HOUSE OF COMMONS

Public Administration and Constitutional Affairs Committee

Oral evidence: Parliamentary and Health Service Ombudsman Scrutiny 2018-19, HC 117

Monday 18 May 2020

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Watch the meeting

Members present: Mr William Wragg (Chair); Ronnie Cowan; Rachel Hopkins; Mr David Jones; David Mundell; Tom Randall; Lloyd Russell-Moyle.

Questions 1-55

Witnesses

I: Rob Behrens CBE, Parliamentary and Health Service Ombudsman, and Amanda Amroliwala CBE, Chief Executive Officer and Deputy Ombudsman.

Examination of witnesses

Witnesses: Rob Behrens and Amanda Amroliwala.

Chair: Good morning and welcome to another virtual session of the Public Administration and Constitutional Affairs Committee. I am in a committee room here in Portcullis House with a small number of staff required to facilitate the meeting; obviously, socially distanced from one another. My colleagues and the witnesses for today's meeting are in their homes and offices across the country.

The Committee is very grateful to our witnesses, Rob Behrens, the Parliamentary and Health Service Ombudsman, and Amanda Amroliwala, the Deputy Ombudsman and Chief Executive Officer of the PHSO, for making time to appear before us today. I should say at the outset that we do not have enough time in this evidence session to cover everything we would like to ask, so I will be writing later today with further questions. These additional questions will soon be available on our webpages.

To begin with, could I ask each of our witnesses to introduce themselves for the record, starting with Mr Behrens, please?

Rob Behrens: Good morning. I am Rob Behrens. I am the Parliamentary Ombudsman.

Amanda Amroliwala: Good morning. I am Amanda Amroliwala. I am the Chief Executive of PHSO.

Q1 **Chair:** Thank you very much, both of you. Our members have agreed areas of questions. I will be starting and then I will be handing over to David Mundell. My first question is to Mr Behrens. In general terms, what progress have you made on your 2018-21 strategy?

Rob Behrens: Thank you for this opportunity, Chair. We are now into the third year of our strategy. We are seeking to be a research-led, exemplary ombudsman service, with talented, committed staff connected across the widest range of complainants and stakeholders. These connections are the keys to our further progress.

As you know, we have three strategic aims: to increase the quality of our decisions, to make PHSO into a transparent organisation, and to turn us into an outward-facing ombudsman service, engaging effectively with stakeholders and sister ombudsman organisations around the world. Together, these aims in being delivered constitute both an organisational transformation but, more important, a cultural one.

The peer review of PHSO in 2018 and last year's scrutiny report by this Committee endorsed our approach to recovery but warned us not to become complacent. We have not been complacent. We have been focused and determined and have delivered significant changes, all in line with the schedule we have set out. That is not to say that everything we have done has been entirely successful.

In terms of logistics, we have moved to Manchester. We have recruited 100 new case handlers. We have refreshed and reduced the size of the leadership team and we have cut costs by in excess of £8 million.

In terms of the quality of our decisions, we have introduced comprehensive training and development across the office. We have accredited almost all senior case handlers. We have conducted and have begun to implement the clinical advice review advised by Sir Liam Donaldson. We have introduced early resolution and a mediation pilot to modernise our case handling. We have a whole new case management and IT system, which was one of the criticisms made of us by the peer review. We have a new quality strategy, which supplements extensive complainant feedback with more objective quality standards to produce what we call a balanced scorecard.

In terms of becoming outward facing, we have a new, vibrant connection with national and international ombudsman services, seen at its best during the present Covid crisis. We are now launching an international survey, in partnership with the International Ombudsman Institute, to see what other countries are doing and to make our practice better. We have

a complaint standards framework now ready for public consultation, which has the support of all health regulators and many advocacy groups. We have an outward-facing Radio Ombudsman podcast and annual open meetings, to deepen the connection with civil society and the wider ombudsman community.

How successful have we been? We are a long way from being the exemplary ombudsman we want to be, but we have made significant progress in the last three years in what has been a team effort across the organisation. Indications of progress include that most KPIs are now met. Commitments made to this Committee last year have been delivered. Staff surveys for the last three years show a massive cultural change in the organisation. There is independent validation of our charter commitments and these have held up. The external validation from peer review and the Chartered Institute of Personnel and Development award for best change management strategy in 2019 indicate that there is external validation for what we are doing. We are expanding the way we make a difference in terms of being a force in the international ombudsman community, our insight reports, and the compliance by other organisations that are in jurisdiction.

I am happy to comment on looking forward and our ambitions, but that is a broad indication of where we are at the moment.

Q2 **Chair:** Thank you, Rob, for that comprehensive overview of where you are as an ombudsman at the moment, particularly following on from recommendations of the predecessor Committee to the current one, for which I am grateful. Could you tell me some of the biggest challenges to that strategy?

Rob Behrens: Indeed. The first challenge is to conduct our strategic plan with a 25% budget cut from the last comprehensive spending round. Your predecessor, if I may point this out, said that if we could demonstrate value for money in what we were doing by the peer review, there might be support from your Committee in any subsequent bid we made to the spending round. Money is not everything, but that is an issue in terms of the ambition we have to make us into a world-class ombudsman service.

The second thing is that we have excellent people who are case handlers in PHSO. They have an immensely difficult job on the telephone and in mediation and the case handling they are doing. They have told me time and again that it is a very difficult job; they like doing it, but they need absolute support in what they are doing and professional development to ensure they can give a good service to complainants. We have spent a great deal of time—it is a big challenge—trying to increase the skills of our case handlers to be more empathetic, to understand and better communicate with complainants, to try to resolve cases without necessarily going to adjudication, to be better on the telephone, and to present in their written reports a friendlier, more clear view of what we are doing. These are big challenges.

The third and final one I would mention is that we have had to change the reputation of the organisation externally in terms of being invited back into the international ombudsman community, who thought we had departed, and in our relations with stakeholders in bodies in jurisdiction. In the last two years, we have made 130 visits to bodies in jurisdiction to explain what it is we are doing, to try to work with them, and to change the expectations of this service, which incidentally—this is my last point—is not terribly well known in the community. The public recognition rate of this organisation is at around 25% when last assessed, whereas in my counterpart organisations in Austria, for example, the public recognition rate is 70%.

Q3 **Chair:** Thank you for outlining that, Rob. That is very helpful. We are going to explore those issues through the rest of the session, but I wondered if I could begin formally with this. You wrote to me last week about a data breach. Could you set out for the record how that breach occurred?

Rob Behrens: Yes. I would like to invite my chief executive, who has dealt with this, with personal responsibility, to give the answer to that.

Amanda Amroliwala: First, I would like to start by saying sorry to those individuals who were affected by this data breach. We take data security very seriously in the organisation, and I am personally very sorry that this happened.

In terms of the circumstances, we were made aware on 28 April that a spreadsheet that we had uploaded to our website in support of an annual report contained some hidden data tabs. The spreadsheet was uploaded on 5 March this year, and we became aware of these hidden data tabs on 28 April. At that point, the spreadsheet was immediately removed and we checked to make sure that there was no other data on the website of a similar nature and obviously made sure that nothing else could be uploaded.

In terms of the data itself, as I said, the spreadsheet was supporting information for an annual casework report. Within that supporting information, these hidden tables had some personal information from complainants. The personal information constituted predominantly a name—the name of an individual who had brought a complaint to us—the organisation they had complained about, whether the complaint had been upheld or not, and a very limited amount of other information.

I would like to make clear that there was no other personal identifying information contained on those spreadsheets. Alongside the name, there were no dates of birth, no ages, no home addresses, no e-mail addresses, no contact telephone numbers—nothing else of that nature.

We immediately reported this issue to the Information Commissioner, as you would expect us to do. We then looked at the requirements and rules of the EU Agency for Cybersecurity. It has a methodology for assessing the severity of personal data breaches. We followed that methodology, immediately went through all of the information in great detail, and using

that methodology followed the requirements. That was, first, to put a notice on our website saying that this event had happened, but because the data was for the most part simply a name and an organisation, the requirement was simply to notify on our website.

