HOUSE OF COMMONS

Public Administration Select Committee

Oral evidence: The work of the Parliamentary and Health Service Ombudsman, HC 634

Monday 10 November 2014

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Written evidence from witnesses:

- Parliamentary and Health Service Ombudsman

Watch the meeting

Members present: Mr Bernard Jenkin (Chair), Paul Flynn, Mrs Cheryl Gillan, Sheila Gilmore, Kelvin Hopkins, and Greg Mulholland

Questions 1-70

Witnesses: **Dame Julie Mellor**, Parliamentary and Health Service Ombudsman, and **Mick Martin**, Managing Director, Parliamentary and Health Service Ombudsman, gave evidence.

Q1 Chair: May I welcome both of you to this annual scrutiny session with the PHSO, and could I ask each of you to identify yourselves for the record?

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

Mick Martin: I am Mick Martin. I am the Managing Director at the Ombudsman and I run the day-to-day service provision.

Q2 Chair: Thank you. Since we last met in this format, we have produced our report *Time for a People's Ombudsman Service*, and you have given us plenty of reaction to that, one way or another. The Government has responded half with an interim response, as we expected and informally invited them to do, because they wanted much longer to think about the large implications of the reforms that we have suggested. They have set up a review of the public sector ombudsman landscape under Robert Gordon, who will consider the structure and powers of current ombudsmen. What is your reaction to the way that the Government is responding to our proposals?

Dame Julie Mellor: As you know, we were working very hard to look at how we could make ombudsman services for the public sector better for the public and for Parliament. We are thrilled with the report that you did, and I am really hopeful that the Robert Gordon review for Government will take forward the Committee's recommendations, particularly that to create a public ombudsman service that covers all public services in England, local and national, as well as the non-devolved services that report to Westminster. I am hopeful that they will feed back to you by the end of the year, and then we hope we will see all the political parties committing to legislation in the first Queen's Speech after the election, because we are hungry to get on.

As you know, we see the legislative reform as the third part of what we are doing. The first part was the listening that said you have to do more investigations, on which we have made good progress. The second part was the part that we are just in the foothills of, which is changing the nature of our service. We are getting on with those things, and we are also getting on with convergence with the LGO, the Local Government Ombudsman, so that it should be less risky and less costly to move us to become one organisation in due course.

Q3 Chair: How much confidence do you have in the review being conducted by Robert Gordon in your interaction with him so far?

Dame Julie Mellor: There are probably two things to say. One is that I was very pleased with the way that Oliver Letwin, giving evidence to this Committee, said that since we are Parliament's ombudsman service he would be led by Parliament's recommendations. The second is that Robert Gordon has been very good at going out and listening to everyone, and our team has been working with him. For example, Jane Martin, the Local Government Ombudsman, I and our team have been working to say what this future service will look like and how we can move towards it as much as possible now. We have fed that in to Robert Gordon over the summer, and I know our staff have had regular meetings, so he has been very open and receptive to ideas for how your recommendations might be put into practice.

Q4 Chair: That would include looking at direct and open access for members of the public to ombudsman services, rather than having to go through MPs.

Dame Julie Mellor: That is for the Government to come back to you on. I am just encouraged by their openness in listening to how the recommendations that this Committee made might be enacted.

Q5 Chair: How are you engaging more with MPs?

Dame Julie Mellor: I mentioned that we are just in the foothills of modernising our service, and, in part down to your suggestion, while we have listened to lots of feedback, we want to do a comprehensive exercise to go out and listen to past users, current users and future users of our service. That is the public, the bodies in jurisdiction, advocates and MPs. As part of this going-out-and-listening exercise, we will be listening to MPs and particularly their case workers, probably, in terms of what will make it easier for them to work with our service. All of that consultation and engagement will lead to a set of

promises that we make to our customers and stakeholders, which we are calling a service charter.

Q6 Chair: How are you enabling the other things that we recommended, for example being able to take complaints other than in writing, without legislative change, or are you completely transfixed by the legislation?

Dame Julie Mellor: Absolutely not. Perhaps I could ask Mick to pick up on that one.

Mick Martin: One of the key ways we are doing that is by shifting the basis of our communication with people from correspondence to telephone and face-to-face. What that means in terms of collecting complaints is that we are now moving to taking complaint details over the telephone, which is how many of our complainants would like to give us that information, and at the moment confirming that information by some correspondence, normally by email. That is about shifting us away from a reliance on us sending letters and people sending letters to us, and filling in forms, because it is clear to us that part of our modernising is modernising the way we give access to our service, and making it much less about paper and much more about people.

Q7 Chair: You are using complaints perhaps more proactively to produce more generic reports, but does this get around the lack of own-initiative powers? How does this get around the lack of own-initiative powers?

Dame Julie Mellor: There is an awful lot we can do without own-initiative powers. You are absolutely right that we are looking at the range of tools that are at our disposal now and how we can flex within the current legislation. We are keen for example, as part of our planning for next year, now we know we can cope with greater volume, to look at how we can ensure that we are having the greatest impact for people. That might be the general raising of awareness.

We put our toe in the water this year by specifically marketing to those who are least likely to get to us on their own at the moment, so people with learning disabilities, South Asian and Muslim women, and some publicity encouraging older people to complain. We now want to look at where there is service failure where, if we had own-initiative powers, we could use them, and whether we can work with MPs, the Autistic Society and Mencap to say, "There is this evidence of service failure from your casebooks, from what the voluntary sector organisations are telling us and from what we have seen. Can you ensure that the people who need our service know about it, so that people who are vulnerable to service failure can come to us?" Then we can look either at individual cases or groups of cases, as we did for example with Equitable Life in the past.

Q8 Chair: We have new legislation proposed by David Davies, my colleague, that will effectively set a statutory time limit on how long inquiries take or require you to give proper explanation, so that people like the Morrish family are not left in the way that they were. Do you recognise that that legislation is necessary?

