HOUSE OF COMMONS

Health Committee

Oral evidence: Complaints and raising concerns, HC 1080

13 May 2014

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Written evidence from witnesses:

- Action Against Medical Accidents
- Which?

Watch the meeting

Members present: Mr Stephen Dorrell (Chair); Rosie Cooper; Andrew George; Barbara Keeley; Charlotte Leslie; Grahame M. Morris; David Tredinnick; Dr Sarah Wollaston

Questions 173-262

Witnesses: **Lisa O'Dwyer**, Director of Medical and Legal Services, Action against Medical Accidents; **Liz Thomas**, Head of Policy and Research, Action against Medical Accidents and **Sonia Sodha**, Head of Public Services and Consumer Rights Policy, Which?, gave evidence.

Q173 Chair: Can I begin by welcoming the witnesses to the Committee? I look forward to hearing what you have to say in this inquiry, which essentially follows up a report that we issued—getting on for three years ago now—on complaints handling within the health care system and seeking to improve the way the system deals with complaints about

Q174 patient experience. Could I ask our witnesses to introduce themselves?

Liz Thomas: I am Liz Thomas. I come from the charity Action against Medical Accidents. I am the policy and research manager.

Lisa O'Dwyer: I am Lisa O'Dwyer, also with Action against Medical Accidents. I am the medico-legal director there.

Sonia Sodha: I am Sonia Sodha, head of public services policy at Which?, the Consumers' Association.

Q175 Chair: Thank you very much. Sonia Sodha, you said you would like to make a brief opening statement.

Sonia Sodha: Yes, if that is okay and helpful for the Committee. I will try and keep it brief.

Which?, as some of you may know, is an independent apolitical social enterprise that exists to represent all UK consumers. We are funded solely by our commercial ventures. Our mission is to make people as powerful as the organisations they face in their everyday lives. We think this mission is just as important in relation to users of public services as it is in relation to consumers in private markets.

We welcome the opportunity to provide evidence at this important inquiry. Our evidence is based on and informed by our research with members of the public. We polled members of the public, both in 2012 and 2014, on their experiences of complaining, or not complaining, about public services. We also ran a campaign earlier this year to make complaints count in public services. We had over 13,000 people sign up, and we invited members of the public to share their experiences of issues in public services and their experiences of the complaints system, as part of that campaign. Over 6,000 people shared some form of comment or story about their experiences of the system with us. Would it be helpful for me at this stage to summarise three or four of the key themes that came out of that?

Chair: Yes, very briefly.

Sonia Sodha: Very briefly, we found that a significant minority of people did not complain about health and social care services when they had cause, which obviously chimes with research that others have done. There were a number of issues. We welcome some of the changes that the Government and others have committed to make in the wake of the Francis inquiry. There are three further things that we pointed to in our evidence—some of them have been supported by others as well; they would not be a silver bullet but they would help to promote some of the cultural change that we need to see in the NHS and social care. Those things are, first, a unified public services ombudsman that brings together the PHSO and the LGO, bringing together health and social care complaints handling at the second tier.

We would like to see a stronger link between people's complaints and regulatory inspections, and we welcome what the CQC are doing in terms of risk-based regulation, using complaints to inform that in the wake of Francis. We would like to see even more transparency in that link, as we think it sends an important signal to the public. Lastly, we think there is a good case for establishing a super-complaint power in relation to public services. It is something that designated consumer bodies already have in private markets, and it is a really useful safety valve. When there are clear issues, or systemic issues, operating in a market, it gives a consumer body the power to write to a regulator and get a response. We think there is a good case for expanding that to public services as a sort of safety valve mechanism. I will stop there.

Q176 Chair: Thank you very much. I would like to open the questioning, if I may, by picking up a reference that you made to the Francis report, which was calling for culture change, focus on patient experience, and much greater willingness to listen to the voice of patients and people who use the service. That report was published two years ago. Query: has anything changed?

Lisa O'Dwyer: In our experience, we have not seen a great deal of change. We have a helpline where we receive about 2,500 calls from the public each year. We also have an advice and information service where people can write in and ask for help from us; I would say that about 75% of our written advice work relates to complaints. There may be other issues in there, but it is primarily complaints, as is our phone line. The number of people making those calls is consistent. It has not changed recently, and that in itself suggests that there has been very little change, certainly in the last 12 months or so since the Francis inquiry.

Q177 Chair: I was wrong to say two years; it just seems like two years. So the short answer, from the perspective of Action against Medical Accidents is, "Very little change at all."

Lisa O'Dwyer: That would be correct. In the scheme of things, taking into account that we are looking at such a large organisation, change is often very slow. It may be that there is willingness to change. Certainly in relation to some of the responses to complaints we have seen, I would say that they are still poorly handled and that there is still room for improvement. But we see elements of some of the recommendations, in the Clwyd-Hart report, for example. A recent one we had at the end of April and beginning of May was in relation to a complaint where the complainant was able to identify that there was a pen and paper handy for their concerns to be jotted down, which of course was a recommendation. That suggests that there is some recognition of the concerns raised in those reports, but certainly the substantive part of dealing with complaints has not really altered.

Q178 Chair: That is pretty de minimis, isn't it?

Lisa O'Dwyer: Absolutely.

Chair: The thing that we need to see, if we are going to deliver improved patient experience, improved willingness to learn from mistakes and so forth, is openness to the patient viewpoint—an understanding of what it can sometimes feel like to be in a care provider that is not doing what it should do.

Lisa O'Dwyer: I think it goes slightly further than that. It is about understanding the difficulties and the reluctance that people have in expressing their concerns about the care that they are receiving, particularly the elderly, who know that the chances are that they are going to need assistance and be reliant on services from that particular trust in the future. There is a sense that there may be retribution, perhaps, or that it may come back to haunt them for making complaints.

Chair: Thank you.

Sonia Sodha: As I said, our evidence is based on insight about what members of the public are saying about their willingness to take a complaint forward when they have cause to complain or when there has been an issue. We did some polling back in 2012 and in 2014—either side of the publication of Francis and lots of other things that have happened, like the publication of the Clwyd-Hart review, for example. We found that although there was still a significant minority in 2014—a big chunk saying that they were not complaining when they had cause—there had been a small drop-off since 2012. That is quite interesting. We should not over-interpret that or over-extrapolate from it, because it is polling at just two points of time—it is not a continuous tracker—but it does suggest that some members of the public may be more willing to come forward as a result of some of the publicity that some of these inquiries have generated, which is a positive thing.

I echo the point that has just been made about people feeling that they are able to complain. That is something that came through very clearly from our case studies, particularly people with mental health issues or relatives of people with mental health issues, and older people, who felt that sometimes they needed extra support in the complaints system.

My final point in response to the question of whether things have changed is that it raises a really important question about who is responsible for tracking change. There are so many organisations involved in implementing change post-Francis—as you would expect, because our health and social care systems are very large and complicated—that it raises the question, "Who overall is tracking what is going on, and how much transparency is there?" We think that public attitudes are a really important part of the jigsaw puzzle, but they are only one piece, and we have to look at data on the ground—what is happening from a range of different organisations such as the PHSO,

the CQC and professional regulators, what is coming into CCGs, what is coming into NHS England. How are we building a national picture of what is happening in complaints, and how is the complaints system functioning? That is not an easy question to answer, and it is not a question that one organisation alone can necessarily answer.

Q179 Chair: I understand that, although you link together a number of regulators and complaints organisations that look at the system and the processes. Surely what we should be looking at is much greater focus on the individual, and responsibility for that rests on the service provider, not on those national bureaucracies. It is something that individual service providers need to be more focused on and better at doing.

Sonia Sodha: That is absolutely right, yes.

Liz Thomas: One of the reasons why the change has perhaps been a bit slower is that we have not had structural change around patient advocacy for complaints. It is really important that that does change. That is something that has come out of the Francis report and other reports since. One of the key priorities is to look at how advocacy is provided for complainants in order to empower them in the process.

Chair: That is a good peg for Sarah's question.

Q180 Dr Wollaston: In our last report we recommended that PALS pass the more serious complaints to ICAS at an early stage, because we were hearing evidence that they were better at handling those kinds of complaints. Have you seen any evidence of that happening? What has happened to ICAS and PALS, and how has that changed since the report?

Liz Thomas: We think PALS has a very valuable role in terms of customer interface, particularly when you are talking about large organisations, but they obviously do not have the objectivity that is perhaps required if you have a complex complaint. One of the difficulties with the whole terminology about ICAS—at least now it is called NHS Complaints Advocacy, which is a little bit closer—is being able to identify and locate it; I had difficulty finding my own advocacy service in my area. There are difficulties around that, which is why we are strongly in favour of bringing the advocacy services into the local Healthwatch.

Q181 Dr Wollaston: Do you think there is any public awareness at all about the existence of that body—as you say, it has been renamed—and how people would access it?

Liz Thomas: It is certainly our experience that it is quite limited in terms of people being able to find those services.

Q182 Dr Wollaston: Is there any evidence that PALS are passing over more serious complaints at an earlier stage to a body that is better at handling those kinds of complaints?

Lisa O'Dwyer: I don't think we have the sort of data to say one way or another. The cases that are being referred to us are consistent, which in itself would suggest that there is still a large number of people who are coming to us. Ultimately, I don't think we are being referred by PALS. I don't think PALS have an independent list of people, other than ourselves, who might be able to assist, for example.

Q183 Dr Wollaston: Do PALS never pass people over to you if they think you could have a role in assisting them, so people have to find out about your organisation on their own?

Liz Thomas: Very occasionally.

Lisa O'Dwyer: Occasionally. Some of the other agencies, such as POhWER and so on, refer cases to us, but they are limited in number given the number of cases that we handle each year and on the helpline, so they are a very small minority in the scheme of things.

Q184 Barbara Keeley: Following on from your thoughts about things not having changed, could you tell us what you think the purpose of the health and social care complaints system should be? Clearly it is some sort of mix of acknowledgment and apology and service improvement, and in some cases people are looking for compensation. What do you think it should be?

Liz Thomas: One of the problems is that we seem to have been going round in circles for the last 20 years. We had the Wilson report back in the 1990s looking at complaints, and then we had recommendations about how complaints should be run. It is perhaps more about thinking outside complaints terminology because, certainly from our point of view, we see it very much as an issue of patient safety. As soon as you treat people as complainants you treat them as adversaries rather than participants in improving patient safety. We would like to see alternative terminologies starting to be used around complaints, so that patients are seen as part of the process of improving patient safety and care. That is what most patients want, at the end of the day. One of the top things patients are trying to achieve by complaining is to prevent it happening again.