We have, however, taken a very cautious approach because of our attitude to data security; therefore, we have decided to write to just over 300 people individually to tell them that we had disclosed their name and a limited amount of other data about them on our website. We are in the process of doing that and some of it is by post, so not everybody will have received that information yet. We will give those individuals the opportunity to talk to us about what has happened, and of course we have apologised to them as well.

Q4 **Chair:** Thank you, Amanda. Would you describe this as a human error or a system issue?

Amanda Amroliwala: To be honest, it is both. Our system should not have allowed us to have uploaded a spreadsheet that contained hidden tabs, and we have of course addressed that now so that it could not happen again. But the information was uploaded by somebody who was uploading information to support our transparency agenda and would not have done that intentionally.

Q5 **Chair:** No, indeed. How have you changed any process to prevent that from happening again?

Amanda Amroliwala: We have made sure that information that is uploaded to our website is double-checked and verified. As I say, we went through our entire website and made sure that any spreadsheet information contained on there did not have hidden tables. To upload supporting data in this way is part of a wider Government agenda of transparency so that we provide information in a way that researchers and others are able to use the data, so we have done that. Of course, we need to make sure that there are no opportunities for these sorts of hidden tables to be contained and our systems now do that.

Q6 **Chair:** You said that risk of malicious use of that data was low. How did you come to that conclusion if, for example, it lists the names of individuals and any organisation that they might be complaining about?

Amanda Amroliwala: Again, we have looked and examined the methodology used by the EU Agency for Cybersecurity and have applied their criteria and methodology to the data. In most instances, the data is simply, for example, a name—"John Smith made a complaint about Her Majesty's Revenue and Customs"—so there is no more data that would enable people to identify who that particular person was. Using the methodology, that is the assessment that we have made.

Q7 **Chair:** In your communication with those individuals, and I believe their Members of Parliament as well whom you have written to, how do you provide an opportunity for those people to contact you again to express

any concerns that they might have about that breach?

Amanda Amroliwala: We have created a dedicated web address—an email address—that people can write to, and we will respond to that with as much information as people require. If they have further information needs, of course, they can come to us as well, but in those individuals that we are communicating with personally, we are setting out exactly what has been disclosed about them.

Chair: Thank you, Amanda. I will now pass over to David Mundell.

Q8 **David Mundell:** I have a couple of questions for you, Amanda. Your KPI section target for following a fair and open process is just 65%. Is that figure sufficiently ambitious?

Amanda Amroliwala: Mr Mundell, you are referring to our service charter, and the service charter is a quarterly survey of people who have used our service. For some time it was just for complainants using our service, and latterly we have also been asking the same questions of organisations that we investigate. We ask 14 different questions in that survey. The survey is conducted by an independent research company, and they ask around 600 people each quarter about their experience of using the service.

The questions are grouped in three categories. The first group is giving you the information you need, the second is following a fair and open process, and the third is giving you a good service. Those scores, since we started this survey back at the end of 2016, have stayed pretty stable throughout the last three-year period. They go up slightly in some quarters and they go down slightly in others. Over the three years that we have been surveying, overall the giving you the information you need and the fair and open process scores have tracked up and the good service has tracked down by just 1% in total.

Our challenge is that we have really nothing to compare to as to how good a 65%—or 67% as it is now for that section—score is. Of course we want that to be better, and of course we are continuing to set ourselves stretch targets to drive that number up, but there are no other public service ombudsmen that survey in the way that we do with complainants, certainly on the scale that we do, so it is very hard to judge whether that is, in fact, a good score or not, but it is one that we would want to improve. We are continuing to think all the time about how we do that. All of our transformation programme and the work we are doing in our quality agenda that Rob has already described is very much about driving improvements to those scores.

Q9 **David Mundell:** How was the 65% figure determined? Instinctively, the fact that one in three people might think that it was not a fair and open process does not seem to me to be a positive outcome, even if achieved.

Amanda Amroliwala: Yes. I understand that, but it also means that two out of three people surveyed say that it is. I think that part of our challenge

is that we survey people at different parts in the process, so some are surveyed while they are still in the process of having their complaints considered and others are surveyed after consideration has concluded. We do know that there is a marked difference in people's view of our service depending on whether they have had the outcome that they are looking for. If we uphold a complaint about an organisation, then people's view of our service is a much higher score than if we do not uphold their complaint, and that is the nature of the service that we provide, along with most other ombudsman services, which have a similar experience.

Q10 **David Mundell:** Do you not think it is important that people should think that, even if they do not get the outcome that they want, their complaint was properly handled, or are you suggesting that simply because they do not get the outcome they are never going to have a favourable view of the process?

Amanda Amroliwala: I agree, absolutely. We need to do everything we can so that people at every stage believe that we are treating them in a fair and open way.

One of the areas following our research that we have discovered is that people feel that there is a power imbalance between the position that they find themselves in as individual complainants and that of a big organisation with a whole team of people who are responding to complaints and inquiries. One of the areas that we are taking time on is explaining better how we use the evidence that we get from individual complainants and how we balance that against the other evidence that we receive from, for example, a big health trust. We have just at the beginning of this month published our guidance on balancing evidence so that we can show much more clearly how we take individual complainants' evidence that they produce and their accounts into account when making our determinations. All the time we are trying to find better ways of demonstrating our openness and our fairness, and also listening to what complainants are telling us about why it does not feel fair to them.

Q11 **David Mundell:** One thing that you may have thought about changing is the fact that your KPIs have section scores based on averages across multiple KPIs. Would it not be better to have specific target scores for each KPI?

Amanda Amroliwala: Obviously, we publish all the different questions. There are 14 questions, as I mentioned, and anybody is able to go on to our website and track those scores over the past three years, since we started surveying. You can see and track individually how we are doing. If you take the section on good service, for example, there is a question about whether we treat people with courtesy and respect, and that score is consistently around 90%.

We have them grouped together, but that is because we are looking at how we serve members of the public and organisations, and we think that by grouping them in that way it enables people to look quite quickly at the

service we are providing and see in totality, "What does that look like and what does that feel like?" But the underlying data is all there so that people can check against those and see how we are doing.

The challenge, as I mentioned, is that if you look across the scores over this three-year period, they have changed very little, in fact, over time. They go up maybe by 3% or 4% one quarter and then they go down again the next quarter, so it is quite hard to set a target that will recognise that there is only that very slight movement month on month.

Q12 **Mr David Jones:** Amanda, proceeding with our discussion of your KPIs, KPI8, which is about gathering all the relevant information you need, and KPI11, which is about explaining your decisions and recommendations, have a score of 48% and 53% respectively from complainant feedback. Are you satisfied with these scores?

Amanda Amroliwala: No, I am not satisfied with them, and as I was explaining to Mr Mundell, we are doing a lot of work in the organisation to try to continue to improve those scores.

To the second of your points about explaining, I think that is a real challenge for us. We deal with some very complex medical information and we are looking at some very challenging situations that have arisen largely across the health service. What we realise is that we have not always explained in detail how we have come to the decisions that we have come to. We have done a lot of work with our colleagues across the organisation—a lot of the training that Rob referred to earlier—to train people in those communication skills. We have a professional skills programme that supports and helps colleagues to do that. What we do know is that very many colleagues across the organisation do that incredibly well, but it is something that is a challenge that we need to continue to focus on and continue to drive improvements with. Our training programme is designed to do that.

Q13 **Mr David Jones:** I could understand why explaining your decisions might be problematic, but why is there such a low score of only 48% for gathering information? I would have thought that would be a more straightforward process and less controversial.

Amanda Amroliwala: Again, I think part of the issue, notwithstanding the indicator, is about how we explain what we rely on. People who bring complaints to us obviously have a lived experience of what happened to them or to their loved ones, but we are an independent and impartial service and we need to use evidence. Sometimes people's accounts that they bring to us are not supported by the evidence that we take, for example, in relation to medical records and contemporaneous records of things that happened during a medical process.

What we need to do is better explain to people what evidence we have relied on, why we have relied on the evidence in the way that we have, and that we have taken the evidence that they have provided by way of

testimony or in other ways from them and we have properly given it due account in weighing it against the other evidence that we have seen. I mentioned to Mr Mundell that we have just published, in fact, a guide on our website to explain that in more detail to help people understand how we use evidence that is brought to us.

