this. Their mum's suggestion, that she was "looking forward" to Jo's return home, was taken out of context and used to justify the decision to grant leave. It was also claimed that Jo was fit to provide for her mother's care needs. This could not have been further from the truth.

Throughout the letter, the Trust appeared to blame Maureen for the tensions between Jo and herself, without reference to the paranoia and aggression associated with Jo's mental health. Most significantly, the response failed to acknowledge and recognise the evidence provided as to the impact on her family caused by the granting of extended leave, and misrepresented their views.

The Trust's response was characterised by pure denial and disagreement and Maureen took the decision to refer her complaint to the PHSO for further investigation. Maureen explained that she was unhappy with the way in which the care had been handled, and the clinicians' lack of regard for her family's wellbeing during that time. The seriousness of this impact, and its role in Jo's eventual suicide, warranted investigation.

The PHSO, however, failed to tackle the key matter at the heart of the complaint: the decision to grant a period of home leave to Jo so soon after she was detained under the Mental Health Act and which subsequently ended with Jo's suicide.

The root of this failure is that decisions taken by clinicians under the Mental Health Act 1983 are taken by them in a personal capacity, rather than on behalf of a Trust. For this reason, the PHSO believed it could not investigate, as its powers extend only to the administration of the Trusts involved.

Having raised concerns regarding the significance of the decision to grant leave, and the limited investigatory remit of the PHSO, Maureen received a response that explained that she could refer the case to the Care Quality Commission (CQC), which does have the authority to investigate, or she could ask the CQC to review the Trust's policies. The CQC, however, advised Maureen that the events took place too long ago to investigate the decision and the CQC does not investigate individual cases.

The responses received highlighted the clearly inadequate nature of the regulatory system. The context in which care is provided should not affect the way in which it is investigated, and there should not be hard jurisdictional lines and ill-defined organisational boundaries between different agencies in investigating decisions.

The PHSO agreed to continue investigating other elements of the case but Maureen's feeling was that the gravity of the complaint was severely compromised by the failure to investigate the key decision regarding leave, and as a consequence the clinicians involved appeared unaccountable for the decision taken.

#### Developments since the Patients Association's report in 2014

In the following paragraphs, Maureen describes her experience of the investigation of her complaint by the PHSO since the 2014 report by the Patients Association.

- The PHSO investigation focused only on the main events of my complaint regarding the care my sister received from Southern Health in 2011. The investigation was therefore quite limited in scope and did not attempt to address all the concerns I'd raised relating, for example, to my sister's care in the period leading up to her being sectioned in May 2011, and problems with medication.

- The investigation was limited still further by the fact that the PHSO did not apparently have the necessary jurisdiction to investigate the Responsible Clinician who granted my sister's leave in June 2011 whilst she was still psychotic, and who sent her home to care for our 89-year-old Mum who had extensive personal care needs. The PHSO's powers and authority to investigate complaints is therefore limited and, within mental health, the Responsible Clinicians who are the only individuals able to grant leave to individuals under section, are able to escape investigation and scrutiny of the PHSO and therefore they escape this essential form of public accountability; and this gap in the PHSO's investigatory and regulatory process is potentially dangerous as patient safety is being severely compromised whilst the working practices of Responsible Clinicians are not being actively monitored and appraised by anyone. Consequently, complainants are not able to access a comprehensive or adequate complaints service through the PHSO. I have raised these problems on numerous occasions with the PHSO, CQC, GMC and MPs etc. to no avail.
- The quality of the PHSO investigation was shockingly poor because the investigator's findings were frequently biased towards the interpretation of events put forward by my sister's CCO, and other staff working with her, and this prevented the PHSO from appreciating what had actually happened when Jo's leave was granted in June 2011. In this regard, I was never, at any time, informed of what staff had actually said at interview, and I was never given the opportunity to respond to the assertions being made by staff at interview either. So, in essence, the PHSO investigator simply took what staff said in response to my complaints as the truth, and didn't bother to challenge claims or ask for my feedback regarding their claims either.
- The PHSO investigation was naïve and simplistic in that my letter of complaint was the only evidence used in support of my position, and was the sole document used to direct the investigation in which Jo's medical records were examined and a number of staff involved with her care were interviewed. I find it incredible that the PHSO relied entirely on my quite basic letter of complaint to them for detail of what had happened, and not only failed to ask me to clarify key points and issues that clearly arose during the course of their investigation, but also failed to interview family and friends who were able to support and verify the detail and allegations contained in my letter of complaint – for example, the fact that Jo was psychotic when she returned home in June 2011, and the fact that no notice was given to Mum and I about Jo's leave. My side of the story, so to speak, was not adequately represented and the failure of the PHSO to ask for, and to interview, witnesses in this regard, meant that the PHSO investigation was weighted against me.
- The PHSO investigation involved interviews with staff but the PHSO didn't notice the discrepancies between the assertions being made by staff such as the CCO at interview, and her often contradictory statements in Jo's medical records / Rio (electronic care record) notes. The PHSO also looked at Reports sent by the Trust to the Coroner but the PHSO didn't pick up on the inconsistencies between the claims in these reports and the evidence in Jo's medical records. The quality of the PHSO investigation in this respect was very poor and unprofessional and proper training is clearly required by all investigators to ensure they are able to undertake a rigorous appraisal of a case / complaint, and able to apply questions and questioning techniques that deliver required information, and apply cross-referencing techniques to reveal and to challenge assertions of staff being investigated.
- In the middle of the PHSO investigation, just after all the evidence had been gathered, another investigator was assigned to my complaint and I am sure this was detrimental to the outcome of my complaints.