Lisa O'Dwyer: It is a rich seam of information and it should be fed back into the trust. We see similar complaints and issues arising in different trusts, so there is learning that should be accessible and taken on board. But there is a missed opportunity so far.

Sonia Sodha: We would agree with a lot of that. A good complaints system first of all has to be part of a broader culture, which is about encouraging feedback from patients and users in health and social care. It has to be a system that handles individual complaints fairly, independently and efficiently, and provides redress. People have told us that often in public services it is about an explanation and an apology, and knowing that it is not going to happen again, rather than about financial redress. Indeed, lots of people who wrote to us about our campaign work were very clear that they were not necessarily looking for financial redress from the NHS. It has to be accessible and simple, and support people to come forward and make their issues known. It has to give providers the critical intelligence they need to improve their services as a first point of call. That is the most important thing, obviously, in the system, but it should also provide evidence for commissioners, regulators and Government to take action where there are systemic problems and where providers are not acting on complaints and feedback in the first instance.

We think that points to a number of improvements in the system. None of these are rocket science; they have been doing the rounds for 20 years, so perhaps the question is why we have not seen greater reform. It is about simplification and more accessibility. It is about more independence in the first-tier complaint. Lots of people who wrote to us said that when they were initially making the complaint they did not feel there was enough independence at the first stage of the system. It has to be about culture change, and it has to be owned at the board level. It has to be a source of intelligence for providers, but also for regulators and commissioners.

Q185 Barbara Keeley: Can I ask a follow-up question about service improvement? You said, Lisa O'Dwyer, that it is a rich seam of information. What indication do you have that NHS

bodies are using complaints data in that way, that they are using that rich seam of information? Do you think any are, or many are?

Lisa O'Dwyer: That is precisely the point. There is no data to suggest that they are actually using that information; there is the sense that a complaint is something that needs to be dealt with and then goes away. There is no sense that the complaint is in itself a very valuable source of information that can give a trust the heads-up that there may be difficulties, or that services or procedures need to be improved. That really does need to be fed back within the system itself. Complaints should not be seen in isolation. They are reflective of the whole body that is being complained about.

Liz Thomas: The shame is that we do see some good examples in trusts, where they bring families back in and show the changes they have made, and we see a positive outcome. It is really important that we can share that best practice across the NHS; it is too much in pockets and not sufficiently across the board.

Sonia Sodha: I agree with that completely. Lots of reviews that have looked at this have identified examples of shining best practice in health and social care. None of it is rocket science: it is all the stuff that is pointed to in lots of the reviews. It is about culture change, about board-to-ward and about there being lots of different routes for patients to let their feedback be known. It is about having a system that is geared to the needs of the patient, not one route that somebody must follow. There are lots of different alternative routes. For me, and for Which?, the million-dollar question, as it were, is that we know what good practice looks like, but what is really key is how we spread that best practice and culture change throughout the whole of the NHS, because that culture is not there systemically. It has to be about sharing best practice, but the really difficult, thorny issue at the heart of this is how you create that culture change. That is what Francis was about, at its heart.

Liz Thomas: I agree.

Q186 Dr Wollaston: You talked about seeing some shining examples. Can the panel give us examples of hospitals that are particularly good at handling complaints and actually learning from example and welcoming complaints?

Lisa O'Dwyer: We had a look at some of our complaints before we came out, in preparation for this. There was a Welsh trust that had dealt with a complaint very well. It was a complaint where they readily acknowledged that there had been failings; they identified first of all what the complainant wanted, what the issue was, and then they responded to it appropriately. They offered a fulsome apology and explained what they had done differently, including a whole review across the health board as to the particular issue that had arisen in that case. Of course, there is a redress scheme in Wales, and they confirmed that they had automatically referred it on to redress. They provided information about support and what the next stages would be. That, I think, was an example of good practice. It did not leave the complainant with any obvious questions about what happened next. It was there. There was acknowledgment, a fulsome apology and then a plan for the future and how the problem was going to be remedied, and how the cause of the problem was going to be rectified. I thought that was good handling.

Sonia Sodha: Clwyd and Hart looked at examples of best practice as part of their review and they have five or six good examples at the back of their report. One of those was at the Royal United Hospital, Bath. I definitely recommend having a look at those, if people on the Committee have not already. There are some interesting examples.

Q187 Grahame M. Morris: On that point, I appreciate that you particularly represent the view of consumers, patients and people who are making complaints, but have you made any assessment of the resources that individual trusts put into complaints handling? You gave some good examples from Wales and the south of England. Is that a function of how much resource they put into it?

Sonia Sodha: We have not ourselves at Which? looked in detail at the resources that trusts put into complaints handling. I think there have been studies run by other organisations, such as the Nuffield Trust, that looked at that. I am not sure how much has changed over the last two years, but I think the evidence that has surfaced through several reviews has suggested that where there are issues it is often because complaints are handled by too junior people with a lack of training, and there is not that sort of chief exec and board level commitment to using complaints and feedback to drive improvements in the services that people are receiving on the ground. I probably couldn't say much more than that.

Q188 Grahame M. Morris: I want to ask Liz and Lisa from Action against Medical Accidents as well, because you have reviewed six cases post-Francis, haven't you?

Lisa O'Dwyer: Yes.

Grahame M. Morris: What conclusions have you come to about the qualities of a complaints handling officer? What attributes should they have? Is there a common factor there?

Lisa O'Dwyer: Knowledge, of course, is key. It is about being aware of the nature of the complaint, how to handle people who are in a very vulnerable position and managing those people and their expectations in a sensitive way, but also being able to identify the true issue and being robust enough to go back to their own clinicians and deal with them and ask for proper explanations so that they can be passed on. All of that lends itself to a perception of the complaints process and the complaints department. There is perhaps generally a lack of respect—perhaps "respect" is too high a word, but it is something along those lines—or not enough weight is given to the importance of a complaints department. It is very difficult sometimes for people who have had limited training, if any training at all, to challenge the explanations given by a clinician. There is, if you like, an inequality between the two. The clinician holds the information. It takes quite a determined and confident person to say to the clinician, "But that does not really answer the question, that is not what the patient is asking. Can you explain it and give it to me in layman's terms so I can pass that information on?" You need to be robust and confident to deal with that, so those would be pretty key attributes for somebody in complaints.

Q189 Grahame M. Morris: Do you agree with Sonia about the reporting level at the board, and that back-up from the chief executive is reflected in trusts that handle complaints well and deal with them in a more satisfactory way?

Lisa O'Dwyer: Certainly there should be a relationship between the complaints department and the board, without a shadow of a doubt. That is the way you communicate the difficulties. That is the way you bring potential failings and difficulties to the attention of the board. Stafford is a good example.

Sonia Sodha: I agree with all that, but it is important to stress that it is not just for complaints handling departments; it is a case for all NHS staff. All staff need training to be able to understand how to deal with people who are coming forward with concerns that may turn into complaints.

Q190 Rosie Cooper: Do you think all chief executives should sign all responses to complainants? I insist my chief executive signs all the letters about complaints, especially to me, because I need to know that he knows what has gone on.

Lisa O'Dwyer: In principle, the answer to that would be yes. My reservation would be that it is very easy to sign a piece of paper. You probably need something a bit more than just a signature at the end of a response letter that indicates that a chief executive has looked at it or signed it. You want to know that they have actually looked at it and considered properly the issues that are at hand. That is the key to it, rather than signing off.

Rosie Cooper: Absolutely. I believe the board should see every one.

Q191 David Tredinnick: In your Action against Medical Accidents briefing, you suggest there is little public awareness of the potential to make a complaint to a commissioner or to NHS England as part of the local resolution process. Why do you think that is?

Lisa O'Dwyer: It is generally a lack of information at grass-roots level. As I illustrated, it is not widely recognised or understood by people that it is an option that is open to them, including the ability to make a complaint to clinical commissioning groups as well. I think that comes from lack of information at the initial stages. It might be something that PALS should be obliged to make known to people. I think lack of information, essentially, is why people do not do it.

Q192 David Tredinnick: You say that, but aren't there notices on hospital notice boards explaining how complaints can be made? Have you done a study of that or looked at that at all? Have any of you looked at how the complaints procedure is advertised? Is that something you have managed to look at?

Lisa O'Dwyer: No. We are a small, independent charity, so going into various trusts to examine where their boards are is not something we can do on a practical basis. We work on the feedback that we get, as I said at the outset, from the casework that we do and so on, but certainly when people come to us they do not have that information; they do not know that there is a route through the clinical commissioning groups. In the case examples I gave you there was one person who was aware of that, and that was somebody who was a particularly confident individual who was fairly able, and I think he got the information through his own researches rather than through PALS or from any other place.

Q193 David Tredinnick: Do you think that hospital websites should have a link to a complaints procedure?

Lisa O'Dwyer: I do—very much so.

Q194 David Tredinnick: Do you think that should be a requirement?

Lisa O'Dwyer: Very much so. I think that some hospitals avoid reference to complaints on their websites. Some are much more open about it than others, but there should be something mandatory that there should be a heading—"Complaints."

Q195 David Tredinnick: Have you seen a pattern out there, with some hospitals offering this kind of information and some not?

Lisa O'Dwyer: I do not have specific data so that I can say to you, "I have looked at x number of hospitals," but I do know that—

David Tredinnick: So we are really not quite sure of the advertising landscape.

Lisa O'Dwyer: What I do know is that we have looked at some hospital websites when we have tried to help people with the complaints process, and it is not readily accessible; it is not obvious what the complaints processes are. Some hospitals are better than others. It is not a consistent picture. Some hospitals do; some don't.

Sonia Sodha: We would echo that in terms of what people have told us about their experiences of complaining. Lots of people have said that it is difficult to know where to go. That probably means that how well publicised hospitals' complaints procedures are is patchy. The other thing is that, for some people, written information is not enough. It is quite interesting to come back to the point about commissioners. If you asked lots of members of the public what a commissioner is and what their role is, some people would be able to tell you, but lots of people would not, because for them it is the NHS and they think about a particular hospital.

Q196 David Tredinnick: Fine. Let me stop you there. What are the benefits of choosing to complain first to a commissioner rather than to a provider? Are there any benefits? What routes do you recommend? What is your preferred option?