Q14 **Mr David Jones:** Yes, I can understand that in respect of KPI11, but I would have thought KPI8 is a very straightforward mechanical process. Yet, to repeat, feedback indicates that there is even less satisfaction with your handling of that than the satisfaction in terms of explaining your decisions. It seems very odd to me that there should be such huge dissatisfaction with that element of your process.

Amanda Amroliwala: It is because, for example, if you have been in hospital with a loved one who has gone through a particular experience, you have a lived testimony of what happened. We have to balance that and your view and your recollection of what happened against the medical records, for example, of what they say happened at the same time. Sometimes people do not believe that we give due balance to those two things, so they do not accept that we rely on the evidence that they have provided to us. We try very hard to do that; we try very hard to explain in what way we have taken their evidence into account, and we have taken our caseworkers through an extensive training programme to help them properly balance that evidence and give due weight to the testimony of complainants bringing their complaints to us.

I accept that we need to continue to get better. We need to continue to use the evidence that is provided to us and to explain to complainants how we have done that.

Q15 **Mr David Jones:** Do you accept that if there is general dissatisfaction, as there clearly is, about what happens at the beginning of your process, it is more than likely that there will be dissatisfaction about the whole of the process at the end?

Amanda Amroliwala: As I mentioned, we survey people at all different stages of the process, so what you see in terms of the score, the indicator, is a cross-section of people who have been interviewed right at the beginning of our process while we are still gathering evidence through to people at the end of the process who have had a decision that might not be the decision that they had hoped for and who will have a different view of how we have assessed and used their evidence. We are looking across a whole spectrum with those scores that you see.

Q16 **Mr David Jones:** Your casework assurance process seems to provide a much lower score for KPI9, which is about sharing facts, than the scores you see from complainants—in fact, considerably less: 45% as opposed to 68%. How do you account for that?

Amanda Amroliwala: The assurance score is about our internal process and whether we believe we have done that in the best possible way. That is not taking information from complainants. It is about us looking at our

operating model and saying, "What should we have done in that set of circumstances and could we have done that better?" We are always trying to challenge ourselves to follow our process in the optimum way and to do the best that we can. It is satisfying if complainants are saying that we are doing a better job than we are challenging ourselves to do, but we are predominantly focused on what complainants and organisations are saying about our service rather than what we are saying ourselves about whether we followed a particular process that we have in place.

Q17 **Mr David Jones:** What is your target amount of time for closing cases and how is this set?

Amanda Amroliwala: We do not have a target, a set time, for closing cases. We operate a model now of right decision, right time. We are keen to deal very quickly with those cases that we can deal with promptly, but also to give due time to those cases that are much more complex and need a much more detailed investigation.

You will see from our scores in the annual report that this scrutiny session is about—we are also about to publish another annual report, so we have another set of data that we are clarifying—that overall the average time that we have taken to complete cases is coming down. For the annual report that is published, the 2018-19 report, the average length of time taken to complete a case was 158 days. For the year that we have just completed, we are, of course, still working through the data and we have not published it yet, but that figure is closer to 140 days overall, so the overall amount of time is coming down.

We also have a set of indicators that are common across public service ombudsmen that say for ourselves our first indicator is that we will try to complete 50% of our casework within 13 weeks—so within about three months—and we will aim to complete 75% within six months and then 95% within 12 months, recognising that some very complex cases will take longer than that. What we do know is that we are largely meeting now those performance indicators, certainly meeting the 50% target, exceeding, in fact, the 26-week/six-month target, and just short of the annual target.

Q18 **Mr David Jones:** Those are the figures for closure of cases. How long on average do investigations take?

Amanda Amroliwala: As we have moved more to the right decision, right time, we are making a lot of decisions much earlier, particularly those cases where through an initial assessment of the evidence we do not find any indications of maladministration or any indications of significant failings. We are giving people those decisions as early as we possibly can. That means that we are taking fewer cases through to a more detailed investigation, but when we do take cases through to a detailed investigation they are much more complex on the whole.

The amount of time for our detailed investigations is actually increasing. It has increased over the course of the last year. For the year in question, I think the number was around 330 or 340 days for those detailed investigations, but that is not the experience, as I have said, from our general performance indicators, of most people bringing cases to us.

Q19 **Ronnie Cowan:** Mr Behrens, you will be familiar with the tragic case of Averil Hart. Averil's dad, Nic, complained about failures in multiple NHS trusts that led to his daughter Averil Hart's death from anorexia nervosa. This Committee does not involve itself in personal cases, but the case of Mr Nic Hart shows many failings by the PHSO that do concern us. In particular, Mr Hart wrote to the Committee with his frustration that this was not an independent review but rather one that was controlled and edited by the chief executive. What is your response to that?

Rob Behrens: Thank you for asking that, Mr Cowan. I am happy to respond to this. First, I need to set out again, as the ombudsman and on behalf of my organisation, our condolences to Mr Hart for the appalling experience that he has been through in addition to the loss of his daughter. Nothing that I say or that the organisation or the NHS bodies involved can do, can address that. That needs to be said first.

Our published review of the case, which lasted from 2014 to 2017, identifies a catalogue of failures, which illustrates why I was brought into the organisation in April 2017. There was a failure of consistency, a failure of leadership and a failure of communication to deal with Mr Hart in an appropriate way. I accept that Mr Hart's trust in PHSO had been destroyed by the time I came into the organisation.

I managed to ensure that the final report was concluded and an insight report published within about eight months of arriving, and I did this with great assistance from Dr Bill Kirkup, perhaps the foremost independent reviewer of public and health service failures in the UK. As you know, Dr Kirkup was chair of the Morecambe Bay investigation into maternity and neonatal services. He was a member of the Hillsborough Independent Panel, the Gosport Independent Panel, and Jimmy Savile's involvement at Broadmoor Hospital. He is now a member of my independent advisory panel.

Our investigation, assisted greatly by Dr Kirkup, found unambiguously that Averil Hart's death was avoidable and we made significant criticisms of all bodies in jurisdiction involved. That is very important to put on the record in the light of the subsequent comments.

The National Director for Mental Health in NHS England, Claire Murdoch, stated in May 2019, "I've been impressed with the report. I thought it was fair. It's painful reading. These are the sorts of things that I, and probably other professionals who care passionately, feel hurt by ... hurt because we probably recognise it as a really searing, independent insight to things we must fix, things we must address, things we must do better"—

Q20 **Ronnie Cowan:** Sorry, Mr Behrens, I hear what you are saying and the report does make those observations, but the crux of the question is why was it led by a PHSO senior leadership team member and not an independent person?

Rob Behrens: We made a judgment that it would be appropriate, given that we had already had significant independent contribution to the handling of the investigation, that we should use someone new to the organisation, who had not been involved in any way in the handling of the report, as is quite appropriate for an independent ombudsman service to do. I do not think there is anything inappropriate about the way in which that was done.

Mr Cowan, if you look at the response of James Titcombe to this report, which he wrote on our blog—James Titcombe, who knows about these issues as well as anybody else, who is an expert by experience—wrote that this was a frank, open, honest account of what had been got wrong by PHSO and that there were very valuable lessons that it was important for us to learn. I do not accept the view that this was in any way an inappropriate way to handle the report.

Q21 **Ronnie Cowan:** You do not think that by having an independent person there it would have built a better line of communication with Mr Hart and any other people who want to bring forward complaints? It goes back to what Mr Mundell said earlier on. If people are not going to get the outcome they are looking for, then at least they have to believe that they were listened to, and an independent chair could have done that.

Rob Behrens: I have respect for everything that Mr Hart says. I do not accept many of the things that he says in his evidence to this Committee. Dr Kirkup, who is an independent, respected adviser, also agrees. He says, "My recollection of the meeting which Mr Hart describes differs very substantially from Mr Hart's. My clear recollection"—and Mr Hart criticised my behaviour—"is that your reaction was dignified, calm and professional at all times. I do not recognise the description he has given".