Dame Julie Mellor: I welcome the focus on openness and accountability regarding our performance, absolutely. Yes, we do have cases that take too long. Mr and Mrs Morrish's complaint to us was one that we took too long over. When people's experience is poor, we recognise that it is particularly distressing, given the unique point that we are at the end

of the complaints system. That is why, since Mick has joined, we have been making sure that managers have checkpoints during the investigation process, with a focus with their staff who are doing the investigations on how they can bring this case to effective closure as quickly as possible. There is senior oversight of that and we are beginning to get more consistent in communicating with people about what happens.

We also have to remember that some cases will take longer. We are dealing with really serious cases. Last year, we dealt with 360-odd investigations into avoidable death and 424 investigations into unsafe discharge. We need to get to the right outcome, and sometimes that can take time. We just need to make sure, rather than having an arbitrary target, that we are robust and transparent about where it needs to take time and what time it is going to take.

Chair: We are going to come back to the quality of complaint handling a bit later.

Q9 Mrs Gillan: Taking up something that Dame Julie mentioned about working with the National Autistic Society, I declare an interest because I am Chairman of the All-Party Parliamentary Group on Autism. I wondered if, in that instance, you approached the NAS or did they approach you?

Dame Julie Mellor: We have not done this yet. This is something that we will be looking to do next year, having put our toe in the water in raising our profile among particular vulnerable groups. One of the reasons that might be an area we want to explore is that last year we did six times more investigations than in the prior year. In the first year of delivering the new strategy, our staff delivered six times more investigations. You would think that there would be about six times more investigations on each subject, but among people with mental health problems or with learning disabilities, for example, the rate of investigations is higher than the six times. It is an area about which we are particularly worried and that is why we want to explore it.

Q10 Mrs Gillan: Have you given some thought to making it easier for people who, for example, are on the spectrum and do have autism to be able to access your services?

Dame Julie Mellor: Very often in cases with people on the autistic spectrum, it is their families and carers who would bring the case. It obviously depends on where people are on the spectrum. I do not know, Mick, if there is anything you would like to pick up about that kind of access to our service.

Mick Martin: We invest in training for our staff, because we find that, in terms of the profile of our complaints, significant numbers come from people who need us to have a different level of skill in order to help their complaints. We also try to work as much as we possibly can with advocates and families so that we can give people as much help as they need.

We recognise, in some of the communications and campaigns that we have been doing this year, that we need to do more to get to groups who are perhaps disadvantaged by the standard way complaints are dealt with. We have more work to do with that across the system, so that we are making sure that we are both promoting people having access to the complaints system, but also making sure that we are giving access ourselves.

Mrs Gillan: I can relax and know that you are going to have some autism awareness training within the PHSO.

Dame Julie Mellor: Indeed, in the work that we did to raise our profile among those with learning disabilities, we worked with Mencap on how to do that most effectively—what kind of video, for example, was going to work in GP practices, in the reception and waiting areas, and be accessible to people with learning disabilities.

Q11 Kelvin Hopkins: As we have heard, you have dramatically increased the number of complaints you have handled over the last year, six times in a year, which is remarkable. Is that just down to using the telephone and email, rather than everything being done by letter, or are there other reasons for that increase?

Dame Julie Mellor: Perhaps I will start and then ask Mick to come in on how we have done it. The first set of feedback, from you, from the Health Select Committee and from the cases that came to us for review all gave us the same message, which is: please do more investigations. While we used to assess about 7,000 cases and take on to investigate about 400, which is 6%, we now still assess about 7,000, but we take on more like 4,000. That is where we are now, in this next year, because obviously you are scrutinising us mainly on last year but I have up-to-date information for this year.

The biggest thing we did was to lower the threshold of what we wanted to take on. They are the same criteria, which are whether there are indications of injustice that are due to service failure and that have not yet been remedied. Rather than almost having to provide the evidence before we accepted the case, it is whether there is an indication. It is a lower threshold. That is why we have more cases. In terms of how we have done it—

Mick Martin: The most important thing to say is that we have had a fantastic response from our employees in working differently so that, where we used to place the majority of our resources into assessing cases, we now place the majority of our resources into investigating them, because we recognise that that is what people who come to us most want from our service.

The way we have done that is to reduce the amount of time that assessments take—it has gone from about 46 days on average for an assessment to take place down to about 28—and to change the way in which we conduct investigations. Some of that is about changing the channels of communication; other parts of it are being much more proportionate and proactive around how we are running the investigations.

One thing that I would say, though, and is really important to stress is that we are partway through changing our service. We have a lot more modernising to do and a lot more work to do to reduce the amount of time that it takes us to do things. We are getting much clearer and more transparent about how we communicate and how we go about doing our investigations. While we have switched very much to being able to meet our key customer requirement, which is doing more investigations, we are right in the middle now of what we think is the most important bit, which is to modernise the way in which we do the work. We have some way to go on that. It is the balance of saying very clearly that we have come quite far in a short space of time, delivering the thing that our customers want, but we still have a way to go.

Dame Julie Mellor: Chair, may I just add something? We have been talking about numbers, but we need to move beyond the numbers to why we decided to do more cases. As a result of doing more, last year we upheld two and a half times more cases. This year probably about four times more people will have their case upheld and, for others where it is not upheld, they will have closure because they will get a final adjudication on their case. If you look at the nature of the work and the devastating impact that service failure can have on people, that is why we are making these changes.

Q12 Kelvin Hopkins: It strikes me that what you are doing reflects very much what we saw on a visit to Holland. You can telephone, email and so on, doing cases much more quickly. I just wondered if that had come from our report and whether it might have influenced what you have done. That was just a thought.

A question I have raised before with the Ombudsman is that for those from professional, literate backgrounds writing reports to you is not difficult but, for a lot of ordinary people, that kind of approach is difficult. Telephone and email are easier. Are you getting more people coming forward who perhaps might not have come forward in the past with a complaint, because it is now easier to do and you are more approachable?