Liz Thomas: To be able to complain to the organisation, ideally. If you come to a situation where you are not getting a response from the organisation, maybe then you would involve the commissioner. I agree that most patients have no idea how the NHS structure works and, therefore, the commissioner is something far too removed for them.

Sonia Sodha: That really stresses the importance, I think—

David Tredinnick: You agree with that, do you?

Sonia Sodha: I agree, but a lot of this discussion stresses the importance of signposting and the fact that a written procedure sometimes is not enough. People, particularly when they are in a really stressful situation—their relatives are very sick or they might be very sick themselves—might be vulnerable and they might need to talk to someone about what to do.

Q197 David Tredinnick: We are getting a lot of "mights" and "possibles." Is there any absolutely cast-iron evidence? Has anyone done any surveys? Is there evidence that complaints made to commissioners rather than to providers have produced better outcomes for complainants? Has anyone done a survey?

Sonia Sodha: No, we have not looked at that.

Lisa O'Dwyer: No.

David Tredinnick: I would have thought that this is fundamental to an understanding of the complaints landscape. I will say that to you.

Q198 Dr Wollaston: To follow on from that, in your view, do commissioners take enough notice of complaints? One of the concerns expressed by Francis in his report was that they seemed to see themselves as separate from the complaints process. What is your view, since Francis, on whether there has been any change in that?

Liz Thomas: I do not think we have seen evidence of that. We need to do far more data collection, actually getting feedback from complainants at the end of the process—even as a short five-question thing in terms of how they viewed the outcome of the complaint and whether it

satisfied what they were looking for—so that the commissioners and others can look at information like that, and call them to account if they find that patients are not being satisfied by the process.

Sonia Sodha: I would add that there is still no one way of tracking complaints through the system. A CCG, for example, may be getting complaints, but they may be seeing a small proportion of complaints; some may be going direct to the provider. The ombudsman will see a certain proportion of them. There is a question about who has oversight of the whole. It is really difficult, because this is very complex data. It is welcome that this is something that the DH are very interested in and it is really being driven by the Secretary of State, but there is a long way to go before we have a system that is entirely transparent and where people record. Even in categorising complaints, the DH, the PHSO and NHS England have different category systems, so even at that level it is very difficult to track complaints through the system.

Q199 Chair: Should it not be simply unthinkable that a commissioner places a contract with public money to secure access to health care without first satisfying themselves that there is a proper complaints handling process by that provider? Should it not be a pass/fail test?

Sonia Sodha: Yes.

Lisa O'Dwyer: Yes.

Q200 Chair: Is there evidence of any commissioners asking those questions of any providers?

Lisa O'Dwyer: Not that we are aware of.

Sonia Sodha: It is not a question that we have looked at, but yes, we agree with you, absolutely. Actually, more broadly, commissioners need to pay more attention to patient voice and what patients say about the quality of their services in the design of their commissioning contracts.

Q201 Rosie Cooper: I just don't know where to start. In terms of simplicity—I am going right off the page—were not Community Health Councils a much simpler and much more easily accessible form of getting advocacy and help for local people?

Liz Thomas: That sort of model is where you have a one-stop shop where people can go and get the advice, but also it is the link between listening to patients who have had problems and feeding that directly into their watchdog role. I think now we have that kind of model in Healthwatch, which is a great title—local Healthwatch—so at least you can identify what it is. I think one of our biggest pleas was, "Don't change it again."

Q202 Rosie Cooper: Absolutely. I understand that it is not going to change again. I find the whole thing extremely difficult, as somebody who has been the chair of a hospital. We had summaries of all the complaints coming to the board each month, and I love complaints because that tells me what is going on in my hospital; and when I cure them— properly sort them out—we are a better hospital tomorrow, or a better health provider.

Going away from all the things I would absolutely love to say, the Chairman has just spoken to you about the commissioners knowing, looking at or even having a clue about the level of complaints that are made. I have been involved in a case in Liverpool where I have actually written to the commissioners and asked them what they were doing about an appalling CQC report. Recently the

chief exec has gone, the chief nurse has gone and the director of HR has gone—all within weeks. My answer from the commissioners was, "We are holding meetings, and we will look at it and see what they have to say." If that is the level we are operating at, it is frightening.

In 2011, we recommended that commissioners should be the focal point for local analysis, and very clearly nobody in this room has any idea that that is actually happening on the ground. They should know what is going on with complaints and then share the action plans and progress with Healthwatch. What we have is a complete disconnect. Do you have any evidence that there are effective local accountability arrangements for complaints handling, or any evidence that anybody cares about this system, anybody is doing it and that it is joined up in any way?

Sonia Sodha: It is not something that we have looked at in detail at the local level, unfortunately, so I cannot really comment either way. But I wholeheartedly agree with you about the importance of commissioners in the system. When we are talking about commissioners and the regulator, what happens when things are really going wrong? Who is responsible? Obviously it should always be the provider who holds primary responsibility for dealing with complaints, but what happens when that is not the case? That is a really shocking story that you have just given.

Q203 Rosie Cooper: When a situation is as big as three senior execs going and the commissioners all talked about how bad it was—I know that individually they talk to each other, but taking action was too much like hard work—how do you think we help commissioners to actually come to the point that the Chairman made? They are commissioning services with large amounts of public money. How do we make them more accountable for the decisions they make and the quality of those services? How would you do it?

Chair: We are shooting you to encourage the answer.

Liz Thomas: A lot of it is about empowering the patients, and local Healthwatch would have a key role in that in terms of driving these things forward, particularly if they are hearing directly from patients who have had problems with health care.

Q204 Rosie Cooper: What if the commissioners are not listening, or if they see their job as too big and they are too busy? That is how these things are all falling off the side, but let us leave that.

What role do you think there should be for the chief inspector of hospitals and the Care Quality Commission in evaluating and monitoring intelligence from complaints? What is their role, and how does that feed into the rest of it?

Lisa O'Dwyer: As far as that is concerned, it is already a very big job being head of the CQC, so to take on board the complaints aspect of it as well, while there is a logic to that, it is about capacity and the extent to which it can be done effectively. That would be our concern.

Q205 Rosie Cooper: I didn't intend to suggest they should take on the complaints, but it is more about how they would evaluate and monitor the intelligence they are getting and passing it on.

Sonia Sodha: We think they have a critical role to play. There is a lot of change happening at the CQC at the moment, as I am sure you are all more than aware. We have been talking to them about what they are doing post-Francis, and there is a lot to welcome and watch and monitor the impact of. We particularly welcome the fact that complaints handling is going to be an important part of their inspection framework, an important part of their fundamental standards. They are working with the Patients Association on complaints, to use the Patients Association's complaints handling standard. We also think that complaints are a critical form of intelligence in a world where we are

increasingly moving towards risk-based regulation. The CQC is working to look at how it uses complaints as a form of intelligence for triggering regulatory responses where needs be. We think that is really important and good. Our question would be that there are a lot of data issues around how people are measuring and reporting complaints—sorting them out—and, again, there is a lot of work going on in that space as a precursor to intelligence and risk-based regulation, with complaints feeding into that.

The other point is that we would like to see as much transparency as possible about the link between serious unresolved complaints and a CQC response. We think that it could send an important signal to members of the public. We already know that the public do not complain, sometimes because they are sceptical that their complaint is going to have any impact, or because they feel they are being treated in a hospital or a care home where there is not a culture of welcoming complaints or acting on complaints. We think that sort of safety-valve mechanism would give some members of the public more confidence to complain.

Q206 Rosie Cooper: Is that not the ombudsman's role?

Sonia Sodha: It absolutely is the ombudsman's role to look at individual complaints, and I know that the ombudsman would also like to see a power of investigation—I think the ombudsman will be saying more about that in the next session—but it is the regulator's role to understand. Evidence of serious complaints going unresolved is a signal of something deeply or fundamentally wrong, and the regulator has to play a role in the response to that.

Q207 Rosie Cooper: Who would decide it is unresolved—the complainant? How do you work out what is a severe unresolved complaint?

Sonia Sodha: That is a difficult question, but I do not think it is unresolvable. There would be work to do to understand. First of all, there are ways of assessing the level of seriousness of a complaint. There is no reason why you could not have a system for doing that. As to whether a complaint is resolved, it is about asking people at the end of the process, "Are you happy with how your complaint has been resolved?" As has already been said by the panel, we do not do enough of that at the moment across the system. I think there is definitely scope for more of that. That is not to say that there are not some quite difficult issues around how we track complaints and the data around this. Just because it is difficult does not mean that we should give up, or that it is completely unresolvable.

Liz Thomas: On occasion we certainly come across complaints where it is clear that there is some deeper systemic problem where you would want the CQC to be going in straight away—a rapid response to a complaint.

Q208 Rosie Cooper: Do you pass that on?

Liz Thomas: In the past, I certainly had one case—this is going back to a previous CQC regime—and was told they might be able to look at it in three months. I am hoping that has changed now, but we certainly would like the CQC to be very responsive. It is about having advice available to complainants, to say to them, "This is a really serious issue and we think it ought to be pursued further." It is a very lonely business being a complainant unless you have access to that kind of support, and it is also a context for your complaint; you might think you are the only person who has a complaint, and that maybe it is your problem rather than theirs. It is about being able to go to informative, specialist advice about complaints to give you reassurance and a context for your

complaint in order to push it forward and make sure that you are heard and, if they feel there is a more systemic issue, to pick that up and pursue it.

Q209 Charlotte Leslie: Sonia, I would like to ask you this first of all, but others, please feel free to chip in. You have recommended there should be a single public services ombudsman and that in respect of health and social care the ombudsman should deal with second-tier complaints about all the services the CQC inspects and regulates at present. What is the rationale for that proposal?

Sonia Sodha: There are two key rationales. One is about access—ease of access and understanding. For example, we have argued for a one-stop portal that signposts people and directs them to the right place. They have done that in Wales. There are examples of other sectors where that kind of one-stop approach has been taken. Then there is a question that is more about the back room. There is no question; PHSO and LGO are increasingly working together, but it is still the case that national oversight of the second-tier complaints system in health and social care sits separately, and I think there is a case for bringing that together and combining that oversight as we move towards more integrated health and social care. There are examples of cases where if they are in a nursing home the complaint might be better directed at the PHSO or the LGO. The PHSO and LGO will do signposting to each other, but there is a case for a more streamlined approach.