In response to you, in summary, PHSO got this case badly wrong. Most of it was done before I arrived. The reasons why it went wrong were some of the reasons why I was appointed. I did my very best by bringing in the independent expert, Dr Kirkup, to take key responsibility for the case. He did that. It was published. The report has been widely welcomed and acted upon, including by your Committee. The review, which was conducted under my chief executive's responsibility, is regarded as open and honest. I do not accept some of the things that Mr Hart said in his evidence.

I make this point. It is for the ombudsman, on the basis of the evidence, to come to views about what is the adjudication, respecting the views of the complainant but it is an ombudsman decision.

Q22 **Ronnie Cowan:** One of Mr Hart's other complaints was that he was promised weekly updates, which sometimes were forgotten. I also notice

in the report itself it says, "Five caseworkers worked on the case at different times. These personnel changes meant that Mr Hart had to frequently build new relationships and"—heartbreakingly—"re-tell his story". What have we done in the meantime to make sure that does not happen again?

Rob Behrens: As you will see from the report published, we now make a real attempt to make sure that there is one person responsible for handling a complaint and taking it all the way through. If this happened again, there would be a completely different approach to the way in which it was handled. There would be a team of people to deal with it. There would be a different approach to the clinical advice being handled, and because of the training we have engaged in, which deals with these kinds of communication issues, we have not been in the unfortunate position that I experienced when I arrived in April 2017.

I want to make this point. This is very important, Mr Cowan. I accept, as the ombudsman, responsibility for things that happened in my organisation before I arrived. I am not seeking to duck that, but I am saying we have significantly changed the way in which we address these cases as a result of that unfortunate experience.

Q23 **Ronnie Cowan:** When you say there will be a different approach to clinical advice, could you expand on that?

Rob Behrens: Absolutely. One of the things that happened when I arrived in 2017 was that many complainants told me that one of the reasons for the absence of satisfaction, with the kinds of scores that Mr Jones and Mr Mundell have been talking about, is that they did not have confidence in the way in which PHSO commissioned and used clinical advice. I knew that that was an issue that I had to deal with during my tenure as ombudsman, so I commissioned externally Sir Liam Donaldson to give us independent advice about how we were looking at clinical advice. His report and our response to it have been published, and we are now changing significantly the way in which we are interfacing with clinical advisers.

What Sir Liam Donaldson said was that there was an absence of trust as a result of the engagement, that it was too remote in terms of the relationship between the case handler and the clinical adviser, that it was too inconsistent, and that we had to address all of those issues. When he finished his work with us, he signed a letter, which has been published, to say that he regarded our implementation strategy as being appropriate to deal with the issues that I have described.

There are a number of key things that Sir Liam recommended, and which we are working to implement, which changed the nature of it. First, he said that there should be a much more effective relationship between the professional case handler and the clinical adviser. At the time of Mr Hart's case, the case handler asked questions of the clinical adviser, who submitted answers, but that was basically the end of the engagement. Sir Liam said that was far too insubstantial to give reassurance to service users

that this was an appropriate relationship. He urged us to change the depth of the relationship between case handlers and clinicians by ensuring that clinicians have the opportunity to see provisional reports and final reports to make sure that their views are properly reflected in the report and not misunderstood by the case handlers.

Secondly, Sir Liam recommended that there should be multidisciplinary meetings between case handlers and clinical advisers to deal with serious issues where there was ambiguity about the issues and they needed to be debated. I know because I have responsibility for some of these cases that we are now engaged in doing that, and it is very important that there is a proper conversation between the advisers and the case handlers.

The next point is that we have introduced training days in which clinicians and case handlers can get together to discuss common issues. There is feedback at the end of each case to ensure that both sides are confident that their advice is being properly used, and we are engaging in peer review for clinical advisers to make sure that we are using people who are fitted to the task.

There is one other point that I want to raise, which relates to points made by Mr Mundell and Mr Jones. Sir Liam said that after we have had consultations with regulators, it would be appropriate for us to give serious consideration to naming the clinical advisers that we use in specific cases. If we did that, that would make a fundamental change to the perception of transparency that the organisation currently holds. The issue, though, is sensitive because some of our clinical advisers fear, as a result of experience, that if their names were published they would be trolled by some irresponsible complainants, who would use their dissatisfaction with the handling to report them to the professional body. I am in favour of going down the transparency route, but I do not want to lose my clinical advisers, so I am taking that forward with great care; however, there has been a substantial commitment and change as a result of the Donaldson report.

Ronnie Cowan: Thank you very much and apologies to the Chair. I appear to have stepped on your next question.

Q24 **Chair:** Ronnie, you would never do that, don't worry at all. Thank you, Rob, for that answer.

I want to give Amanda an opportunity to come in at this point, particularly expanding on some of those issues around obtaining clinical advice. The report did outline a lack of robust measures for dealing with contradictory clinical advice. Amanda, could you explain how you are improving processes for obtaining and using clinical advice, please?

Amanda Amroliwala: Of course, thank you, Chair. To Mr Cowan's point about the review that was conducted into Mr Hart's case, Mr Hart came to meet with me in July 2019, and in that meeting, I advised Mr Hart that my intention was to appoint a senior individual who was not in our organisation at the time of the investigation and had no involvement to conduct this

review. I said that we would do that very promptly; we would start it immediately and we would aim to complete it within three months. We would look extensively at what happened, and we would offer him the opportunity to contribute to the review. We agreed that we would proceed on that basis.

I do not accept that the result was predetermined and that there was no opportunity for Mr Hart to contribute, because we made multiple offers to meet with Mr Hart during the course of the review and also to take written evidence from him, but he did not choose to take us up on those offers. We did, none the less, update him each month with the progress of the review and of the timing that we were going to publish it.

As Rob has outlined, the review was incredibly open, frank and honest. My involvement in it was simply to ensure that that would be so and, as Rob has indicated, James Titcombe has given his view about the degree of honesty and openness and the candid way that we dealt with some significant failings.

Coming on to the issue about conflicting medical advice, one of the changes that we have made, following on from the clinical advice review but obviously picking up on this issue in particular, is that we now have started to implement multidisciplinary meetings. When we take advice from more than one clinical adviser, sometimes those can potentially be in tension. Now, we have set up a process where we can bring those clinical advisers together, along with our caseworkers and managers, so that we have a broad discussion about what that advice is telling us. We have a lead clinician who works for us in our organisation, and that individual is able to facilitate a discussion between those clinical professionals so that we can get at the heart of any potential tensions or conflicts or contradictions and come to a point where our clinical advisers are in agreement as to what happened or that they can resolve the issues that seem to be in conflict.

Q25 **Chair:** Thank you. Do you plan to commission a future follow-up review to assess the progress that you have made?

Amanda Amroliwala: In relation to clinical advice, in the review completed last year—we published the review in March—there were a number of recommendations. We have put together a two-year programme to implement those recommendations, and, as is part of any of our programmes now, that involves a review of how successful and what the benefits are of the things that we have implemented. Once we get to the end of that programme, we will of course consider how well those different measures have impacted on the achievements and the outcomes that we set out to achieve.

Chair: Thank you.

Q26 **Mr David Jones:** Amanda, Mr Hart was critical of what he described as reliance upon hearsay of clinicians rather than actual evidence on which clinical advice was requested. Do you accept that criticism?

Amanda Amroliwala: I was not involved in the investigation itself and, as we have discussed, Mr Hart has very real and valid views about things that happened that are not always in agreement with our own experience. It is a challenge for us when we have, as I talked about a little earlier, personal testimony of family members who were involved in the care of their loved ones and we have both clinical records that are supported by written records as well as the testimony of medical professionals who were involved in the treatment of cases. Our job is to try to balance what we are told and the written evidence that we see. That is a very difficult job to do sometimes when you have people who are in direct conflict with each other in terms of the evidence that they are giving. That is why we have completed the piece of work that I mentioned that we published on our website, which tries to set out clearly how we will take both accounts and try to chart a path through that to what is the truth about what happened.

Q27 **Mr David Jones:** But Mr Hart's criticism appears to be that the clinical evidence was not always gathered in a robust manner. He has used this expression "hearsay". What is your response to that? You must surely be concerned if a complainant such as Mr Hart does not believe that the evidence has been collected robustly.