Dame Julie Mellor: As Mick suggested, we are just at the beginning of that stage, so there are lots of things that we have done, but there are lots more that we plan to do, rather than actually having delivered all those changes yet. Certainly from the historical data, the proportion of people who came to us, and then when we told them that they needed to fill in a form did not come back—so they had not made their complaint in writing—was quite high. That is the kind of thing Mick was talking about in being able to take people's case ourselves—for us to write it down over the phone. That is designed to make sure that we do not lose the opportunity to provide a service for those people.

Mick Martin: To add to that, it might be helpful to explain a really big shift, which you were referring to with supporting. Before we embarked on the changes, we were converting about 7% of the assessments that we did into investigations. That is now up to about 60%, so it is partly about making sure that we are getting better at listening hard and helping people, but it is also partly identifying where there is a case to answer and making sure that we speed those things through to investigation.

Q13 Kelvin Hopkins: I have a couple more questions beyond that. You have increased the number, but what about the quality of individual investigations? Has that been maintained or even improved? There are a lot more cases going through.

Dame Julie Mellor: Yes. As you can imagine, we have been looking for that and there is no evidence that there has been a detrimental effect on our service. Our satisfaction rates have been pretty stable over the last five years or so but, as we have said, we are only partway through the transformation. We want to change the nature of the service more, rather than just saying that current satisfaction levels are fine.

Q14 Chair: Can I just come in there, Mr Hopkins? The quality of investigation is something that we have to hold you accountable for. How do we know that you have produced a quality investigation?

Dame Julie Mellor: Again, I recruited Mick Martin as our Managing Director because I wanted someone who was an expert on service excellence and on service transformation, so I am going to ask Mick if he could respond to that. The kinds of things that he has been introducing are, for example, the quality assurance framework.

Mick Martin: The most important way in which we can assure the quality of our services is by listening to the people to whom we are providing the service. We have been doing that a lot this year, more so than ever before. We have learned a huge amount from that exercise. We have learned that some of the key parts of our way of working, our method, need to be modernised. That is partly about reducing the amount of time it takes to do things; partly about making our method much more transparent; and partly about being much more people-oriented, much more oriented on getting into the issues that are being asked of us and much more oriented on finding why things happen as well as what happened. Therefore, the way in which we test our performance in that is by listening to our customers throughout and getting their views.

At the moment, as a key part of a response to our increasing volume, we are introducing the quality framework for assessing our performance. That starts by stating very clearly what we think a quality service entails. Secondly, that is about making sure that, every time we do some work, it is quality-assessed against those criteria. We then do some sampling outside of the local team doing the work. We have a quality audit programme, which entails teams going in and assessing the work that the team is doing.

Q15 Chair: Is that quality audit work an internal audit?

Mick Martin: Yes.

Chair: Does another team go and audit another team? How does that work?

Mick Martin: We are pulling people from across the organisation, so that absolutely everybody within the ombudsman service is involved in the actual work that we do around cases.

Q16 Chair: Why do you not have some external audit?

Mick Martin: We do have external auditors.

Q17 Chair: Obviously you have external auditors, but I mean in terms of external quality audit of your complaints—for example, you publish or issue a report about a complaint—even if it is just on a spot-check basis. We cannot look at every complaint. The only other alternative is to go to judicial review if the complainant is unhappy. When you have finished listening to the complainant, you cannot satisfy them and they are still not happy, how do we know that you have produced a good report? It cannot just be one of your other people ticking a box and saying, "Don't worry, chaps; you did all right."

Mick Martin: We do have external reviewers who review cases, who are outside of the organisation.

Q18 Chair: Who are they?

Mick Martin: They are, normally, professional people who we have hired who have experience in these specialisms or the areas that we investigate.

Q19 Chair: Do they produce something that is for public consumption, in terms of auditing of complaints?

Mick Martin: They normally do a review of an individual complaint that we believe needs an independent review. We are changing the review part of our service, so that we will be using those external reviewers very much from a quality-of-service-checking point of view. We will then be able to publish what they do, because that will not be about individual complaints.

Q20 Chair: What percentage of cases is non-peer-reviewed, i.e. externally reviewed, in that way?

Mick Martin: A small proportion at the moment. The review takes place once we have completed our work on the investigation, taken the case through an internal review and then we feel that there is an external piece of work that needs to be done.

Q21 Chair: How can an unsatisfied complainant persuade you that their case ought to be externally reviewed? Will that become something that you can provide?

Dame Julie Mellor: No, we have chosen to use our external reviewers. Historically, they have done about 15% of cases, but we have also audited the difference in their decision-making around reviews and found them to be the same as our internal reviews.

Q22 Chair: Would this not be a way of increasing your customer satisfaction by saying to people, "Rather than go to a judicial review, we will implement an external review. You can go and talk to the external reviewer, and then they will review the case"?

Dame Julie Mellor: There are lots of different things that I would like to say, so let me just think. One of them is that we are trying to get across that our approach to getting feedback from people about our service is much broader than just looking at when someone is not happy with a decision. We have probably already talked about our customer satisfaction surveys, where we have been piloting new methods.

Q23 Chair: I just want to concentrate on this one question. Is this something you could consider?

Dame Julie Mellor: The second thing was, on the specifics of the review process, as we speak we are looking at changing the way we deal with that, because we think we can do better.

Q24 Chair: The problem we have is that this Committee cannot review every unsatisfied complaint. The courts clearly cannot review every unsatisfied complaint. That has historically been the message: if you do not like what we have done, you can go to the High Court, which is not a very comforting way of closing off your responsibility for the case. I appreciate you do not do that now. Surely the right way to handle this is to provide some alternative assurance of the quality of your reports to the people who need to be

assured, albeit we know that, in some cases, sometimes people can never be assured, because the information is not there.