There are other examples. We would like to see private health care and publicly funded health care brought together. That is particularly important in areas like dentistry, for example, where sometimes consumers are not even clear themselves whether they are getting an NHS service or a privately funded service. We think there is a good case for rationalisation, and it is certainly a case that has been made by lots of other people as well.

Q210 Charlotte Leslie: That brings me to the second point I was going to make, as devil's advocate. Why on earth should a public services ombudsman have remit over a privately provided service where there is no money involved? Surely that dilutes, some might say, the role of a public services ombudsman.

Sonia Sodha: I think it depends on whether you are talking about it as an ombudsman for publicly funded services or with a looser label—what people might think of as public services, things like health and education services. If you asked members of the public, they would probably think more about the world of services, rather than making a clear distinction between publicly and privately funded services. One of the areas where that is particularly true is in social care. Obviously we already have public and private social care complaints handling brought together in the LGO. Dentistry would be another example, and optometry. I take your point, but there is no reason why one institution could not look at both publicly and privately funded services in a sector, particularly given that in several services there are some quite big overlaps.

Q211 Charlotte Leslie: In terms of accountability levers—the remit—are you not going to find that there are very different mechanisms and accountability levers between public and private providers? Would you not run into quite significant problems there?

Sonia Sodha: Yes, I think there are different levers, but it would not necessarily be beyond one institution to deal with them. The key thing is really thinking about this from the perspective of the member of the public who has experienced a problem—the user of the service. It is about making their journey and their experience as smooth as possible. A secondary concern is ensuring that we are using all the critical intelligence that is coming from complaints and making sure that it is not in two separate places when perhaps it is about some very related services.

Lisa O'Dwyer: We would agree with that. There is a natural overlap between social care and health issues, without a doubt, so it makes sense to have that under one umbrella. I would echo the point about private care as well, because it is about a uniform approach for everybody.

Q212 Chair: Can I come in on that? Do you think that this unified ombudsman, looking across health and social care, should be specific to health and care, or should it be embedded in a broader public service ombudsman role? Is there a case for an ombudsman role that is specific to the health and care sector where that expertise, and indeed that signposting, might be stronger?

Liz Thomas: That focus would probably be preferable, because otherwise the remit would be far too wide. Health and social care would appear to make a good option.

Sonia Sodha: But that said, there are things that the PHSO does and that the LGO does. For example, the PHSO obviously does central Government Departments and LGO does local government administration, and it might feel a bit strange to hive off bits as you are bringing health and social care together. I think the key thing is—

Q213 Chair: If you are a patient—taking your point about the service user's perspective—would you not first of all be more likely to be aware of such a service and, secondly, have a greater sense that you are in the right place if that service was not also dealing with complaints about rent collection in housing or some completely unrelated form of public service?

Sonia Sodha: That almost comes down to branding and how you advertise a service, how you signpost towards it. Those things are absolutely key, but as long as you have the idea that there is a health and care ombudsman service sitting as part of a merged PHSO and LGO and you have very clear signposting towards that—we do not think there is enough signposting, or as much as there could be, at the moment—that gets around those issues.

Q214 Charlotte Leslie: Another of your recommendations is that service users should be able to trigger automatic CQC investigations into health and social care providers if enough of them complain. Does this add anything to the current CQC approach, which can evaluate and act on intelligence received, which includes complaints?

Sonia Sodha: Yes. I think the CQC is very much going down that road. We would like to see perhaps a bit more transparency about the threshold around a certain number of complaints—serious unresolved complaints, for example—triggering an inspection, notwithstanding some of the issues around data that we spoke about earlier. But we think it is important that the public understand that, even if they are complaining about a service and their complaint is not being dealt with rightly or appropriately, there is recourse to action further down the road.

Q215 Charlotte Leslie: Do you think that would need to be publicised sufficiently among users, so that they know their powers and know what they are able to do, if they work together, in a sense?

Sonia Sodha: Yes. I think that should be transparent and something that is talked about in the system.

Q216 Charlotte Leslie: In the work that you have done, where did that recommendation come from? Was it a suggestion that people came back to you with?

Sonia Sodha: It came from the sense of powerlessness that came out from the research that we have done with members of the public—some of the stuff that was coming through from their stories. It is a really big problem when people feel that they can complain but that it is not going to have any impact at all. I think it is about sending a strong signal that it will have an impact and that there are clear links in the system.

Lisa O'Dwyer: The other thing is that, when people complain, they complain because—it is almost an adage now—they do not want the same thing to happen to other people. That is where the ability to go directly to the CQC and ask for an inspection, and the immediacy that they can instigate now, is very powerful and potentially very useful.

Sonia Sodha: That is absolutely right. In our research we asked people what would make them more likely to complain and the vast majority of people—80% in one poll that we did—said that they would be more likely to complain if they felt that it would result in action that meant that this would not happen again.

Chair: We need to go and vote on the Floor of the House. We will come back, if we may, for another 10 minutes. Grahame Morris will lead the questioning. In another role, hopefully somebody can find some place where we can turn the heat up in this room a little bit. We are going to take some exercise in the meantime, so we will be better.

Sitting suspended for a Division in the House.

On resuming—

Q217 Grahame M. Morris: This is a question about the complaints advocacy service, about PALS and how effective they are, and about Healthwatch, and in particular some of the evidence that you gave the Committee. What are your thoughts on a publicly funded advocacy service? Is it appropriate for all complaints, and what do you think about the effectiveness of PALS? You gave a bit of an indication earlier about it being variable, but this is just for the record.

Lisa O'Dwyer: Certainly PALS, as we said, is variable. I think they do a good job. They certainly have a place in relation to identifying complaints that are more readily resolvable than others.

Q218 Grahame M. Morris: You mentioned the more complex complaints as well.

Lisa O'Dwyer: Yes. The more complex complaints are ones where PALS ought perhaps to be referring on, or where an impasse occurs, and they feel that they ought to give information so that complainants know where they can go. Local Healthwatch is obviously one starting point. I think there are difficulties with local Healthwatch. Certainly from what we have seen, the service is not consistent. I don't know if that is because of funding. There seem to be differences in funding. There are problems with that. I don't know how accurate the reports are, but apparently the funding that was allocated is £10 million short, and I think there are further complications because the funding has not been ring-fenced specifically for complaints. It goes to the local authority, and it is for the local authority to decide how best the complaints need to be served, so I think there are real difficulties. If you are going to look at strong complaints, you need uniformity and consistency. That is not going to happen unless it is properly funded.

In relation to local Healthwatch, there are certainly those points to be made. I think that the local authorities can contract out to other providers as well. That is fine, but there needs to be something that correlates what the patient or complainant is complaining about with the service that they are offering. We have an example of one local authority that contracted out to Mind. I have huge respect for the organisation, but it is not obvious when you have a hip fracture that that is where you would need to go.

Q219 Grahame M. Morris: I was going to ask you about other publicly funded advocacy services, and you have given an example. What is your general impression of their effectiveness? Was that a particularly good one, or is the issue that it is not known about enough?

Lisa O'Dwyer: In relation to Mind, it is one that just came in two days ago; we have not had experience of dealing with Mind specifically. What we could say about it generally is that it is patchy; some are much better than others.

Q220 Grahame M. Morris: Can I ask Sonia as well? You mentioned at the very beginning, particularly from the point of view of Which?—the Consumers' Association—the perception of PALS as being independent, or rather not independent. Do you think that is an issue?

Sonia Sodha: That comment was more in relation to first-tier complaints in general. We didn't have specific comments coming back in our campaign about whether or not PALS is independent. That said, certainly other reviews have picked up on people saying that they are confused about the role of PALS and where it stands vis-à-vis complaints departments. They are often run by the—

Grahame M. Morris: By the trust, yes.

Sonia Sodha: So that has been picked up as an issue by others. First of all, advocacy is critical because there are some people whose voices will never be heard, and they will never really have the support they need to make a complaint unless they have support through an advocacy service. At a time when budgets are obviously constrained, and advocacy services do cost money, it is important not to see it as an added luxury if we are genuinely committed to the idea that complaints are a critical source of intelligence for service improvement.

There is something useful, as well, in thinking about the difference between signposting, triage and advocacy services. We all know that in the new landscape advocacy has become much more fragmented. These services are being contracted out by local authorities. That might lead to some excellent services being on offer; it might lead to some very poor services being on offer. But it also leads to more fragmentation and loss of a national brand. Signposting is key, and that is one of the reasons why we are putting forward the idea, which others have also recommended, such as the Public Administration Select Committee, of a kind of one-stop telephone and web portal. That can do some basic signposting and some very basic light-touch advice, which a lot of the contact centres, say at the PHSO and LGO, might have been doing. They are probably picking that up already, but why not bring it together and really strongly brand it as a place where you can go for light-touch signposting and support? Then that kind of place can signpost you on and help triage you to advocacy services if you are somebody with a more complex complaint, or somebody who is vulnerable and needs support.

Q221 Grahame M. Morris: I appreciate that. Liz, can I go back to the issue you raised, or the answer you gave, about local Healthwatch? In your evidence you said that local Healthwatch should have a clearer role as front-line monitors of complaints handling, but you also suggested that

they should take on responsibility for local NHS complaints advocacy. Is there any kind of conflict between having an overview of how it is going and monitoring it, and taking on the advocacy?

Liz Thomas: If you are doing the monitoring, I do not think you can do it without hearing from patients directly. The present system is so confusing. You need specialist advice so that people actually providing the advocacy know about health services locally and are working with them all the time, and potentially know where the problem areas are. What you want is a one-stop shop where you have advocacy embedded within local Healthwatch, so you have that knowledge and expertise within one organisation rather than it being fragmented, because the advocacy services do not have a policy role in terms of actually following up complaints to lead to improvements, which is what you want.

Q222 Grahame M. Morris: In the earlier session when I was asking you what good advocacy looks like, from your review of those six cases, you mentioned you thought that Healthwatch is under-resourced. Does it have the capacity to take on this role? You said a good advocate would have the experience, and would be able to challenge a clinician and seek more information on behalf of the complainant and so on. Would Healthwatch have the capacity to do that?

Lisa O'Dwyer: I would say, with proper resourcing and training, absolutely, yes.

Grahame M. Morris: Thank you.

Q223 Barbara Keeley: I have a simple final question about signposting to patients. What improvements would you make to how complaints procedures and advocacy bodies are signposted to patients?