Amanda Amroliwala: Unfortunately, as I have outlined, people who are involved in caring for family members can sometimes have one view of a set of circumstances, and we have to balance that view against what is said by the clinical professional who was caring for an individual at any one time. We try to be very careful about that balance, but there are and can be differences of opinion in relation to what a medical professional says were a set of circumstances and what a family member says were a set of circumstances. We try where we can to rely on written evidence because obviously contemporaneous written notes at the time can be pointed to as a record of events, but when we are relying on individuals' accounts, obviously that is a much more difficult challenge for us to do.

Q28 **Mr David Jones:** Do I infer from what you have just said that you are very politely rejecting Mr Hart's criticism?

Amanda Amroliwala: What I am saying is we try to take into account everybody's evidence. We accept that in Mr Hart's case there were a number of things that were done wrong, and we accept that there were a number of failings in our handling of that case. Those are set out in some detail in the review. But we have to take the accounts of clinical professionals alongside other evidence that we receive, and we should and we do listen to those accounts and afford them due weight.

Q29 **Mr David Jones:** What would you do if a complainant wanted to adduce his own clinical evidence in the course of an inquiry?

Amanda Amroliwala: We would of course look at any evidence that an individual complainant produced, but we rely also on our own independently commissioned clinical advice. In the process that Rob described, we have a bank of internal clinical advisers—people who are

contracted to us on a part-time basis for those clinical specialisms that we use and rely on frequently. For example, we have GPs and other people who work for us contractually. We also have a huge bank of external specialists who we can call upon, depending on the type of clinical advice that we need.

If an individual complainant comes to us with a complaint and their evidence of what they believe went wrong, we then go to the organisation concerned and ask it for its account of what happened. We then consider those two sets of evidence and, from that, determine what type of clinical specialism we need to seek advice on. Then we go to an independent clinical adviser—one who has not had any contact with either individuals in the case or with the organisations that have been delivering the care—and we seek that independent view of the care that was delivered.

Q30 **Mr David Jones:** What opportunities do either complainants or the organisations complained against have to challenge either clinical advice or the evidence upon which that advice is based?

Amanda Amroliwala: We have a process in terms of the clinical advice that Rob also mentioned. One of the recommendations of our clinical advice review was that we give complainants and organisations the opportunity to see the clinical advice fully before we start to form our provisional views about what happened. We have started to do that. We have implemented that for our more serious cases that are investigated by our senior caseworkers, looking at what that is telling us. When individuals want to see the full clinical advice, we are sharing that beforehand and giving them the opportunity to input and comment on that advice.

We also have a process of sharing what we call our provisional views. Once we have taken all of the evidence from both parties, as well as any independent advice we have collected, we form those into a draft, a set of provisional views about what has happened. We put those views back out to the complainant and to the organisation and say to them, "This is what we are thinking, this is what the evidence is telling us," and we give an opportunity to then comment on those views and to say, "We don't agree with that. We don't think that that happened in that way. You need to look at this additional evidence." We give people the opportunity at that stage to come back and comment on what we are proposing, what we are seeing, what we are finding, so that they have an opportunity to input further when they can see the direction of travel of our thinking is.

Mr David Jones: Thank you.

Q31 **Rachel Hopkins:** Amanda, moving into staffing issues now, we have seen that in most categories the PHSO matched or outperformed the average in the Civil Service People Survey in 2019. What is your view on the 2019 Civil Service People Survey results for PHSO?

Amanda Amroliwala: I arrived in the organisation three and a half years ago, just before Rob—we arrived within a few months of each other. In

applying for the job, I looked at the staff survey scores, and at that time, back in 2016, they were some of the worst scores that I had seen in a public service organisation. People felt very down, very despondent. There was no sense that it was an organisation all pulling in the same direction and that staff were being valued.

We have set about over the last three years trying to fundamentally change that. We are trying to show our fantastic staff just how valued they are, to recognise their commitment and their achievements, to recognise their contribution to the organisation, to involve them in the change that we are going through, and to communicate far better with them than in the past. I think what you see in those scores from 2018 and then into 2019 is the result of that investment in trying to make people feel that they are part of an organisation that is trying its best to be the best it can be, because that is what our staff expect of us as an organisation and that is what they give every single day.

It is really encouraging to see where scores have improved. Obviously, there are areas within those survey scores and a lot of questions where we could do better, where we are determined to do better, and where we are continuing to work together with staff colleagues across the organisation to try to drive those scores up further.

Q32 **Rachel Hopkins:** Just building on that, which results give you the biggest concern, and what are you specifically doing to address them?

Amanda Amroliwala: We have invested a lot of effort and a lot of time in learning and development. We have an extensive learning and development programme, recognised by the independent peer review as a leader of its field in ombudsman services. Alongside the professional skills training, we have also been investing a lot in the health and wellbeing of our colleagues across the organisation. Therefore, for the section in the Civil Service Survey score on learning and development, the scores were really disappointing for me to see. When you drill down into those scores, the scores on the delivery of training and development itself have been increasing, but the scores are poor around career development and career opportunities. I think that is a real challenge for us.

The last survey was done at a point where we had been going through a complete change to our pay and grading structure. We were in the middle of a pay dispute, and it was a very difficult time for us. Because we were going through these changes to pay and grading, we had held back a number of vacancies at the more senior levels—opportunities for caseworkers to progress up to senior caseworker and up to operational manager. There had been quite a long period where people could not see anywhere for their career to go within the organisation, and people were very disheartened and despondent about that, and I can understand why that would be.

Following the pay and grading review, we were able to conclude successfully with our trade unions and with our staff and implement new

structures. We have been able to release some of those vacancies, so people have started to see movement in the organisation and to see the opportunity for career progression. What we have also done is try to talk in terms of career development as opposed to progression, because we are quite a flat organisation. We have purposefully tried to take out a lot of the senior management grades and invest more in the frontline. Therefore, we do not have limitless opportunities for people to progress up through the organisation.

We are trying to talk in terms of development and give people opportunities to do other roles within the organisation at the same level—to expand their careers through doing other types of jobs—and not only be looking upwards at whether they can get one of a small number of senior posts. I am confident that we are doing much more to address that particular concern about career progression.

Q33 **Rachel Hopkins:** Thanks. I picked up on those points, and it links in to turnover as well if only 35% of people believe they have opportunities to develop their careers at PHSO; your turnover is fairly high. I appreciate it is dropping after the big change. How can we balance those for the future stability of the organisation?

Amanda Amroliwala: Our turnover was high two years ago. Our staff turnover rate was about 15% or 16% as we were going through those big transitional changes. Over the last 12 months, that number has come right down. It is now at around 8%, which is below the civil service average turnover, showing that we have moved into a much more stable period. As we demonstrate that people have lots of opportunities to work in our organisation doing different roles—moving from, say, casework into supporting our technology developments, or moving from our support services into looking at quality improvement and continuous improvement—we are helping people to see opportunities within the organisation in different sections of our organisation, as opposed to simply rising up. We have opened some opportunities up, and I think that will certainly help in terms of people seeing that there will be opportunities for them in the years ahead as well.

I would also say that it is really important that people are able to use our organisation as a stepping stone to go elsewhere for their careers. I see it as a big success if people leave us to take promotion jobs in other organisations. I think that is fabulous. I would hope that they would then come back to us again later on and bring the skills that they have learned elsewhere. We have seen, certainly, in the past 12 months, that people have left us to go off and do other things, and have then applied to come back to us and bring those skills back. That is really welcome as well.

Q34 **Rachel Hopkins:** Thanks. One other area where overall the percentage had dropped was around leadership and managing change, and there were some quite low scores there as well. What are your thoughts on the skills on leadership, and what are you doing in that area?

Amanda Amroliwala: We have been implementing a programme over the past 12 months of exemplary leadership and exemplary management, and that is starting to have an impact. Certainly, if you look at the manager scores in the last survey, we have seen those really starting to rise, and that is really welcome that people are putting into effect the coaching and support and the development that we have been giving them.