Dame Julie Mellor: I absolutely accept that, because Parliament intended for us to be the final adjudicators on complaints, we have to focus on the quality of our work. One of the things that we are going to be doing is sharing facts earlier in the process, so that both the complainant and the service provider get the facts earlier and have a chance to comment on whether we have expressed the facts accurately. When we get a draft report, we are going to be asking people to feed back at that stage, at the draft report stage, on the quality of the service, the method of investigation and the quality of the decision-making so that, hopefully, before we issue a final report, people will have had the opportunity to raise all their concerns. That would be sorted before we make our final adjudication.

Q25 Chair: I think your answer is "no"; you are not going to do this for the moment. You are not going to say to complainants, "Okay, you can have an external review." You do not feel you can do that.

Mick Martin: We would say, at the moment, we recognise that we need to change the process of review. We are focused on that.

Q26 Chair: In a manner that responds directly to the complainant? That stays under your jurisdiction. It is satisfying Parliament that you are exhaustively looking at these cases. Surely it would only be a tiny number that would finish up asking for such a review, but it would give assurance to those people that it was an independent review and it was not just you validating your own decision.

Mick Martin: The short answer to that is we recognise that external review has a role to play and plays a role now, and we also recognise that it needs to change.

Q27 Chair: I am not going to press you any further on this, because I do not think we are getting anywhere. Can I just press one further point? It has been raised with us. Let me emphasise that we do receive evidence from individuals, some of which we feel able to publish as evidence, some of which we cannot publish because it contains personal information or is specific to a complaint, but we have agreed to publish two pieces of evidence this afternoon that we have received very recently. One of the things that I have personally been pressed on, by a representative of the Patients Association—and the President of the Patients Association is now Robert Francis, who chaired the Francis inquiry—is that evidence that tends to come from the Health Service, particularly medical records, tends to be evidence that you do not challenge. However, you do challenge the evidence that comes from complainants, so there seems to be an inequality in the regard you have for different kinds of evidence. What do you say to that?

Mick Martin: The thing I would say most directly to that is that the impartiality and the independence of the work that our investigators do is right at the heart of our work.

Q28 Chair: I am sure that is their intention but, if the medical records say something, how can the Ombudsman challenge that?

Dame Julie Mellor: The process that we use, and a very important principle of an ombudsman's service, is that our investigators are laypeople. You will have seen there is

a tribal nature to the process in other areas where you have professionals, so you do not want professionals, as in clinicians or any other of the professions that are providing services that are in our jurisdiction, being the main decision-makers. Our role is to do our investigations in an inquisitorial way, rather than an adversarial way as it is in the courts. That is why we are free, and that is why it is easier for the public: because we do the investigating, rather than the individual.

Q29 Chair: That means you have laypeople, who tend not to challenge medical evidence.

Dame Julie Mellor: We will take evidence from a range of sources. We have clinical advisers who have not been involved in the cases, who are not conflicted and who will give our investigators that impartial advice about what happened, what should have happened and what guidance says should have happened.

Q30 Chair: Looking at one or two of the cases where you have had to reopen the case and you have subsequently reached a decision—there are one or two very high-profile cases—has it turned out to be the medical records that have not been accurate?

Mick Martin: Answering that would be a little too general an answer, from my point of view. There are cases where that has been the case. There are cases where the clinical advice that we have received has changed in the course of us questioning the clinical advice.

Chair: There are some cases where the clinical advice has not changed even though you have reached another finding that is at variance with the clinical advice.

Mick Martin: Yes, on occasion. The broader issue, which we have heard very loudly and clearly from complainants, is that they believe we do not always take into account their feedback and input, and their views about evidence and new evidence.

Q31 Chair: Do complainants always get an opportunity to challenge every piece of evidence that you have accepted from the hospital, practice or whatever? Do they get that chance?

Mick Martin: Yes.

Chair: That was a little "yes". Is it an emphatic "yes"?

Mick Martin: It is an emphatic "yes". We send the draft report.

Q32 Chair: Before you do a draft report, why do you not just show them the evidence you have been given?

Dame Julie Mellor: That is exactly why we are saying we will do more of sending people the facts before we reach a view on the findings.

Q33 Chair: "This is what we've been told. Do you agree with it?" before you start assessing the evidence.

Dame Julie Mellor: Exactly, and that is why we have introduced that stage.

Chair: That will be a change.

Dame Julie Mellor: We will be introducing that stage in our process. That will be a change, yes.

Q34 Chair: How have your staff reacted to that change? Is it difficult getting them to adapt to this new way of working?

Mick Martin: Our staff have been terrific in the changes we have been making. That is not to say that the culture of our organisation and the tone of how we do our work do not still need work and effort. However, the process is one of making sure that, when we do our investigation, we have a plan that we share with the body and with the complainant; we share early views of the facts and the chronology of the case, and that clinical advice that you referred to; and we then share where we think we are in terms of draft findings, giving a further opportunity for people to let us know if they have any more evidence or any different evidence, or if we have misinterpreted the facts.

Q35 Kelvin Hopkins: The numbers of complaints upheld have increased as well as the numbers of cases dealt with, but the proportion of those upheld has dropped substantially. Have you ensured and how have you ensured that complaints that would have been upheld in the previous regime would now be upheld under your regime? Has there been a change? Are you upholding more cases or fewer?

Dame Julie Mellor: As you have indicated, when we did a lot fewer cases, the uphold rate was 86%. That was because the bar was so high. In order to accept for investigation, you almost had to have evidence that there was a problem before we would investigate. Now we uphold about 42%, which mirrors other public ombudsman services, but you are right to ask how we know if we are getting that right. That is where things like the quality assurance framework that is being introduced will help us.

Q36 Kelvin Hopkins: One more final question: you have had to make savings. There are constraints on public spending all round. How are you coping with that and how will you cope in future if there are further budget restrictions?