Lisa O'Dwyer: Signposting is a difficulty. Earlier, we touched on unresolved complaints, and there are other agencies out there that can help. Certainly we often receive concerns from people who have unresolved complaints. The situation we are in is that we can get independent medical expert evidence and we can bring conclusion to those complaints. It is about information and knowledge, and about that information being disseminated to people so that they know that there are other agencies that can be of assistance. Again, it is patchy. Some people know to refer, others do not; there could be consistency in that, and it would not be difficult. It would just be a question of a list of agencies that might be able to assist, and making that list available to people so that they have the opportunity or option to at least explore those avenues if they wish to.

Sonia Sodha: I would agree with that. We do not think a portal is the only answer, because we do not think that people in their complaints journeys just go down one route. It would be really helpful to have a portal that would bring signposting together. The other aspect is making sure that all organisations involved in having contact with patients—whether it is providers themselves, charities like AvMA or ourselves as a consumers' association—are able to signpost, and that there is something to signpost to, which is the critical thing. A portal is not a silver bullet, but we think it would really improve what is, at the end of the day, an incredibly complex landscape for people and difficult for them to negotiate. It is not enough to do a minimalistic posting up of the complaints procedure in a hospital. There are a lot of complexities involved in the complaints procedure itself, and often people need to talk about it with someone and have a bit of support. That is key.

Chair: Thank you very much. That is probably a good note on which to end. We appear to have a genius for making what ought to be a relatively simple thing extremely complicated.

Barbara Keeley: My colleague Grahame Morris thinks this is the first time we have had two all-women panels. Congratulations.

Chair: Whoever it is, or whatever process it is, that selects the panels is to be congratulated.

Rosie Cooper: And bigger congratulations if somebody can come up with a system anybody else can follow and we actually get patients treated really well.

Chair: Thank you very much indeed.

Examination of Witnesses

Witnesses: **Dame Julie Mellor**, Parliamentary Commissioner for Administration and Health Service Commissioner for England, and **Dr Jane Martin**, Local Government Ombudsman and Chair of the Commission for Local Administration for England, gave evidence.

Q224 Chair: You are both extremely welcome. Could I ask you briefly to introduce yourselves? Then I am going to ask Barbara Keeley to lead the questioning, because she has to be somewhere else in a few minutes.

Dr Martin: I am Dr Jane Martin. I am the Local Government Ombudsman for England and chair of the Commission for Local Administration in England.

Dame Julie Mellor: I am Julie Mellor. I am the Parliamentary and Health Service Ombudsman and chair of our board.

Q225 Barbara Keeley: I understand you would like to develop a set of expectations for complaint handling by commissioners and providers that is measurable. Could you give us an example of a measurable expectation and how that would assist commissioners and providers in practice?

Dame Julie Mellor: Yes. This work, which we are doing with the Local Government Ombudsman and Healthwatch England, supported by the Department of Health, is something that we suggested to Government last year when it was responding to Clwyd-Hart, because we felt the whole set-up, as we have been hearing earlier this afternoon, needs to be about what is good for the consumer. We are developing a set of consumer expectations with consumers that we hope can be used by individual boards to look at whether what they are doing is effective; by the regulator, in terms of looking at their effectiveness; and by commissioners, following on from the questions in the earlier session.

I can give you examples from some research that we did when I started two years ago. I wanted our strategy to be evidence-based; we did some research with the public and they told us everything that was not right. If you flip that round, the kind of things that consumers are saying would be in a great complaints system for them are: "I feel confident that when I complain it will be straightforward and fair. When I complain I feel that I am listened to and my concerns are addressed. When I complain I can see, because I am told, that they have learned from the mistake in my case and are improving services for others." That is the kind of outcome, vision, standards—whatever you want to call it—for consumers, for what good would look like, which we think needs to be the foundation that drives the culture change.

Q226 Barbara Keeley: What practical measures do you think can be put in place to help providers learn from errors that led to complaints and errors in handling complaints? Clearly we have

heard that there does not seem to be much improvement or much change. Given that there is all this information, all this data that could help providers learn, what practical measures could be put in place to it make that happen?

Dame Julie Mellor: To make—

Barbara Keeley: To make learning happen—learning from the mistakes that were made or learning from the incorrect way that complaints were handled.

Dame Julie Mellor: It is probably the same things as will make the system work to deliver those kinds of consumer outcomes. There is quite a simple blueprint, which would involve learning. It has to be easy for the public to use, which means, instead of the snow-blindness of leaflets and posters telling them where to go, that they know, whatever the care setting is, who they go to if they have a question, a concern or a complaint; and that there is advocacy with one brand, with common standards across the country, probably provided by Healthwatch, so that everyone knows where to go, and they can do the learning and feed that back in as well.

For each care setting the complaints system has to work effectively. I was very pleased with the PASC report, "More complaints please!" that came out a few weeks ago, which really emphasised leadership and measurement. If every board was asking their consumers the three things that I said—if they were asking the users of their hospital or GP practice if that is how they felt—what they actually scored would tell them what they needed to do differently. That would be one thing: leaders measuring properly. Then they need to be looking at how they can shift the blame culture. More than 50% of staff, in anecdotal reports to us, said they fear they are going to be blamed. That does not make them likely to feel non-defensive; it makes them likely to shut up and not want to deal with it. Then all of that needs to be looked at in terms of the experience of the consumers, and in terms of what they have done to drive change and say, "What have we learned?" It is exactly as you were asking: "What have we learned about complaint handling and how we need to improve it? What have we learned about where mistakes have been made or there has been some kind of fault or service failure? What are the themes, what are the issues and what have we learned from that?"

I think there is a particular role for non-execs, because it is easier for them to be the scrutineer, to be the challenger and say, "Have we really got everything out of this set of complaints in this place, and do those issues apply to the other clinical directorates, all those other wards?" There is a particular role for non-execs in terms of making sure the learning takes place.

The final bit is being accountable. If we have that shared measurement framework of consumer outcomes—if everyone is focused on that—that is what the commissioner should be looking at: "What is the consumer experience of complaining to this service provider?" It is what the regulators can hold them to account for delivering. All those things will mean that you get learning at the different levels.

Dr Martin: I completely go along with that. I would not add anything in particular, but just summarise by saying that it clearly is a question of local leadership and corporate leadership in the bodies in our jurisdiction, wherever they are. Of course in my jurisdiction that means also local councils. We already do a lot of work with local councils to encourage a co-operative approach to learning from complaints and building those into a scrutiny process, which I think mirrors what Julie has been mentioning.

Q227 Chair: I was interested in teasing out where, in the local government sphere, you think you are on the learning curve, or where you think local government is on the learning curve—in particular, in the context of this Committee, in social car—compared with the health service. Is either

side better or worse than the other given that you are two separate organisations and have a slightly separate view of what we all agree should be a unified service for the individual user?

Dr Martin: Of course. I would begin by saying that I do not have any definitive research to answer the question. My organisation has been working with local councils for 40 years—1974 was our legislation—so we have developed very effective ways of working to ensure that there is good complaints handling in local authorities. That has built, latterly, into good scrutiny processes; you will know about the health scrutiny process, for example. Having said that, it is patchy, like a number of things across the country in relation to local councils, so some local authorities are better at doing it than others. I could not say, because I do not have the definitive evidence, but I think we are in a good place. I would begin by saying that local authorities have probably had more experience over many years of working in that way, and perhaps there are some things that colleagues in health might learn.

Q228 Chair: It is a bold public servant who says, "I think we are in a good place."

Dr Martin: Yes, it is. Well, I have just said it.

Q229 Chair: I was struck that you said, "I think we are in a good place," but you also said, "It is patchy."

Dr Martin: Yes, that is true.

Chair: I wonder how uniform the experience is for a resident of a care home supported by a local authority, for example, knowing where to go to complain and being satisfied by the complaints process when it has run its course or, if they are unsatisfied, knowing where to go in the ombudsman process.

Dr Martin: Again, I want to stress that I cannot give you definitive evidence on that. Let me give you a specific example, which is that local authorities for many years have signposted complainants effectively to their ombudsman. I have no reason to believe that that has not been happening effectively, and I think it has been one of the things that puts us in a good place now and is shared across the country. What happens in terms of the feedback and the learning, I think, is patchier, to pick up on the point that was being made earlier, and that is the challenge for my organisation working with local government.

Q230 Chair: I will get back to the script, as it were, but how often do complaints come to you, as a result of having come through the system from the service provider, about the fragmentation, in particular, of health and social care for the elderly?

Dr Martin: I am sorry, how often do they—

Chair: Of the complaints that come to you, how often is the core problem that led to the service failure the failure to deliver a joined-up service?

Dr Martin: Okay. Again, I cannot give you a percentage, but certainly I would say it was on the increase. That is the kind of work that Julie and I—our two organisations—do together about joint investigations, when it is very often the case that there is confusion or lack of co-ordination, for example, on discharge from hospital, or when people have complex physical and mental health needs. Certainly we have many cases we can point to that show that that is part of the problem.

Dame Julie Mellor: I completely agree with what Jane said. If you look at the eight cases that we published this year—the joint cases that we published because we felt they raised issues of wider

public interest—a number of those are poor co-ordination between the clinical commissioning groups now and local authorities and providers. To give an example of one that we did jointly, we found in the end that 15 families had lost out on speech and language therapy for their autistic teenagers because the council had given the right to those services as part of special needs assessments, and commissioned it from what was the PCT—now the clinical commissioning group—who, at some point, decided they were stopping it for financial reasons. No one told the families, and the commissioners did not tell the council. It was only when the families raised it that anyone knew anything had happened, and no one took responsibility for sorting it out, which is why they dealt with us.

Q231 Chair: The commissioner is no doubt still paying for it. Can I go back to a question that I started the previous panel with? This is post-Francis—I wrongly remembered Francis as being two years ago, but it was only one year ago—and is about the central conclusion of the Francis report and the virtually unanimous commitment, repeated many times, about the need for culture change, the need for openness and the need to be honest with ourselves about service failure. Do you think anything has changed?

Dame Julie Mellor: Yes, I do, not at the level of delivery but at the level of commitment. The analysis is now fairly well rehearsed. I have seen it in previous sessions that you have done in terms of what we call the toxic cocktail—the reluctance to complain and the defensive response—and you are not going to crack that with some tick-box exercise. It is culture change to a more open—not defensive, but open—and transparent welcoming of feedback in order to restore trust. We are seeing national commitment and momentum, but the pace of change on the ground, going back to my answer to Ms Keeley's question, will be determined by local leadership.