In the most recent survey results, there were some falling scores in relation to the senior leadership of the organisation, and I think some of the associated commentary and narrative was very anchored in the particular time that we were going through in terms of the pay dispute, and people felt very disheartened. I am hoping that as we go into the survey this year, that will be long in the past and we will see those scores start to readjust.

For change management, again, we have invested a considerable amount of time and effort in putting in place really robust programme management structures and change structures in our organisation, so that we can give our colleagues confidence that we are doing the right things in the right way. Again, three years ago, the confidence in change management was around 18% in our organisation, a very low score. In terms of change management, it is up now running at about 40%, which you could say, and I would say, is still low. It is much higher than it is on average in the rest of the civil service—I think it is something about public sector organisations—but we are not satisfied with that. We are continuing to develop our change management capability, continuing to involve our staff in change, and again, I am confident that we will continue to drive that number up.

Q35 **Rachel Hopkins:** Thank you, Amanda. I have one final question, and it is more directed towards Rob, around the recent value for money study, which flagged a risk of potential loss of the specialist and expert knowledge as a result of moving to the general caseworker model. We touched on it earlier, but what steps are you taking to mitigate this risk?

Rob Behrens: Before I respond to that, could I just add to what Amanda said about the staff survey? To me, and I am not overconfident on these things, the survey results represent since 2015-16 a cultural transformation of the office, which needs to be put on the record. For example, the confidence of the office in the ombudsman and the chief executive having a clear vision for direction of PHSO was at 23% in 2016 and is at 77% in 2019. I understand that confidence in the aims and objectives of PHSO was less than 50% in 2016. It is now at 85%. There is evidence in the survey that senior managers are open and approachable, almost double the extent they were in 2015-16. This is not to say that everything is right, but it does represent an absolute transformation in the views of staff. That is the first point.

The second point is that the learning and development was recognised in the peer review report as being exceptional in ombudsman services, and we have run chastening masterclasses with staff in Manchester, bringing in the very best in the world of people commenting on empathy,

communications and how to deal with complainants. We brought over Nora Farrell, a distinguished Canadian ombudsman, to talk about empathy. We used Scott Morrish, a complainant by experience, to say what it was like to be on the receiving end of a PHSO investigation. We used the distinguished Northern Ireland ombudsman, Marie Anderson, to talk about human rights; she said she got the concept from PHSO, not from anywhere else.

The issue is not about the quality of the training. It is, as Amanda says, about the opportunities to develop and to develop your career and move on, and we need to take note of that very carefully. That is why the accreditation scheme that we have is so strategically important, because it gives people an opportunity to demonstrate that they have professional qualifications and they can move on to other ombudsman services to demonstrate that.

As far as your question about the value for money survey is concerned, I think some members of the Committee were a little sceptical that the VFM peer review was about marking our own homework. That is not the case. There were significant criticisms of some of the things that we were doing—for example, our IT structure—which we have addressed. Also, we are addressing the need to balance having a generalist approach with specialist expertise. We did not just accept that; we have taken it on board and we are developing it in a way that balances the need to have staff who can deal with a wide range of issues with specialist expertise.

We have developed teams that deal with continuing healthcare in a specialism. We have now created teams that will deal specifically with parliamentary cases. We have upgraded the way in which people have access to Ombudsnet to get expertise and information about best practice in the areas that they are dealing with, and we have mentors who teams can go to to make sure that they can rely on specialist expertise. I think we are dealing with that issue. We have not got to a perfect solution yet, but we do recognise that we need a twin-track approach as far as this is concerned. That was prompted specifically by the peer review.

Rachel Hopkins: Thank you.

Q36 **Lloyd Russell-Moyle:** Amanda, you explained to our predecessor Committee that except, of course, for apologies, you do not track the implementation of the long-term recommendations you make for such things like producing action plans. Does this not limit the incentive for anybody to follow your recommendations?

Amanda Amroliwala: We have a series of discussions with those bodies that we investigate about the outcomes of our investigations and the sorts of recommendations that we are going to make. We agree with those bodies, where we can, that they will follow those recommendations. If, when we are in the process of finalising our reports and saying what our recommendations will be, those bodies indicate that they are not prepared to accept them, then we have an escalation process up through our

organisation, up to the point of speaking at chief executive level about why those recommendations are important.

Once we have reported, we follow up with those bodies and see whether they have followed through with those recommendations. For some things like apologies or financial payments, we can check that those have happened. Where people are putting in place a long-term programme of change activity or service improvements, it is not our role. We are not a regulator. We are not able to go in and determine whether those have been followed through. We provide copies of our recommendations to the Care Quality Commission, and the Care Quality Commission has the opportunity in its inspections of those bodies, if they are health bodies, to see whether recommendations that are more systemic in nature and long-term have been followed through.

Where we have a situation that a health body or a Government body refuses to comply with our recommendations, we have opportunities to advise the professional regulators that they have done that. We also have the opportunity to lay reports before Parliament so that this Committee and other Committees can—

Q37 **Lloyd Russell-Moyle:** Sorry, I get your point, but an organisation could just agree with your recommendations and then not implement them.

Amanda Amroliwala: They could. We follow up with them and ask them to produce evidence of how they have implemented the various actions. We are also now starting to publish our recommendations alongside our quarterly data so that members of the public can see what organisations have—

Q38 **Lloyd Russell-Moyle:** That is produced against your quarterly data; then for all of those recommendations, there has been agreement from the organisation that they will follow that up as you have asked?

Amanda Amroliwala: There is. Once we publish, we either say within a document whether those recommendations have been agreed to or not, and all the ones that the organisation has agreed to, for health organisations, we are now starting to publish those alongside our quarterly data so that—

Q39 **Lloyd Russell-Moyle:** Only for health organisations?

Amanda Amroliwala: The health organisations, yes.

Q40 **Lloyd Russell-Moyle:** For the non-health organisations, you do not send it to the CQC. Is there any other body that these recommendations should be sent to for follow-up? Other regulators, for example.

Amanda Amroliwala: Not with Government Departments, but with Government Departments, of course, we have the opportunity to lay reports before Parliament, so Parliament can call permanent secretaries or Secretaries of State in and hold them to account if they refuse. It is very rare that bodies refuse to accept our recommendations, but it does happen.

Generally, we are able to resolve that through escalation to myself or to the ombudsman, where we would expect to go along and meet with a permanent secretary and discuss the particular recommendation and why it was necessary for that to take place.

Q41 **Lloyd Russell-Moyle:** Do you think it would be any help—maybe in your annual review, for example— not only to provide the recommendations, but to do a piece of work to see whether these recommendations had been fulfilled, for transparency of whether you are effective or not?

Amanda Amroliwala: As I said, we do say where we have evidence that our recommendations have been complied with, and that compliance rate is very high because we do follow up with our caseworkers following up with the complaints teams, and asking for evidence to be produced to us. Increasingly, with our transparency agenda, we would look to put as much of that into the public domain as possible.

We have to be careful because there is a crossover into regulation, and we are not a regulator. We do not have enforcement powers. While we can—

Q42 **Lloyd Russell-Moyle:** I am not asking you to enforce. I am suggesting that it might be useful for you, in an annual review, to list for that year the outstanding actions that are needed and the progress on those actions, and to have someone compile that piece of work. That would help the Select Committees so that we could follow it up. What is the problem with doing that?

Amanda Amroliwala: We are starting to do that—we are starting to publish that information.

Q43 **Lloyd Russell-Moyle:** Yes. I think that is particularly not just the actions, but a bit of the follow-up. Yes.

Amanda Amroliwala: The compliance as well.

Lloyd Russell-Moyle: Perfect. Thank you very much.

Q44 **Tom Randall:** Mr Behrens, could I ask some questions about the complaint standards framework, which you plan to launch in 2020-21? How will you demonstrate the impact and the effectiveness of this framework?

Rob Behrens: We have done a significant amount of research and work on this, and we were about to publish the inside report on the consultation when the Covid crisis kicked in, so we have held it back.

This is a very, very significant development in the work of the ombudsman. It has a strategic possibility of changing the quality of complaint handling in frontline bodies, not only in the health service but wider. In doing this, we have worked with 20 different organisations, advocacy groups, regulators and Government Departments to make sure that we are doing something that is wanted and is sensitive.