Dame Julie Mellor: We have been asked to save about £0.5 million a year over the last few years, and we have done that. The increase in volume has largely been from moving staff who were assessing cases to investigating cases, and some changes in method. As Mick has indicated, we are also looking at how we can be more effective by better use of technology. For example, we are just in the middle of purchasing a new casework management system, which will cost us around £0.5 million to purchase, but the savings over the next few years are £1.7 million. By becoming more digitally savvy, we both can provide a better service but also more efficiently.

Q37 Sheila Gilmore: One of the buzzwords that every public organisation uses is "transparency". I think, Mr Martin, you used that yourself. Could you perhaps be a bit more explicit about what you mean by "transparency"?

Dame Julie Mellor: If I can give a couple of examples, you may want to add, Mick. One of the bits of feedback that we heard from people is that we were quite a secretive organisation, and part of that is because we have to investigate in private, because we are

dealing with very private information about families. That put an onus on us to look at how we could be as open and transparent as possible.

There is a lot more to do but, just to give you two examples of where we are doing that, we now publish our performance information on numbers of cases that we have completed online monthly. Some of that performance information is now a lot more transparent than it was. We have begun publishing case summaries. The advantage of that transparency is huge, because it gives the public greater confidence to complain, because they can see how complaining makes a difference. It provides huge learning for service providers, in terms of not just their own complaints but seeing how other people have dealt with complaints and our adjudications.

There are other areas where we want to be more transparent. For example, people have told us that we do not communicate particularly well with them about how we consider cases, so we want to provide much more information on a more regular basis to people about what they can expect at each stage in our process, and indeed discuss the plan for an investigation with them. There is a whole range of things like that. Mick, you may want to add some.

Mick Martin: The most important piece of transparency that people have told us they want from us is to know exactly how we are going to go about doing our work. It is obviously hugely important to people that they understand how we are going to work and what we are going to do. That flows through our service provision. For example, we have been through a process to explain exactly how we go and assess cases, so that people can know what criteria we are using, how we apply it and they can then see what the flow through of cases from assessment to investigations is.

As Dame Julie says, when we get to investigations, it is about being transparent about the way in which we are going to investigate and the plan we are going to use. As the Chair indicated, it is about sharing facts, chronology and details as quickly as we possibly can. It is then about sharing any professional or clinical advice that we get, but it is also being really clear throughout, so that people understand what to expect from us, because we do find that there is sometimes a mismatch between what we can provide and what people are asking us to provide.

Q38 Greg Mulholland: My apologies for being late. Good afternoon. I had another meeting that clashed with this. This is an issue that I think you both know I have been very keen on pursuing since I joined the Committee in 2010. I will start by saying that I am very pleased that there has been very clear progress in this area by the Ombudsman's office. We as a Committee, as you know, believe that there needs to be a radical overhaul of the ombudsman system, which will deal with some of the issues more than you are able to in the current circumstances.

There is one thing you can deal with that I am not convinced is being dealt with at the moment, and this is something that I was very strong about with the previous Ombudsman. Whilst I can see the improvement in the figures and the number of satisfied customers, to use that word, what I am still not seeing is a clear distinct acknowledgement where the Ombudsman's office admits that they themselves have made a mistake. That needs to be clearer. The Ombudsman will then say, "Our own investigation has been flawed and we will therefore look at it again." Can I ask that you look at that and make sure, in the future, we do

very clearly see where the Ombudsman's office admits that they, in their own decision, have made a mistake and that is reported separately from some of the other categories?

Dame Julie Mellor: When you say "reported separately", do you mean in our annual report?

Greg Mulholland: Yes—acknowledged at the time and then reported in the annual report.

Dame Julie Mellor: The information that we put about learning from feedback, including complaints about us, does not do it for you yet.

Greg Mulholland: Not in the current reporting.

Dame Julie Mellor: What kind of thing would you like us to be putting in there?

Greg Mulholland: Just a very simple acknowledgement saying, "In these number of cases we have made the wrong decision or failed in terms of the process." That needs to be clearly there to give people that acknowledgement. Everyone knows, and you have been very honest about it, that sometimes of course, like any organisation, you yourselves will make mistakes. Can we move towards that clarity going forward?

Dame Julie Mellor: That sounds like a good idea. We will look at that.

Q39 Chair: How many cases can you think of that you have reopened and then reached a different determination?

Mick Martin: We have upheld in review about 60 cases so far this year. That is of course a small percentage of the cases both that we have handled and reviewed. Nevertheless, they are cases where we felt the need to re-look at the case because we believed that the original decision, service or the method that we used was not appropriate and, therefore, we have taken action to change our view. Reporting on that more fully would be a good exercise for us, in terms of being clear with everybody.

Q40 Chair: However, if you reopen a case, having closed and dismissed it, and then come to a different determination, somewhere there needs to be, "I'm sorry; we got that wrong."

Mick Martin: For me that is a thing that we take as a leadership task. I am spending lots of time talking to people who feel that we have not provided a good service, often where I have taken the decision that we need to change the decision that we have made or the service that we have provided. Of course, it starts with the person-to-person recognition that this change or this service has had real impact on them, but it is also being willing to change course, do things in a different way and reach a different decision.

Q41 Chair: We as a Committee need to recognise that some of your determinations will be wrong first time and we should join in the apology, because it is something that is bound to happen from time to time, and something that we need to make sure that we learn from.

Dame Julie Mellor: Absolutely. In a sense that is our mantra right now, in the second stage of modernisation that we are embarking on, because we recognise that to learn you have to listen. We are; we recognise that, given our unique stage at the end of the complaints process, it is particularly distressing when we get it wrong. That is why we are so keen to listen in all the forms that we already are, but to do this concerted exercise whereby we go out and listen to previous users, current users and potential future users.

One of the things we have done to make sure that we include those who are critical of us is set up a consumer panel, which is going to help us all the way through this next stage of our modernisation. When we have gone out, engaged and got feedback on what things people would like us to keep and build on and what they would like us to change, we are taking that to this consumer panel that includes people who have been critical of us in the past to make sure we are really harnessing the learning and building that into our service charter.