Q232 Chair: If one was being sceptical about that, one would say that there is recognition in the speeches and the writings that something has to happen, but if you are a patient who has received substandard care your experience has not changed.

Dame Julie Mellor: Probably.

Dr Martin: We are publishing figures later on this month looking at the year 2013, which is the period you are interested in and has been a period when we had increasing numbers of adult social care complaints come through to us. We have to be very careful what conclusions we draw from them and only a small number, 9%, are about privately funded care. It is still an increase in commissioned care, and a good deal of them are around assessment and care planning. Most of them are about residential care, but we also have a good deal of complaints about domiciliary care. These are very tentative figures. It is the first time we have published them as a separate report, so we will be able to make comparisons year on year from hereon in, but it is the fastest growing area of work coming through to us.

Q233 Chair: The critical question must be, mustn't it, what is it that needs to happen? What does somebody need to do in the system that is going to convert the rhetoric and convert the Francis analysis, and the endorsement of the Francis analysis that we have all heard until we can recite the lines, into something that changes for a patient in Barsetshire General when Barsetshire General gets it wrong? What has to change? What makes the difference?

Dame Julie Mellor: I would say that, a bit like the previous witnesses were saying, it is not rocket science, but it will take time. As I answered earlier, the first thing is having a clear view of what success would look like from the customer perspective—from the consumer perspective—and having that as the common thing that is measured across the system. Then the simple blueprint is

the support that needs to be given to users, with better information and better advocacy; for the leadership to actually be measuring, to be looking at where they are not doing well enough and changing things to do better; for the leadership to stop the blame culture and reward staff for admitting mistakes instead of making them fear that they are going to be blamed and disciplined; and for the leadership to say, "Actually, people do not like complaining." In all our research, they hate that word. They say they might like to ask a question or express a concern. They do not like to make a formal complaint. What they want is it sorted out on the front line, not when it becomes part of some formal procedure. The boards need to make sure that the focus of improvement is on the front line. For that you need to build the capability of staff. Front-line staff have said to us in deliberative research that we have done: "We don't know how to deal with people when they are angry and upset because they think something has gone wrong. We'd like a bit of support and training on that." Complaint handlers acknowledge themselves that they would like their competence improved. Sometimes I think they are too junior.

Q234 Chair: You placed a lot of emphasis in your answer on the word "leadership."

Dame Julie Mellor: Yes.

Chair: Which implies a personality somewhere—leadership requires leaders, doesn't it?

Dame Julie Mellor: Yes.

Chair: It requires responsibility, somebody to step up and say, "This is my baby."

Dame Julie Mellor: In the largest health settings, the hospital settings, that would be the board—the leadership of the board collectively.

Q235 Chair: But it is not just the board, is it? It is people then connecting the board or an individual and accountability. The thing that I find so frustrating in this world is that everybody can make the speech about how something must change, but then they go on doing it the same.

Dame Julie Mellor: Yes. You need the range of mechanisms in place, whether it is skills or mechanisms like formally rewarding people when they have admitted a mistake and put it right. It can be mechanisms like deciding how you are going to do it so that whenever anyone has a question or concern in your care setting they know who to ask their question of, who to express that concern to. Those kinds of mechanisms need to be put in place, but it is the leadership that has to drive them.

Q236 Grahame M. Morris: In relation to complaints handling, rather than the substance of the complaint, if we think about the way it has been handled, if there were systematic issues that indicated in a particular trust that there was a problem with the way they were dealing with it, is it part of your role to identify that systematic failure in complaints handling?

Dr Martin: Yes.

Dame Julie Mellor: Yes, and in fact we do quite a lot. Sorry, I jumped in there, Jane.

Dr Martin: Keep going. I won't forget the question.

Dame Julie Mellor: That is always my worry in these things. There are three ways, for example, in which we make sure we give information to the regulators, because our job is to provide the remedy for the individual. That is our unique job—to investigate, adjudicate and provide remedy

for the individual. But we want to make sure that information is used, so we will provide the CQC, for example, with all our investigation reports where there is a recommendation for action—an action plan. That is the point that someone was making earlier: what people really want is to improve things for others. For example, in 2012-13 we sent 299 of our investigation reports to the CQC and 11 to professional regulators. The second thing we do, at any point in an investigation if we have a critical patient safety concern, is that we refer to the regulator. The third thing we have started doing more recently is actually providing intelligence to feed into their inspection intelligence packs, so that they have information about complaint handling as part of their intelligence packs.

Dr Martin: We do a lot of similar work with the CQC, but I think your question was about local complaints handling, which is clearly absolutely key. I do not think either of us is here—I certainly am not—to tout for business for the ombudsman. We sit at the kind of apex of a system, and we have been discussing how the system is not working effectively at the moment. We will always comment on local complaints handling as part of a case that comes through to us. Where there has been substantive failure we will always comment on that and we would feed that back to the CQC because, of course, their regulation 19 is about social care providers having an adequate complaints handling process. The answer is yes, we do feed back.

Q237 Grahame M. Morris: The route would be through the CQC rather than the provider organisation, as a matter of routine.

Dr Martin: It would depend. If we had a concern about the complaint handling process we would do two things. We would feed it back to the body in jurisdiction, the body concerned, and we would also feed it back to the CQC. All our statements are public anyway, but we would feed it back.

Dame Julie Mellor: Yes. I would say the same. I specifically mentioned what we do with referring things to the CQC, but very often people's complaint to us is about the quality of the complaint handling and how their complaint has been dealt with. One of the reasons we decided to take on more investigations is so that we can give more feedback to the service providers about the quality of their complaint handling, and we will be reporting publicly on it.

Q238 Charlotte Leslie: I am going to look at a kind of "Doctor, heal thyself" situation, which I think, pre-Francis and historically, has been one of the concerns people have felt about the PHSO—that it was not able to conduct investigations into itself properly. I am going to put to you, in a way as devil's advocate, a concern that I know has been raised with you before. It is a specific case, but it is more an illustration of whether things are as in order for the PHSO as we would all like them to be. This is how the external person might look at it.

As you know, in 2010, I think it was, James Titcombe raised a complaint about the north-west SHA and I think a chap called Jonathan Tross within the PHSO, who investigated it, said, "Everything is fine." James said, "No, isn't not fine. I am launching a legal proceeding." An external review was done, and indeed it was found not to be fine. I know that James and yourself had quite a lot of contact and a lot of things have progressed since then. But one thing I think members of the public might be concerned about is that there may be seen to be a repeat of history. As this Committee knows, there were quite big questions about collaboration between the CQC and Ann Abraham, in her time at the PHSO, which did not seem to be answered in the Grant Thornton report, for reasons I think the Committee can all recall, and James has, as I understand it, requested an external review. A review has been done into whether there was collaboration by Jonathan Tross, the same chap, and it has all said, "Everything is fine." James is saying, "No, I don't think it is fine. I am going to have to launch a legal process again," which, for an onlooker, looks horribly like history repeating itself. From your

point of view, historically—I am just trying to understand the situation—do you think that Ann Abraham and the CQC acted entirely independently in that instance, just so we can get the position of the PHSO on this?

Dame Julie Mellor: There are about a million questions in there.

Charlotte Leslie: There are, I am afraid.

Dame Julie Mellor: To try to take you through them, I would like to say a bit about what we learned in that case and from other feedback, and what we are doing differently, and what we have said publicly about the cases we have investigated from James Titcombe.

When I met James Titcombe and heard of his experience, it had a profound effect on me in giving me the steel to make changes in the way that we operate. Indeed, this Committee's previous inquiry on the subject—less your conclusions but more the individual evidence that I read—and similar feedback from PASC and from other users, and from Rennie Fritchie, who did a review for us on how we dealt with potential avoidable deaths, all said one main thing to me, which was that we needed to do more investigations. So we are. This last year, which has just completed, we did six times more investigations than in previous years. We have done close to 1,778, compared with 300 the year before. That is obviously significant learning.

The other thing on feedback was to do what we tell others to do, and to learn from complaints to them. I was very clear that where people complained about the decisions that we had made, the vast majority were about us declining to investigate. All of that means that we have changed that.

Q239 Charlotte Leslie: Can I cut in very quickly on that point about really upping your investigations, which, from the patients' point of view, is welcome? How have you managed to do that with—I am presuming—the same number of staff?

Dame Julie Mellor: We have three times as many staff doing health investigations as we did before. The reason we have been able to do that within existing resources is that we had a very large group of staff who were assessing complaints to make the decision on whether to investigate. They are nearly all now investigators. In addition, the ones that we investigated in the past were the most serious and complex, and we were pretty sure that there was something wrong by the time we decided to take them on for investigation; they were complex ones. Now we are taking on a much broader range of investigations, a lot of which can be done a lot more quickly. Those two reasons are why we are able to do it within existing resources.

I am obviously not going to comment specifically on the current discussions with James Titcombe, but I can repeat what I said when we published. We have investigated every case that James Titcombe brought to us, and we have published them all. When we published them I made it clear that I apologised for the impact on the family of the original decision not to investigate his case. He and his family may have had answers sooner if we had investigated earlier. It is not a decision we would make today, because we would take on that kind of case for investigation, for all the reasons I have just given.

The other thing is that there was some significant learning for the systems from those investigations. He was right to say he wanted those investigations looked at by an ombudsman service. The ones that we published just before Christmas showed a fundamental conflict in the arrangements for regulation and supervision of midwives locally, from his case and two others. Then the investigations into Morecambe Bay and their dealing with his complaints showed that there were botched investigations, and showed a lot about what is needed in those kinds of serious cases—independent investigations that use human factor science and root-cause analysis, to not

just say, "Did something go wrong?" but ask why and learn from it. All of those recommendations are in the seven published reports that we made.

Q240 Charlotte Leslie: It is a remarkable achievement that you have managed to up the level of investigations without having to expand the work force; I suppose you are spending more time investigating instead of arguing about whether you should investigate. That is really to be commended, but I suppose someone looking at the new organisation who has significant doubts about the old organisation would want to know not just about the learnings you have taken from the case but the learnings about the way the PHSO is then able to investigate possible wrongdoing in itself. If there was collaboration between Ann Abraham and Cynthia Bower on that, as it seemed to many onlookers, it really is a very serious case of maladministration, and you would expect an organisation that was really serious about making sure nothing like this ever happened again to be on the front foot in investigating that particular instance and everything around it—I suppose, to ascertain which existing members of staff may have been involved or may have been party to that, and who knew if anything did go on, and perhaps to hold those who were involved accountable appropriately.