I go to hospitals on a regular basis. We have made 130 visits in the last two years. Hospitals are thirsting for a standard framework that they can use in developing their complaints handling on the frontline, most particularly those people who have responsibility for conducting the complaints. This is a big idea.

In direct response to your question, there are two ways of doing this. You can do it through the Scottish way, which is to give the ombudsman the regulatory power to require bodies in jurisdiction to give information to the ombudsman to demonstrate that they have changed their behaviour and that their complaints processes are in line with good practice. That works very well in Scotland. I am in regular contact with my Scottish counterpart to look at that and to see what we can learn from it. That would require a change in legislation.

An alternative model is the one that I used when I was the higher education ombudsman—a very similar model called the good practice framework, which I introduced in 2014. There, it is done on an entirely voluntary basis, and the key is to work very carefully and closely in consulting bodies in jurisdiction to make sure that they see that they have an advantage in adopting this process. In this case, and in the absence of legislation, that is what we are going to do. We will consult first. We will set out the core elements of the complaint standards framework, and will ask bodies in jurisdiction to submit annual returns to demonstrate to us what they are doing to adopt the good practice framework. We will align that with the experience we have of handling complaints.

The OIA addresses this by publishing an annual statement for each university so that service users can see what impact the good practice framework has had. I am not saying we can go to that very quickly, but that is the logical route that we will want to go down if there is no legislative change.

Q45 **Tom Randall:** Do you see it as part of the role of the ombudsman to improve complaints handling by other bodies?

Rob Behrens: I see that there is a strategic problem for my organisation to get 120,000 inquiries a year, most of which are not within our jurisdiction because they have not been addressed by the frontline body in the first place, so we cannot look at it. While this is regarded as a useful public service, it would be much better if the frontline bodies resolved cases effectively so that cases did not come to us unless they were difficult and contentious, so that people knew where they could go in order to address the issues that they have. This is a big problem that the Government has not yet addressed, in that there is in the ombudsman framework no commonly understood way in which people can go and have complaints addressed.

Q46 **Tom Randall:** Thank you. If I could just move on to the issue of value for money, I understand there was a value for money study published in November 2018 and that you indicated to the predecessor Committee that

you would be in favour of repeating a value for money study. Do you have any plans to do another, and when will it be?

Rob Behrens: Absolutely. I need to report to the Committee that there has been very great interest in the peer review approach that was adopted in 2018 by PHSO. In autumn last year, I hosted a conference in London of the International Ombudsman Institute to see if we could create guidelines to regularise the way in which peer reviews are undertaken. Only last week, the IOI published a guide to effective peer reviews to be used by the 150 members of the organisation. There is great interest in it. I was invited to go to Canada to talk about the value of peer review. I have been invited to conduct and have completed a peer review of the ombudsman of Catalonia. We are in the lead in terms of the methodology of this. I am confident that this is a new way of addressing scrutiny—it cannot be used on its own—and we will commission another peer review before the end of my term in two years.

I would like to make one point. Mr Jones was somewhat sceptical about the membership of the peer review panel when it was discussed at the last scrutiny hearing. That was one of the issues that I took to the International Ombudsman Institute. You cannot have a peer review unless those on the review are peers. That is critical. However, I accept Mr Jones's important point that there needs to be some validation of the members of any peer review, and the International Ombudsman Institute will validate membership of peer reviews to make sure that they retain the necessary independence.

In short answer to your question, before I leave in 20 months' time, I will have commissioned another peer review of the organisation.

Q47 **Tom Randall:** Thank you. Looking forwards again, you said in your written evidence to the Committee that your ambitions over the next 12 months are contingent on whether we receive the necessary investment for the next comprehensive spending review. What is that necessary investment for?

Rob Behrens: That is a good question. The answer—and I want to ask Amanda to come in here—is that in the last period we took a hit of 24%. Since then, the volume of cases being submitted to us has risen, as with most ombudsman services, by 13%. That puts added pressure on what we are doing.

Our next strategic plan, which will be for the next three years, will be an incremental plan, but we cannot do everything we need to do on the basis of the existing budget that we have. I mentioned a number of things. The clinical advice function needs financial support in order to assure quality. We have plans to develop the complaint standards framework to provide support to people in frontline services and other ombudsman services to deliver the training that we have the expertise to do, which means something that we are talking about even now, which is the creating of a learning academy to further professionalise what people are doing as case

handlers. These are about assuring the quality of the service that we provide. We will be looking to your Committee to have discussions about what is appropriate in the new economic climate, to make sure that we put something forward that is realistic but still ambitious.

Q48 **Tom Randall:** How are you going to demonstrate value for money for that potential investment?

Rob Behrens: We are already doing that as a result of the scrutiny that we experienced from the peer review. We have an Audit Committee, which is working on VFM measures, and as far as the articulation of that, I will ask Amanda to deal with it in detail.

Amanda Amroliwala: I have just a few things to add. Rob talked about the potential for a learning academy, and one of the things that we have been doing is looking at the accreditation framework that we have put in place for our senior caseworkers, which is a professional accreditation standard, and looking at how that could be developed into an external, academically recognised professional qualification. Within the terms of that, we are also looking at whether such an external, recognised professional qualification could be developed at a number of levels, from frontline complaint handlers up through ombudsman services, through to a postgraduate level of complaint handling and dispute resolution.

We believe that if we could get sufficient funding to develop that model in partnership, for example, with a university, we could offer a consistent standard of education and training and development for complaint handlers throughout public services. That would have enormous benefits not only for the organisations concerned in terms of knowing that their complaints were being handled in that way, but rather than simply focusing on resolving an individual complaint, it would enable those organisations to be confident that they were taking the learning back and improving services as well. It would be an uplift in the professionalism of complaint handling across the board. That is one area where we think that investment could add substantial value across the country.

The second one is more local to us, and that is about insight. We implemented a new data system last year, a new casework system. It has the opportunity for us to extract more information from it, and I think, with investment in data analytics capability, there is an opportunity for us to extract more learning from that system and to share that learning more broadly across health and Government bodies.

There is a third area that investment could really help with. We know, as Rob mentioned in an earlier question, that public knowledge of our service is reasonably limited. We also know that while those coming to our helpline are diverse in many ways, there are areas of the community that do not access our services. That is particularly true of people from lower socioeconomic groups, and those are people who often can be very big users of public services but just do not complain. They do not complain first to the bodies in jurisdiction and they do not complain to us. I think

that there is something we could do to do much more targeted outreach to those communities to help them understand what their rights are in relation to getting good services and to bringing complaints to us when they do not. There are a number of areas where we could expand and do more if the funding were available to us going forward.

Tom Randall: Thank you both.

Q49 **Lloyd Russell-Moyle:** Rob, does the lack of own initiative powers impair the value for money for the ombudsperson service? You have talked about some of this area before. For example, by preventing you from fully investigating potential systemic issues, does that mean that you end up just looking, like that fable where people are looking at different parts of the elephant but they are never allowed to step back and see the whole picture, if you understand what I mean? What are your feelings on that?

Rob Behrens: Thank you. We need ombudsman reform in the United Kingdom. We are lightyears behind my European counterparts in not having it. Indeed, we are behind the Welsh, Scottish and Northern Ireland ombudsmen in not having that power. Across Europe, having own initiative power is regarded as normal and routine, and it enables the ombudsman to look at, as you describe it, the elephant as a whole.

More seriously, my colleagues in Europe are able to uncover failures in public administration, particularly in areas where people do not complain, as Amanda has just been talking about. For example, in Ireland, my counterpart there uncovered a scandal of the failure to properly reward people who worked in Catholic institutions, in laundries. In Finland, my counterpart there discovered that people with intellectual difficulties were being confined, chained to beds in Finnish hospitals. All these things were issues that had not been complained about and were necessary to be addressed.