- During the course of the PHSO investigation, it is clear that investigators would have read my sister's mental health medical records and in these they would have encountered evidence that clearly indicated serious malpractice and the culpability of staff working with my sister. None of this detail was revealed to me by the PHSO and it was not formally addressed by the PHSO either, or referred to the relevant authorities, because the PHSO is not legally required to do so. (I didn't have access to my sister's mental health medical records when the PHSO investigation took place, so I was not aware of all the incriminating facts they contained – but my point here is that the PHSO investigator would/should have seen this evidence.) I am referring here to serious failings on the part of staff which should / could have been referred to the Police for criminal prosecution.
- The PHSO Final Report was reassuring in that it identified two counts of maladministration and two counts of service failure, but it was immensely frustrating that important parts of my complaint were not addressed at all; for example, the Responsible Clinician was not investigated and the CCO's lies and deceptions were accepted by the PHSO and this served to obscure the truth about Jo's leave in June 2011.

In February 2016 I was issued with detail of Court proceedings against the PHSO. One of the Consultant Psychiatrists involved with my sister's treatment, objected to the PHSO's findings of Service Failure and Maladministration against him, on the basis that he was not given the opportunity to respond to the PHSO findings when the Draft Report was issued in April 2015. As a consequence, the PHSO's findings of Service Failure and Maladministration against this Consultant Psychiatrist have been legally 'quashed' in court, and the already inadequate findings of the PHSO investigation and report relating to my complaints were effectively diminished by half! In fact, this problem was not actually down to the PHSO but was a result of the fact that Southern Health NHS Foundation Trust failed to ensure that the Consultant Psychiatrist was informed of my complaint and that he was given the opportunity to respond to the PHSO findings against him. Proceedings in regard to the Consultant Psychiatrist are ongoing whilst the PHSO carries out a review of his response to their own findings relating to my complaints.



In March 2016 I finally acquired my sister's mental health medical records and I was shocked and angered at the sheer extent of the lies omissions and deceptions that I found – so angered that it prompted me to compile a 100-page Critical Analysis of the electronic case notes. On the basis of what I found in Jo's records, and the inadequacy of the original PHSO investigation, I asked the PHSO to review their investigation into my complaints, and they agreed to do so. Their review is ongoing.

### Case Study 3: Averil Hart update since Nov 2014

Averil's case study was originally included in the 2015 report into the PHSO by the Patients Association. This case study updates the material in the light of recent developments as supplied by Averil's family



Averil Hart succumbed to anorexia following her A-Level exams. She lost a significant amount of weight and was admitted as an inpatient at Addenbrooke's with a BMI of just over 11. As she recovered, she accepted a place at University in Norwich to study creative writing. She was discharged from the Addenbrooke's unit to the Norfolk Community Eating Disorder Service (NCEDS), run by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), with her medical monitoring the responsibility of the UEA Medical Centre.

After a significant delay, Averil had her first appointment with a psychologist, who took on the responsibility for weighing her, telling the Medical Centre that it would not be necessary for them to continue. Shortly after this, her appointments with her doctor ceased, leaving her only point of contact as her psychologist. During this time, her weight was recorded as declining, while her physical deterioration was dramatic. The cleaner in her flat thought she should have been in hospital on a drip, while her family, seeing her only three days after her last psychological appointment, realised she looked worse than she had been when admitted as an inpatient. Despite an emergency call, the only response was to schedule a review over a week later, by this stage, Averil had been admitted to hospital, and a week later in December 2012, she had died.

#### Complaints to the NHS:

The family raised complaints with the Trusts involved, but received variable responses. The Norfolk and Norwich Hospital commissioned an independent external review, acknowledged mistakes and made a full apology for the deficiencies in their care. Addenbrooke's Hospital has also agreed to carry out an external review following further explanation of the family's concerns. These responses reflect the seriousness of what happened, the wishes of the Hart family, and the need to acknowledge and learn from mistakes.