The reason I am pressing on this is that I would have thought it was an important signal for the PHSO to make, to be very much on the front foot in seeking an external investigation into the allegation that has been made about collaboration, which is, I imagine, one of the highest order.

Dame Julie Mellor: As you say, we shared all the information with the Grant Thornton review that was done for the Care Quality Commission. We shared information with the Kirkup investigation too, and I think that is the place for those discussions to be had.

Q241 Charlotte Leslie: Just to clarify, will the PHSO be under the jurisdiction of the Kirkup review?

Dame Julie Mellor: As far as we are concerned, we have provided all the information they asked for, or we have offered—where people's data is protected under the Data Protection Act and not ours to give—to contact those individuals and ask them if we can give their contact details to the investigation so that the investigation can source it directly. We are co-operating as much as we can to make sure that investigation has what it needs.

Charlotte Leslie: Thank you very much.

Q242 Dr Wollaston: Can I direct a question to Dame Julie, please? In 2011 this Committee recommended that the legislation be amended so that PHSO could investigate the actual investigations undertaken by providers themselves, and at that time that was turned down. It was about investigating internal reviews. At the time the response was that you were not intending to do that. What is your view?

Dame Julie Mellor: I am sorry, but I do not think I understand the reference.

Dr Wollaston: We understood that you were not allowed to conduct independent reviews of the findings of internal reviews by care providers.

Dame Julie Mellor: That would be a normal part of what we look at when we are investigating a complaint.

Dr Wollaston: Have we been given the—

Chair: We were told then, "The Ombudsman's current terms of reference prevent her from launching a formal investigation unless she is satisfied in advance that there will be a 'worthwhile

outcome.' We have concluded that this requirement represents a significant obstacle to the successful operation of the complaints system." I think in some ways that relates to—

Dr Wollaston: So it has genuinely moved on. It covers those internal reviews as well.

Dr Martin: It does.

Dame Julie Mellor: One of the things that we are working together on, in converging our two services, is using the same criteria to assess cases for investigation. Based on our legislation, they are roughly: "Is there an indication of injustice? Is it due to maladministration or service failure? Has it been or can it be remedied?" Those are the criteria that we both use in our general discretion to decide whether to take on cases. Historically, there was a high bar. My organisation has reduced the threshold.

Q243 Dr Wollaston: It has lowered the bar, so it lowers it for that as well for individuals.
Dame Julie Mellor: Yes.

Q244 Dr Wollaston: The other point, following on from that, is how would anyone outside the organisation know how well you are achieving your objectives as an organisation? Charlotte raised one individual case, but I have been contacted by another family, Mr Scott Morrish, who has been with the PHSO for 25 months now and has concerns about the way the organisation handled his complaints about the PHSO, and he has asked to meet with you. Hpw do you yourself as an organisation—how does the PHSO itself—respond to complaints about your own organisation's handling of events?

Dame Julie Mellor: Again, there are lots of elements to the answer. We are starting this month to put all our performance statistics on the website so that people can see for themselves how many cases we are doing and how many cases we have closed. We want to be as transparent as possible. Like the Local Government Ombudsman, from July, we will be publishing case summaries of all our decisions on our website. We obviously have a quality assurance process which historically has looked at quality of decision making, timeliness and customer service standards.

We are in the process of changing that, because a lot of it—or at least the quality of decision making—was in the line boards, by team leaders. But when you have a high-volume service you need to move to a quality assurance sampling process, and we are in the process of doing that. Where people are unhappy with a decision that we make—as I said, historically, that unhappiness was around declining to investigate cases; obviously in doing six times more investigations that is going to be a lot less—they are able to request a review. To start with, if we are investigating, they have a chance to comment on the draft report, so that is a chance to tell us whether we have got the facts wrong or whether we have misconstrued things. People very actively comment at that stage, as do the service providers that we have been investigating. That is the fundamental chance people have to engage with us. But if they are not happy with the outcome, with the decision, they can request a review. If there is no evidence, or if the facts have been misconstrued or there is some evidence that it is a flawed decision, we will review.

Q245 Dr Wollaston: One specific complaint that has been raised is that there is a tendency to want to narrow the scope of an inquiry, and that there is no option for those within the system to say, "Well, actually, no, you missed this important point." The information, I am told, is that they are unable then to broaden that to cover very important aspects they feel are missing. Do you think that is a fair criticism?

Dame Julie Mellor: There are a range of issues like that that we are looking at this year. Last year—the first year of our new strategy—I was very clear that the biggest thing we had to do was more investigations. This year we are looking, as I said, at our quality assurance process. We are looking at what we need to do to help manage expectations and help people through our three processes of being an inquirer, whether we are assessing it for investigation, and our investigation. The point that you make is one that we want to get better at, which is helping people scope their complaint up front before we start.

Dr Wollaston: Thank you.

Q246 Chair: Can I come back to this concept of a worthwhile outcome? Is that part of the primary legislation? Is that a legislative constraint?

Dr Martin: Not as such, but we have to consider any alternative remedy, which is quite closely aligned to that. I would not use the phrase "worthwhile outcome," but, as Julie said, what we do in our organisation is use an assessment code, which both our organisations are going to pick up, where we look at the discretion that we can apply. An ombudsman's discretion is very wide and is supported by the courts, as you will no doubt be fully aware, and that has served us well, I think, in giving us the opportunity to look at each case on its merits. In doing that, all things considered, we have to take a view on the remedy that we feel we can procure from the process. Also, we have to think about whether there are other alternate remedies. The one that springs to mind—I do not know whether it is behind your questioning or not—is that certainly in our organisation, if somebody came to the Local Government Ombudsman feeling that they had had a bad experience and they were looking for a big sum of money to put things right, that would not be appropriate. I am generalising like mad—each case on its merits—but if you were looking at a personal injury-type issue you probably would be much better going to the courts. That is not to try to make life difficult for anybody. It is trying to bring an intelligent view to bear on what the best route for anybody is. I do not know whether that is helpful.

Q247 Chair: I think it is helpful in that it illustrates the issue, and the neighbouring issues that are outside the scope of the ombudsman's role. I get that. I suppose the question is whether the current framework—either of the legislation or of the case law—prevents either ombudsman function from investigating cases of service failure as experienced by an individual citizen which the citizen might reasonably expect you to be able to investigate without straying off into personal injury adjudication.

Dr Martin: My answer is that we have discretion on those matters. There is no limit. There is no reason why we should not consider those, and indeed we will. All I can say is that we have wide discretion and we have to exercise it, and those who exercise it on our behalf have to exercise it intelligently.

Q248 Chair: The reason why I push you on it is that it is within the memory of the majority of members of the Committee that Dame Julie's predecessor pleaded legislative constraints as a basis on which she was prevented from investigating cases where the citizen thought she should be able to investigate.

Dr Martin: You have my understanding of my legislation. I had better check that I have not misunderstood yours, Dame Julie.

Dame Julie Mellor: No, it is based on the same legislation. I think what Jane said is right and adds to what I was saying about us having a different threshold now for complaints, and, as far as I am concerned, that deals with it.

Q249 Rosie Cooper: I am not sure whether the first part of what I wanted to ask you has been asked, so I am going to ask it, because it will be followed on by questions a bit later. To both of you, what percentage of complaints made to you do you investigate, and what outcomes do you think your involvement in the process should provide?

Dame Julie Mellor: One of the things that I have found reassuring as we are transforming our service—Jane's organisation is ahead of the curve because they have been doing it longer than I have—is that we have reached a similar point, which is that we both investigate about 55% to 60% of those that are ready for us to assess and make a decision on whether to investigate. That is what we take on. Of those that we take on, we have a similar uphold rate; we both uphold around 45% of cases. That gives you a sense of it.

Q250 Rosie Cooper: Could you just expand on the 55% to 60% of cases available to you? In the evidence that comes to us—I understand that it reflects history as well—most people see the ombudsman service as an independent referee where, when they made complaints, those complaints for the most part were not investigated, and that figure of 55% to 60% would seem rather alien. I have to tell you, Dame Julie—it does not apply so much to the local government ombudsman—that I and, I think, the public see you as an independent referee who is only on the pitch for 10 of the 90 minutes and all hell breaks loose in the other 80 minutes, so your 55% to 60% seems very alien to me.

Dr Martin: I am sure Julie will want to answer that in a moment, but can I come in to give you some up-to-date figures on my organisation? This is just in adult social care complaints, not the whole raft of stuff that we look at: for the calendar year 2013, we had 2,456 complaints and inquiries registered with us, of which we considered 1,846. I have not done the percentages, but we can get them for you, or I am sure you will be able to work them out. We considered 1,846, and, of those, the uphold rate was about 46%. That is purely on the bit of the business that comes to us, so that might be helpful when you are thinking it through.

Dame Julie Mellor: You are right that this largely relates to historical cases. I have huge sympathy for the kind of frustration that people experienced when a high proportion were declined.

Q251 Rosie Cooper: You are saying that of the cases that come to you—I do not know in what period; you will outline it for me—you are actually investigating in the area of 55% to 60%.

Dame Julie Mellor: Yes. To give you the concrete figures at each stage, we both run a kind of inquiries service, so people ring us up. In the last year, in health we had about 17,000 people calling us up and making inquiries. Around 12,000 of those were people who wanted advice and information on how to complain, where to go, how to get a final response from their service provider and so on. Of the 5,000 that were actually saying, "We want you to look at our complaint," we are investigating between 55% and 60%, based on a full year of our new approach from April to April. Of the 5,000 we took on for investigation—I put the piece of paper over there so I do not have it in front of me—we assessed around 5,136. We accepted for investigation 3,075. That is 60%.

Q252 Rosie Cooper: Forgive me; I will go back to the questions I was going to ask you in a second. We have been supplied with figures which say, Dame Julie, that you plan to complete 5,000 investigations in 2014-15, against 232 in 2012-13 and only 904 in April to December 2013, which is the year you just quoted. You are going to have to go some to go from 904 to over 2,000 in three months.

Dame Julie Mellor: We completed 1,778 health cases in the last financial year.

Rosie Cooper: Okay.

Dame Julie Mellor: The average range, the productivity, has gone up over the year. The number per month is now much higher than it was at the beginning of last year.