Q42 Mrs Gillan: We have a section where we were going to look at customer satisfaction, but a lot of it has been covered in a completely ad hoc way. I would just like to probe in slightly more depth. One of the first things we were going to ask you is how you define customer dissatisfaction, but I would just like to take it a little deeper than that and find out how you measure it and at what stage you measure it. People can become dissatisfied with the service that they are getting from you on a time scale, so I would be quite interested to know in more depth as to when that dissatisfaction sets in, in what proportion of cases, how you judge it and how you then remedy it. Following on from that, I would quite like to know where the dissatisfaction lies. Is it with timing? Is it with the quality of your personnel responding? Is it the process itself? If there is a breakdown in communication, do you then switch personnel on a particular investigation? I wondered if you could cover that for me.

Dame Julie Mellor: That is a very good question, and you are quite right: we need to look at customer satisfaction at different stages in our process, and see what issues are coming up where. Since Mick is the expert on this, as this is why we hired him, I would like him to deal with this one.

Mick Martin: The simple answer to your question is that there are key points in our service provision that are pinch points for satisfaction. The first one is that the vast majority of people who contact us have not reached the end of the process in terms of liaising with the organisation they are complaining to. Therefore, our key task is to try to help them re-engage. Obviously we have a level of dissatisfaction there, where people would like to jump the local stage and come straight to us, that comes from that interaction.

As Dame Julie has explained before, by far the biggest single area of dissatisfaction that we have experienced is those people who would like us to undertake an investigation and we have decided previously that their case must end at assessment, and therefore us not investigating those cases. We have seen a very drastic reduction in dissatisfaction with decisions on assessment, simply because we are now investigating over 60% of those areas.

When we get on to investigations, the areas of dissatisfaction become much broader. They are very focused on the time that we take, which is viewed as being too long. They are

very focused on the communication that we provide and the level of customer services that we provide whilst we are doing the investigation, and they are very often focused on a perception that we are arm's length in the things that we are doing. I take that to be not only from the complainants but also from the organisations that we are dealing with. Our response to that is along the lines that we were talking about earlier around changing some of our modes of communication but, very importantly for our most serious cases, moving from a paper-based view of evidence to a much more personal-based evidence process, whereby we go into the location and interview the people who are involved in the case.

Chair: I am afraid we must have shorter answers. I know our questions are sometimes a bit long too, but we will not get through it unless we have shorter answers.

Q43 Mrs Gillan: When you know that something is going wrong and there is dissatisfaction expressed, do you have a triage system? Do you say, "This can be dealt with by the team that is handling this," or do you have a process of escalation?

Mick Martin: We have a process of escalation. At any point in our service provision, from inquiry to investigations, we give our customers the opportunity to get some help outside of the investigative team that is working for them. We will review service complaints, method complaints and decision complaints as we go along, and not just at the end.

Q44 Mrs Gillan: Can I just ask what you therefore think your biggest challenge is in this area of customer satisfaction, at the moment? Will for example your casework management system ease any of the pressures and improve customer satisfaction?

Mick Martin: Our single biggest challenge at the moment is about review, which we spoke about before. It is about making sure that people are confident that, when they get to the end of the process, we have provided good service—we have used a good method and we have made the right decision—but also that we are really clear with them about what happens next: where we are and are not able to provide them some additional review and additional service. We need to get that right, because we are at the end of the process, because we have to give final decisions, and also because as an ombudsman there will always be a proportion of people to whom, unfortunately, we will not be able to give the answer that they really are looking for.

Q45 Mrs Gillan: Your number of judicial reviews has gone up, and the reasons for judicial review are fairly tightly drawn, but one of those was in particular that the PHSO often does not fully understand the specific relevance of a new piece of evidence to a case. This is a complaint that is made by people. Do you think that there is room for you, and are you looking at ways in which you can, improve that part of the review process so that, if new evidence comes forward, the people who feel you have not fully understood it or taken it into consideration have a better chance of understanding what you are doing about that new evidence?

Dame Julie Mellor: This comes to something that we discussed last year, before you were a Member of the Committee. It was partly at Mr Mulholland's suggestion that we looked at introducing clear criteria, so that the basis on which we would take cases on for review was very transparent. One of them was new material evidence, and this is something that

Mick has been looking at, in terms of how much we are still just saying we are checking the process and, if the process is okay, that is the end of it; and how much do we seriously say, "Is this new evidence and do we need to take a fresh look?" I do not know if you want to add to that, Mick.

Mick Martin: Continuing the theme of our evidence, which is around listening to customers, our customers believe that, if we have made our mind up and have strong views about the direction the investigation is going, we view any new evidence in that light. The only way of overcoming that perception is by being really transparent about our consideration of it, i.e. being really clear what the new evidence is and what it is we think our answer to that is: if it is new, then using it; and if we think that it is not, then explaining why.

Q46 Sheila Gilmore: One of the major complaints that people have about the complaints procedures of other organisations is that they are very formalistic. They feel that they get sent a letter saying, "That was stage one dealt with. This is stage two." It would be ironic if, as the Ombudsman, you replicated that. For example, do people have a specific individual they can contact if they are dissatisfied? Is there a clear line of contact there?

Mick Martin: First of all, at every stage of the process, the answer to that is "yes": either someone in our customer services team, the person assessing their case, the person preparing the case or the person doing the investigation. One of the things that we recognise, though, which we are right at the heart of now, is that we need to create a customer care team that is available to all of our complainants regardless of the stage, so that there is one point of contact. We also need to separate that out from the actual service provision, so that people always have recourse outside of the work that is being done for them, if they need help or are dissatisfied.

Q47 Chair: Can I just ask one other supplementary on customer satisfaction? It has been raised with us by people that your customer service satisfaction is not independent. Do you conduct an independent service for customer satisfaction that would give external reassurance that your understanding of customer satisfaction is genuine?

Dame Julie Mellor: Yes, we do. An independent research company contacts the complainants completely separately from us as an organisation.