In contrast, the response from both UEA Medical Centre and CPFT has been less helpful, and suggests a focus on "reputation" at the expense of the quality of the service provided. A review into her care in the community was commissioned, but the family had grave concerns about the reviewer chosen, and were not given a separate opportunity to submit further questions. Having attempted to raise these questions in Summer 2015, the family received an exasperated response, suggesting that answering questions such as "Did Averil's psychologist have any experience of treating patients with anorexia?" was too much of a burden. The family didn't even receive her full medical records on their original request. This culminated with a complete refusal to answer further questions.

The PHSO:

In August 2014 the Hart family submitted an 80-page summary of Averil's case to the Ombudsman. It detailed the manner in which the care was deficient, and the ways in which the Hart family's concerns were handled by the different organisations involved. This was accompanied by a ring binder containing detailed logs of the e-mails sent and received, the reports produced and the various questions and responses received from the Trusts. However, it took over two months for an investigator to be appointed, and any information that the family received was given as a result of continuing inquiries and requests from Averil's father.

After pressing for several weeks, the family arranged a face-to-face meeting with the investigator in order to discuss their main concerns and the practical considerations that would have to be taken in the course of the investigation. An agreed timescale was reached, but at 12 months was lengthy given the amount of information provided.

The initial advice given to the family by the PHSO was that the investigation would take a maximum period of 12 months to conclude. After 8 months, the first investigator who was allocated to the case resigned and it took some time for an alternative to be appointed. Eventually the Head of Investigations was appointed but this proved unsatisfactory due to the volume of other cases he was dealing with. The Head of Investigations later resigned and was replaced by a further investigator who has also subsequently resigned. The Deputy Ombudsman became involved in the case but he also resigned. To date 5 separate investigators appointed to review Averil's case have resigned.

The initial advice given to the family was that a series of reports would be prepared in acknowledgement of the number of different Trusts involved in the complaint. This advice was subsequently revised after a year with the PHSO deciding that they would compile a combined report. A draft copy of this report was ultimately received by the family in September 2016 over 2 years after the family had brought their complaint to the PHSO. On examination, the family found the report to be very badly assembled and many of the basic elements that failed in Averil's care weren't covered properly. The family subsequently outlined the details which they found to be missing and the report remains in a draft form.

The regular changes of investigator have meant that the family have had to frequently re-brief the PHSO with details of their case. The experience of the family has been akin to reading a transcript describing a car crash that one's daughter was involved in every day never being able to properly grieve for their loss. At the time of the compilation of this report In December 2016 there is no sign of the PHSO's investigations into the family's concerns being drawn to an effective conclusion.

## 11 Conclusion

In 2014 the Patients Association called for a complaints system which is “designed in partnership with patients and has patients at the very centre of the whole process” (2014: 5). Sadly, the experience of too many complainants remains of a system which is complex, lacking in compassion and unresponsive. The vast majority of complainants are motivated to complain by a desire to improve the system for others by sharing the poor experiences they have had. The PHSO, representing the final stage in the process, should act as a reliable and robust final arbiter. For too many people, as evidenced by the wide variety of contacts received by the Patients Association, this is not the case.

In 2014 in response to criticisms contained in the Francis enquiry, the PHSO in conjunction with the Local Government Ombudsman and Healthwatch England, produced a user-led vision of the complaints system (Parliamentary and Health Services Ombudsman et al, 2014). In considering the outcomes of a complaint and the experience of the complainant the vision suggests that complainants should be able to say ‘I felt that my complaint made a difference’ and ‘I would feel confident making a complaint in the future’ (2014: 9). The PHSO’s procedures should exemplify a system that enables complainants to make these observations. Regrettably for those people who contacted the Patients Association for support, this was not their experience.

The proposals set out by the Gordon Review published in 2014 brought forward recommendations to Government for establishing a unified ombudsman service bringing together the different public services ombudsmen into one unified service. The report envisages a requirement on the part of the Public Service Ombudsman of “building trust in the final tier of the complaints handling structure, and in turn actively demonstrating the benefits of doing so” (Gordon, 2014: 17). Proposals for the creation of a new Ombudsman, which in the first instance will bring together the Local Government Ombudsman and PHSO, is welcome but this will require legislative change with associated time delays. Until such time as the new organisation is created it is critical that all necessary steps are taken to ensure the PHSO fulfils the role envisaged in the Gordon review.

Our assessment of the accounts we have received from the many dissatisfied users of the PHSO since our reports in November 2014 and March 2015, has convinced us that there remain many problems with the performance of the PHSO and the ways in which reviews of complaints are undertaken. In addition to the detail supplied in the body of this report we would highlight the following points for further consideration:

### **Recommendations are ineffective**

Making 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 the same problems don’t affect anyone else. The PHSO makes recommendations to put things right and to prevent the same problems from happening again, however, they have little or no effect.