Q253 Rosie Cooper: It doubled in the last three months. The next question, therefore, is to what extent is that increase accounted for by now calling the assessments formal, whereas the investigations that you did previously were undertaken informally? Is that what is going on?

Dame Julie Mellor: At one level I understand people's scepticism, but on another it is very frustrating because we have really changed things, so the figures are real. A statutory investigation, as Jane will say, is a statutory investigation. Those 1,778 are statutory investigations. That means that what people are getting that they were not getting before is a final adjudication on their complaint, and where it is upheld they are getting individual remedy.

Q254 Rosie Cooper: Great. Earlier, you talked about the three tests and how organisations should apply them to themselves. Have you applied them to yourself, to the ombudsman service?

Dame Julie Mellor: Which three tests are you talking about?

Rosie Cooper: I am talking about how your complainants are dealt with; you gave them earlier on—your three measures. I don't want to repeat them and get them wrong.

Dame Julie Mellor: Yes: "I feel confident that it is straightforward and fair, that I have been listened to and that my concerns are addressed." No, we haven't yet, but we will be. That is part of what we are doing this year.

Q255 Rosie Cooper: How do you think you will fare?

Dame Julie Mellor: We know from our customer satisfaction data that, where we investigate, the overall satisfaction rate is 67%. Where we have upheld the case, the satisfaction rate is 98%. Where we do not uphold, it is 57%. That is something that is common to all ombudsman services. There is always a difference in customer satisfaction, which is obviously influenced by how people feel about whether we have upheld their case or not. But those satisfaction ratings are actually higher than any other ombudsman service I have looked at.

Q256 Rosie Cooper: The individual submissions that we received to this inquiry and that were received by the PAC's inquiry have been critical of the treatment of the evidence they supplied in support of investigations. The Public Accounts Committee recommended that you should review the transparency of arrangements for reviewing decisions. How would you respond to that?

Dame Julie Mellor: In the cases that we are talking about and the individuals who gave evidence, I think it was to the Public Administration Select Committee rather than the PAC.

Rosie Cooper: Even people who submitted evidence to us.

Dame Julie Mellor: Yes. Nearly all those cases were historical cases where the organisation had declined to investigate the cases. They never had an investigation report where they could look at the draft and comment. What they got was a reason for the decision not to investigate, which would include some reference to information they had received from the service provider. I can

quite understand that it would feel as if that was biased information, and it is part of why we changed. It is part of why we are making sure that what they get is a formal investigation report that lays out the evidence from the service provider and from the complainant, gives our findings based on those facts and then gives an adjudication. Again, I think it is a historical problem that is related to how people felt about the letters they got saying we were declining to investigate. It is different when we are investigating.

Q257 Rosie Cooper: So you are happy with the transparency now.

Dame Julie Mellor: We will look at the quality assurance. I do not think anyone is ever completely happy, because we always want to learn and improve, so we will use the feedback we get. We do not yet have, for example, a full year's analysis of the reviews where people are not happy with our decision, or of the complaints about our service, because last year's data is clouded by the fact that at the beginning of the year we were still closing cases from the previous approach. We do not have a full set of data yet. But we will be looking at that to see what it is telling us. What has worked about the change? What else do we need to work on?

Q258 Rosie Cooper: No doubt we will come back to that another time.

This is the last question from me. There have been several proposals for a single public service ombudsman for England to cover health and social care and other public services. Do you support that principle, and what changes in legislation will be required to make that work of benefit?

Dr Martin: I will give you a breather, Julie, and start off. First of all, the short answer is yes. We both on record—I certainly am—as supporting a public services ombudsman for England. The key driver for me is the increasing integration of health and social care. While we can do joint investigations together—we already have the legislation which allows us to do that, and indeed we are making lots of progress on the way we do that—I think, for all the reasons we have heard, including in the prior session, about making the system less complex and much easier for complainants to access, that we ought to have one institution, for want of a better word, which is easy to access, where we get a seamless service. We are in the same business. Why would we not have common standards, common operating processes and so on? Much of that we should be able to do, and we are already talking formally about the way we can harmonise our two organisations; joint investigations are the Trojan horse, if you like, for doing that. In my organisation, we have already spent some time transforming the way we do things, as Julie has already mentioned. We are talking about the ways in which our two organisations can agree on a way forward.

You asked about legislation. We can do a huge amount without legislation, but of course when it comes to jurisdictional matters and actual structural change, we would need Parliament to decide precisely what the institution should look like for the future. Both our organisations are already helping and supporting the work that is being done, and we will wait to see what comes from that.

Dame Julie Mellor: From my perspective, I more than support it. I thought it was needed when I applied for the job and I have been pursuing it ever since, so I was thrilled that PASC decided to hold the inquiry on the framework for ombudsmen. I was thrilled with its findings and I am thrilled that Oliver Letwin said that he will take the findings from PASC, and that he has commissioned Robert Gordon to do a review. I pray that it leads to action, because previously we had a Law Commission review and the Calcutt inquiry. We have had a range of pieces of work on these issues over time. There is such consensus that this needed to be done, for one main reason—it is better for the public. They can think, "If I have a complaint about a public service in England, there is one place to go," and they do not have to think about which organisation. I completely support it.

In terms of the powers, there are a couple of specific ones on the health bit of the remit. One is that we have this old-fashioned thing where people have to complain to us in writing. We have not been challenged on it, and the LGO do not have that constraint. It would be nice to take that away and then we can make sure it is really easy for people to complain to us.

There has been some debate about the issue of alternative legal remedy. We are prevented from looking at cases where someone has access to another legal remedy, like the courts, or clinical negligence, where they would get large amounts of money, for example; they would get financial compensation. We think it would be better if the law said that actually, we as ombudsman services have discretion to take on cases even where someone is pursuing a legal remedy. A legal remedy does not give people an apology, and it does not give people the learning and the action plan. A huge proportion of our remedies will include an action plan to prevent the same thing happening to others. We would like to see that in place.

The third thing we would like is to have the power particularly to deal with the most vulnerable people, who are most likely to experience service failure and least likely to make it to us. We would like to have the power to investigate on our own initiative. An example could be, as one of the early questions was, "What do we see as the lack of co-ordination between councils, CCGs and providers?" We could take on an investigation on our own initiative where we see that leading to service failure, consumer detriment and loss of service or lack of care. We would like that power as well.

Q259 Rosie Cooper: I suppose there is one final bit; Charlotte asked about it earlier, really. Would you contemplate accepting second-tier complaints from privately provided health organisations? For example, we have dealt with a fair bit of cosmetic surgery. Should the public pay for that service—for a private service?

Dame Julie Mellor: It might be worth hearing about the Local Government Ombudsman's experience.

Dr Martin: We already have private providers in social care in our jurisdiction following legislation in 2009. Since 2010 we have effectively been the social care ombudsman, and that has meant that, if you have two people in adjacent beds in a residential care home and one is paying for their care privately and the other is receiving the same care commissioned by the local authority, both those people can come to one ombudsman if they have a complaint. That seems to make complete sense to me. We have been working with that system, as I say, for three years or so. It is probably only scratching the surface, frankly, in terms of the private providers, but that is a whole other debate and discussion we might want to have. It works. Why would we not want to have one place where we have simplicity in the system and you come through to one ombudsman?

Your question about funding, of course, is a good one. Certainly we have had Government funding, because it was an initiative that it was felt important to support. As to whether that continues in the future, maybe we need to talk about funding models. Let's do that.

Dame Julie Mellor: From my perspective as the head of an ombudsman service, there is a principle here, which is that any consumer of any service, public or private, should have access to an ombudsman service for the final adjudication on their complaint. Why would private health care be any different? There is a second-order issue, which is who is best placed to do that. There are different arguments and we have said, because we were asked by Government, that we would be very happy to take it on; we have a whole clinical advice team already—we have the expertise—so we would be well placed to do it. Also, a bit like social care, you are seeing now with foundation trusts that they have private provision within the foundation trusts as well as

public provision. Again you have one consumer and it would be better for them not to get confused and wonder where they have to go; there should be just one place they go for health complaints.

Rosie Cooper: Thank you.

Chair: Did you want to come back, Dr Martin?

Dr Martin: I wanted to make one point, which is that in the broader sphere of public service delivery, the boundary between private and public provision is increasingly blurred. It should not be an issue.

Chair: It's meaningless. If you were to have an NHS prescription dispensed by a community pharmacy, is that public or private sector?

Q260 Charlotte Leslie: I was going to ask you what powers you would like that you do not already have, and, Dame Julie, you have very effectively answered. Dr Martin, I do not know if there are any powers that you would want that you do not already have that you think could enable you to do your job even better.

Dr Martin: No, I do not have a shopping list. My main concern is that my organisation, like Julie's, stays relevant to the landscape that we are working in. If that means that we need to look at the way our legislation is currently put together, I am up for that. I think we have very good free direct access to our organisation. Some of the issues that Julie has raised are not issues for us. No, I don't have a list.

Dame Julie Mellor: It is not an absolute power that we want; actually, we would like a more active relationship with Parliament. If we are going to make better use of the insight from the complaints that we get, whether it is to improve services or to improve complaint handling, we would like a more active relationship with Parliament.

Again, I was particularly thrilled with the PASC recommendations, which I do not know if you have seen. PASC recommended that they were required to use the intelligence that we gathered to hold to account the administration of Government, but that they would also ensure that our reports were referred to the relevant departmental Select Committees, and the Committees should use those reports to hold their respective Departments to account. I would be very keen to do that. To give just two examples—the two last year—there was one report on midwifery regulation, where we made recommendations for changes in the regulation, and one on sepsis, where the UK Sepsis Trust estimated that if our recommendations were acted upon it could save 12,500 lives a year. I would love it if Parliament was able to use that insight and use our reports to hold Government services to account.

Q261 Charlotte Leslie: If the Committee made recommendations, you would like that to be one of them.

Dame Julie Mellor: I would, and, even more than that, I would like to offer, if it would be useful to this Committee, that we have a private seminar where you share the things that are on your minds about health services and we share our insight. It might help inform your programme and it would inform our systemic activity.

Q262 Chair: That is an interesting question, which I am going to suggest we leave in the air because there is another vote coming. We will leave it in the air with the observation that Select Committees prefer to hold their meetings in public.

Dame Julie Mellor: It doesn't have to be private. I don't know why I said that.

Chair: Thank you.