Can I give you an example of where it would be beneficial in England at the moment? We undertook—you may have seen the report—an investigation into the deaths of two young people in mental health institutions in England, on one of whom we subsequently published the whole report, Matthew Leahy's case. There were 19 failures of care of a vulnerable young man, who eventually died a very few days after going into hospital. We published a hard-hitting report addressing that issue, and the truth is that there are several cases in the same hospital, perhaps more than 25, where similar events have occurred but where the families did not complain. If we had had own initiative powers, we could have done the investigation to include looking at those cases, and that would have been a cost-effective, quicker and value-for-money way of dealing with the issue. Instead, what happened was that we published the Leahy report, and the Department then commissioned its own institution to do a wider study, which we could have done all along if we had the power to do it.

Q50 **Lloyd Russell-Moyle:** Thank you. To be clear, what you are saying is that there is a cost implication to this. If any of those complainants who did not

come forward initially came back to you now, would you have to do a new inquiry?

Rob Behrens: That is unsatisfactory because there are time limits in law on what we can look at, and most of them would be out of time.

Q51 **Lloyd Russell-Moyle:** What kind of legislative changes, finally, in terms of specific legislative changes, would you recommend? You talked about the Scottish model earlier on.

Rob Behrens: We have been waiting, like "Waiting for Godot", for ombudsman reform since 2015. It simply has not come. All credit is due to your Committee for raising the issue time and again, and I am grateful for that, but the truth is we are exactly where we were five or six years ago. The Bill that was published then is now not fit for purpose and cannot be used as a basis for new legislation.

We need a fundamental change in the structure that deals with certain issues. First, there needs to be a joined-up ombudsman service for England, which includes a merger, a bringing together, of the local government ombudsman and the parliamentary and health service ombudsman. That is accepted as being common sense by my counterpart, the local government ombudsman. Every other national ombudsman has that power.

One of the failures in the current Covid crisis has been the difference between the seriousness with which care homes have been treated compared with health service issues that have been completed. Across Europe, that issue is addressed by one ombudsman. In this country, it cannot be addressed by one ombudsman because health and social care are looked at by different ombudsman services. It is not impossible to overcome that, but it shows the strategic weakness of the oversight mechanisms that we are dealing with. That is the first point.

The second point is—and I do not know whether you know about it—there is now a charter called the Venice Principles for Ombudsman Services, which has been adopted by the Council of Europe, which sets out the core conditions for national ombudsmen in Europe. We are strong supporters of the Venice principles, but we do not meet some of the terms that we need to meet in order to be credible with our European counterparts. There should be direct access for citizens to come directly to the ombudsman, rather than go through their MPs. The Venice principles say that there should be direct access, and we do not have it at the moment.

Q52 **Lloyd Russell-Moyle:** On that point, is there not a danger that if you weaken the link between the MP and the ombudsperson, what you end up doing is weakening the link between political power and decision-making and a body that suddenly becomes put in a broom cupboard and ignored?

Rob Behrens: I cannot imagine in all seriousness that that would apply to MPs. Our relationship with MPs is vibrant and constructive, and we

understand the constitutional position that you have in being the prime representative of a constituent.

Q53 **Lloyd Russell-Moyle:** A good example is that my interaction with yourself as an office—I go through every case that comes through my office, I understand it—compared to my interaction with the local government ombudsperson, which is almost negligible, and it is only if an issue is flagged up to me that I go delving into their work. Is that not an example where actually, by devoiding MPs of an involvement, you do then move it further away, and suddenly the local ombudsperson publishes something and an MP might be none the wiser?

Rob Behrens: I pay tribute to those MPs—and there are very large numbers of them—who treat seriously the complaints brought by their constituents, but the truth is, in my humble view, that citizens are put off coming to us by the need to go through their MPs.

Lloyd Russell-Moyle: A fair point.

Rob Behrens: I think that is a weakness in the credibility of our system. I looked at the 1967 legislation very carefully. It is very deferential. It talks about the ombudsman being a service for "the little man". We have got past those days now. There can be trust placed by this oversight body in our institution to make sure that we do not neglect the views of MPs and of Parliament.

Q54 **Lloyd Russell-Moyle:** I know you have a list there, but I am sure Mr Wragg wants us to move on to other questions. I think this is an issue that I am sure will come back to and, as a Committee, push further. Unless there is something really important on this point that you need to mention and so we have to move back?

Rob Behrens: I do, thank you. I think that there are two further things that need consideration. First is the possibility of becoming a complaint standards authority. As I said to Mr Randall, we can get around that by adopting the OIA model.

The final issue that concerns me is the way in which the Government is now thinking of creating a safe space for the investigation of certain serious cases in the health service, with the creation of a body to deal with that issue. Effectively, we have a very good relationship with HSIB, the body that is being created in statute. We have supported it. We agree that it has a key role to play. However, it is contrary to the Venice principles and, in my view, unacceptable that the ombudsman is excluded from the same space, as is proposed, without going first to the High Court to get permission. That undermines the power of the ombudsman, it is against the Venice principles, and it is something that I am really concerned about.

Lloyd Russell-Moyle: Something, I am sure, for us to follow up. Thank you very much for that.

Q55 **Chair:** Thank you, Mr Russell-Moyle. I appreciate that. Just coming back

to me to round off the meeting, if I may, obviously in this situation you have moved many of your caseworkers to working from home, and thank you for your update on that. Perhaps most noticeably, you have paused some investigations and are not accepting new investigations. I wonder, Mr Behrens, if you could update me on that status, please.

Rob Behrens: Yes. I will answer this together with Amanda. We have paused the complaints as a result of looking very carefully at the crisis situation that hospitals were in, where we were told that they were having to deal with an epidemic, which meant that clinicians were being put on the frontline and could not deal with an issue of handling complaints, where complaints teams were being disbanded and redirected to handling issues like bereavement. We are being kept up to date by daily contact with bodies in jurisdiction to make sure that, as soon as the situation is more regularised, we can stop the pause and start investigating complaints again. One of the issues for us is use and deployment of our clinical advisers, who are also involved in the crisis.

As Amanda will explain, our phone lines are open, our intake team is working very hard, and we have a full and comprehensive list of those people who ring in to make complaints about the current Covid situation and what it brings forward. I will hand over to Amanda at that point.

Amanda Amroliwala: From very early March it became increasingly clear to us that frontline teams and complaint handlers were struggling to be able to respond to our inquiries as, increasingly, clinical professionals were consumed 100% in dealing with the crisis, and complaints teams were being redeployed. We saw from very early March that we were not able to pursue inquiries.

We took a decision upfront that we would not place additional burden on the health system in this time of emergency, and we paused cases in terms of those that needed us to engage with the health system, and paused those coming in to our office, but doing so in a way that would not disadvantage people and would enable them to bring a complaint to us later on, once we reopen that service.

For the casework that we have in hand, we have continued to do as much work as we possibly can on those cases; everything that we can do that does not involve having to seek input from a medical professional, we have continued to do. We also had a queue of unallocated cases in this build-up to the pause, and we have been allocating those out to caseworkers so that they, again, have started to work through those to do as much work as they possibly can on those cases, short of contacting medical professionals. We have continued to do all of our work on Government bodies and parliamentary cases whenever and wherever we can. Obviously, there are some Departments that are facing particular pressures at the moment, but a lot of them are continuing with business more or less as usual in terms of complaint handling. We have continued with all of those investigations, too.

We are talking regularly to NHS England and to individual health trusts, and we are considering very actively when we can both start to work again on the complaints that we have in the system and when would be the right time to reopen the service more broadly.

The NHS itself, shortly after we made the decision to pause our complaint handling investigations, took its own decision to suspend some of its frontline complaint handling as well. That is the case across quite an extensive part of the health system, particularly in areas like primary care, which faced particular pressures in that respect. We are talking to them about when they are going to reopen, and we would look to start our investigations again as soon as it is reasonably practical to do without putting additional burden on the system.

Chair: Thank you both. That is a very useful answer, given the current circumstances. Can I thank you both, Rob and Amanda, for your time this morning? There are a number of areas that I will be writing to you about later in the day, and if you could write back to the Committee at your earliest convenience, I would be very grateful indeed.

Can I also thank colleagues and staff, particularly broadcasting staff, for their assistance in these virtual proceedings? Thank you all.