Q48 Chair: Is that material all in the public domain? Do you publish the report?

Dame Julie Mellor: I do not know if we are publishing right now. I know we have done historically. We publish the data in our annual report.

Q49 Chair: Did you publish the whole survey?

Dame Julie Mellor: Yes. I am hesitating because I just do not have that detail. Maybe we should come back to you in writing on what we currently do.

Chair: I would consider it a bit odd if you could not and, if you cannot, please can you ensure that you commission one that you can publish in future, because I think it will provide public assurance.

Q50 Kelvin Hopkins: As you know, there has been a National Audit Office investigation, in which you have been involved. What lessons have been learned from the investigation and why did it require an investigation to learn any lessons?

Dame Julie Mellor: With the help of both our internal and external auditors, and our external auditors are the NAO—they had a look specifically at some procurements—we identified a number of areas for improvement last year, and they are very fully covered in our governance statement in our annual report. The four things that we identified as areas for improvement were the operation of our procurement processes and contract management, real focus on evaluation of value for money, financial management and our staff morale.

At the heart of some of those weaknesses was the very nature of the transitional year last year, where we had embarked on the new strategy, because we were ambitious to start to deliver but we did not have all the right management skills in place, so we were changing around the senior management team. There was a lack of both continuity and capability at the top of the shop. We did not embed our procurement processes and our management arrangements.

The things that we have learned from that and the things that we have acted on are that we have an action plan that focuses on stronger leadership in finance, including having an executive director of finance and corporate resources on the board, which we had not had before. We have a better resourced finance team, improved procurement processes and more accessible guidance and training for staff, and procurement doing more compliance checks, and there are clear requirements for any investment that we are really clear on the benefits. We track the benefits and we look at value for money. I have asked that anything over £100,000 as an investment must come to the board to be both approved and reviewed.

Chair: I am going to have to adjourn the Committee. I will adjourn it for 12 minutes, because we have sat here for three minutes already, since the first bell went. We will resume as soon as Mr Mulholland and Mr Hopkins come back, because the other two might be delayed, so it might be shorter than 12 minutes.

Sitting suspended for a Division in the House.

On resuming—

Chair: The Committee will resume.

Q51 Kelvin Hopkins: The NAO investigation: there was a £120,000 contract that was involved. What was that designed to deliver? There are two sub-questions to that: what proportion of it went to annual learning and development, and how did the costs impact on the provision of training for the rest of the organisation? I wonder if you can spell out some of the detail.

Dame Julie Mellor: You are probably referring to a contract that we let for both board development and leadership coaching. That is what it was designed to deliver. It was a

three-year contract and, roughly so far, 18 months in, 50% of it has been spent on board development. As you can imagine, having set up a completely new kind of board that did not exist before, we needed to consider our governance arrangements; we needed to make sure that executives, once they were recruited, got to know and worked effectively with the non-executives. As anyone would recommend, as part of corporate governance, you need to do annual board effectiveness reviews, so 50% of the work was for that activity. 50% of it is being spent on leadership coaching of three members of the top team: me, Mick Martin, and our previous COO, Helen Hughes.

In terms of the impact upon wider training provision, I honestly do not know, because I do not know which bits of budgets things came out of, but I do not understand that it would have reduced funds available for staff more generally, although I have to say we have done less training as we have gone through our transition. We are now rebuilding that function and looking at specific training. As we move to do more interviews, staff want training on interviewing witnesses, so we are building up that training at the moment.

Q52 Kelvin Hopkins: You have changed things as a result of the NAO report, presumably. Has it influenced the direction of travel of what you are doing? They were concerned particularly about the £120,000 project, weren't they? That is what it was about.

Dame Julie Mellor: They looked at a number of different procurements. As I said, they helped us conclude that the operation of our procurement processes needed to improve. Most of the policies were sound, although there were some gaps, but the operation of the policies needed to improve.

Q53 Chair: The NAO did find a potential conflict of interest in the allocation of that training contract. How can you reassure us that there was nothing untoward?

Dame Julie Mellor: As our governance statement makes clear, we have been very open and transparent. Our external auditor did look at whether there were conflicts of interest and assured us that there were no conflicts of interest. However, prior relationships can create the risk of a perception of conflict of interest, and it is just as important to manage that. Certainly where I was involved in procurement, where I had a prior relationship, I put some distance between myself and the decision-making but, with hindsight, the actions I took still left room for perceptions of conflicts of interest. That is why, as soon as I understood there were concerns, and prior to the NAO investigation, I put in place really detailed protocols for identifying prior relationships, for identifying whether there were perceived or actual conflicts and for managing those conflicts.

Q54 Chair: Is the NAO satisfied with that?

Dame Julie Mellor: The NAO was satisfied with our governance statement as an expression of the problems and of the action that we have taken.

Q55 Chair: We await another report from the NAO that will cover that.

Dame Julie Mellor: As I said, we have been open and transparent in our governance statement, but the NAO report is still being cleared with third parties, so we are not at liberty to share that with you. Once we have it from the NAO, we will make sure relevant information is put in the public domain.

Q56 Chair: Moving on to learning from clinical failure, we have already discussed in this session how you essentially use laypeople to conduct investigations. Medical accidents or untoward medical incidents are effectively being investigated either as maladministration or as service failure, rather than clinical incidents, which is what they are. We have a paper from Carl Macrae of Imperial College London and Charles Vincent from the Department of Experimental Psychology at the University of Oxford, who are effectively arguing for a new body to do independent clinical accident investigation in the whole of the health sector. What do you think of this proposal, which has been published in the *Journal of the Royal Society of Medicine*, of which I have provided you with a copy?

Dame Julie Mellor: You have, and we found ones for ourselves as well. I absolutely agree with their analysis of the problem. People complain to us because they want what happened to them not to happen to other people and for safety to be improved, yet we find in our investigations that, too often, there is a defensive response; there is a culture of blame; and the quality of investigations, if indeed an investigation is done, is incredibly variable.