One in eight of the people contacting the Patients Association to raise concerns about the PHSO in the last six months stated that the recommendations made by the PHSO were too weak to affect any

positive change. There is also no system in place to evaluate whether suitable action has been taken in response to recommendations made. If the PHSO required that the Trust Board had to demonstrate that their organisation had implemented their recommendations, (or had good reason why the recommendations couldn't be implemented), the mistakes would be less likely to be repeated, with proper accountability forming part of the governance arrangements for NHS Trusts.

### **What influence or power does the PHSO have?**

In their review of the role and function of the PHSO the Public Administration Select Committee summarised the Ombudsman's powers in the following way:

“Complaints made by members of the public to the PHSO must be directed through a Member of Parliament, unless it is an NHS-related complaint, and the complainant must first have put their grievance to the department or public body concerned to allow officials to respond before PHSO can take the matter further. PHSO cannot investigate an issue unless there has been a complaint. Subject to this, it has statutory discretion to consider cases as it sees fit. PHSO has sole accountability for the decisions made, subject to judicial review. The office holder also has powers analogous to the powers of a judge of the High Court, namely the right to summon persons and papers, (i.e. to require the attendance of witnesses and to have access to information), and absolute privilege to protect his or her reports” (2014: 8)

Patients report that NHS organisations seem apathetic about patients taking complaints to the PHSO. The impression gained is 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.

The powers available to the PHSO are considerable if effectively used, but its actions have in a number of cases been restricted by its statutory discretion to consider cases as it sees fit. Often the logic applied in whether to take a case forward seems opaque to the many people who contacted the Patients Association. Amongst evidence submitted to the Public Administration Select Committee one respondent suggested that:

“PHSO consistently identify malpractice in fewer than 2% of the total number of cases presented. Therefore 98% of complainants do not receive remedy and feedback to organisations is reduced accordingly” (ibid 2014: 9).

In response to greater scrutiny the PHSO has expanded the number of cases it investigates. However, this will only represent progress if the investigations conducted are robust and (where necessary) sufficiently challenging to offer adequate remedies to complaints raised.

### **The Future for Health and Social Care Complaints Handling?**

We don't know how many other patients have had negative experiences of the PHSO. Nor do we know the number of patients who didn't contact the PHSO even though they had cause to. Patients may have had no confidence in the PHSO or may not have had the strength to initiate the PHSO process if they have had a negative experience of the complaints procedure at a local level.

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 should be. There have been many reviews and recommendations aimed at improving the system, so why is it still not



working? The Commons Health Committee report, 'Complaints and Raising Concerns.' (2015) 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. This was borne out by many of the patients and families who contacted us. For example, one correspondent 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 this frequently not provided?

Commissioners must start to hold organisations to account and insist on receiving assurance that recommendations from the PHSO and other serious incident investigations have been implemented. 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."<sup>1</sup> However there is an apparent widespread failure to learn as the same problems continue to be reported.

Sir Robert Francis called 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. Everyone, however busy or senior they are, has a responsibility to ensure that incidents and complaints are properly investigated and learned from. Too often this doesn't happen.

## 12 Recommendations to the Public Administration Select Committee

Two years on from our first report about the PHSO there is little evidence of significant improvements in the performance of the organisation or outcomes for patients. The Patients Association continues to receive a high number of contacts from people dissatisfied with their experience of working with the PHSO.

There is considerable evidence that the NHS is operating under strain at the moment reflecting increased demands on the service and financial constraints. In these circumstances, it is essential that the public has confidence in its ability to raise concerns where the NHS has failed to provide a satisfactory service and have these concerns properly addressed.

The PHSO will itself be subject to change as the Government brings forward proposals and draft legislation clarifying the role of a new Public Services Ombudsman together with detail of the structure, governance and accountability of the new body. Nevertheless, until such time as this legislation is enacted we call upon the Public Administration Select Committee to effectively hold the PHSO to account and ensure that action is taken to address its poor performance. As envisaged by the last Public Administration Committee in 2015 this should include scrutiny of the PHSO's competence in conducting investigations, adequately reviewing evidence and providing legal

interpretation. We would further recommend that the Public Administration Committee should expect clear evidence of the following from the PHSO:

- Action taken to establish a robust external audit mechanism to benchmark and assure the quality of Ombudsman investigations.
- A proper acknowledgement by the PHSO that problems exist in its performance and that it is committed to taking effective action to address these.
- Verifiable improvements in the adjudications made by the PHSO supported by reliable evidence to confirm this is the case.
- A clear programme of action that has the aim of restoring the public's confidence in the PHSO.
- A logical and adequately resourced internal change programme with demonstrable outcomes for users of the PHSO's services.
- Demonstrable continuity in respect of case handling, despite changes in staff.

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## 14 Appendices

### **Appendix 1: Findings of the original 2014 Patients Association 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.

## Appendix 2: Recommendations from the original 2014 Patients Association 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.