As you know and as they say in that article, in other industries there is a much better focus on the more open questions when there is a safety incident—"What are the human factors that allowed this to happen?"—rather than apportioning blame. Because in our casework that is not happening, we have just embarked on a systemic investigation to look at this further and indeed come up with recommendations that should improve patient safety. We have that body of cases—365 cases of avoidable death last year, and 220-odd that we are investigating so far this year—that we can analyse to see what is going wrong. Sometimes it is almost too shocking to express.

Chair: Of course your investigations have to be occasioned by a complaint, and there are plenty of incidents that perhaps should be investigated without the occasion of a complaint.

Dame Julie Mellor: Absolutely, which is why there is definitely room for improvement, as I said, in the quality of investigations. We hope that we can contribute to that by our systemic investigations.

Q57 Chair: What would be your reaction if this Committee took up this proposal and investigated it, with a view to possibly recommending the Government adopt it?

Dame Julie Mellor: From where we sit, it would be up to the Department of Health and the NHS to determine the best way to improve the quality of investigations. Certainly this proposal would be one that they should consider.

Q58 Kelvin Hopkins: Just to reinforce the point the Chairman is making, there was a report on the front page of *The Times* today about prostate cancer treatment and how it is immensely variable across the NHS. Some hospitals just do not have the equipment to do the job, and yet outsiders would not necessarily know that there was a problem. Is that not the kind of thing that really needs some inside medical expertise and knowledge to be able to tease out, if someone has died of prostate cancer or if someone is terminal and does not know that the hospital that they have been dealing with just does not have the equipment to do the job?

Dame Julie Mellor: I am not sure I understand the question, to be honest.

Kelvin Hopkins: It is the fact that you do not have internal medical expertise to make those kinds of judgments.

Dame Julie Mellor: We do. Our investigators are laypeople, but we have clinical advice teams and we have associate clinical advisers. They would bring that knowledge of analysing what happened and advising us of what should have happened, in terms of the relevant national guidance from the General Medical Council, the royal colleges or NICE.

Q59 Kelvin Hopkins: If someone dies of prostate cancer or is terminally ill, and they have made or make a complaint that they have not been given proper treatment, you would be able to make that judgment.

Dame Julie Mellor: We do have that expertise. The proposal that is being made certainly does not cut across what we do, because we think the NHS needs to get better at the quality of investigations it does, so that it can learn and improve safety. We need that expertise as part of our team as well, because our unique role is to investigate individual complaints, decide whether to uphold and, if so, provide appropriate remedy for individual complainants. That needs some of the same expertise.

Q60 Greg Mulholland: Does not the situation around health complaints in particular, alongside the smaller number of general complaints into things covered by your remit, really demonstrate the need for the kinds of reforms that the Committee has discussed? I know they have been touched on today, but clearly there is a particular kind of complaint with the clinical cases, and then also other complaints. Ordinary people do not necessarily see the difference, and they do not necessarily see the difference between things being done by local government, by you and by others. Does this not really show that we do need a citizens' ombudsman to deal with all public sector complaints, with then specialist departments and, if you like, sub-ombudsmen dealing with these very important areas?

Dame Julie Mellor: Absolutely, and that is why we were so thrilled with the recommendations of this Committee to reform the very outdated legislation that we have to operate under at the moment. To give you an example of that kind of case, there was a woman who was falsely accused of abusing her sister, both emotionally and financially. She came to us. We had to investigate two local authorities, the Local Government Ombudsman looking at that side, and two hospitals in order to understand that she had been completely let down by a failure to get on with the proper safeguarding process, which found her innocent. By the time they did that, her relationship with her sister had broken down for good.

Q61 Chair: Moving on lastly to organisational culture and staff engagement, this Committee attaches great importance to your employee engagement index and, in 2013, it fell to 47% and it had been 73% in 2011. To what do you ascribe this quite serious fall in employee engagement?

Dame Julie Mellor: First of all, I would like to acknowledge our staff, because they have delivered the increases in numbers of cases that we have talked about in very difficult circumstances. You asked what we would ascribe it to. Radical change is always disconcerting, but it was made much more difficult for staff by this lack of continuity in

senior leadership positions last year. It has had a significant impact upon staff, and you have given the figures on staff morale.

I am pleased to say that one of the other indicators of staff morale is turnover. While turnover last year went up to 22%—19% if you took out voluntary redundancies—it is back down. Right now, it is 8.5%, but I would expect it to be back down to the norm of about 12% by the end of this year. What did I do about that? The most important thing I did was complete the recruitment of the executive team, so that we had the strategic leadership and we had the new expertise on service transformation. In March, we recruited Mick as our Managing Director with that expertise. What we are doing corporately I will ask Mick to cover.

Mick Martin: For me, it is really simple things. We learned very clearly from the last staff survey that we had become disengaged from our employees, in terms of whether we were leading them in the direction that we wanted them to go. We needed to really change our modes of communication and change how we work with our employees to deliver the changes we need.

Q62 Chair: How confident are you now that your employees are feeling heard and supported?

Mick Martin: Much more confident, and that is really based on very basic things like each member of the senior leadership team spending direct time, all the time, talking with our employees, talking them through what it is like on the ground to be delivering the sorts of changes that we are asking from them, listening to their issues, having an issues log of how that works and then responding.

Q63 Chair: What sort of training and support are they asking for?

Mick Martin: That is very closely linked to the method changes that we are making. For example, where we are now moving to doing more interviews, interview training; where we are changing our methods, foundation training around how we are wanting them to work differently. We have used this year the method of piloting the new work, which was very much what our employees asked us to do, rather than just applying changes to pilot them and test them first, and then rolling them out.

Q64 Chair: What feedback have you had on the pilots?

Mick Martin: Very strong feedback. We started with a single pilot team. We have rolled that out into other teams. We have sent our management team and our employees to spend time with the pilot teams, so that we are getting our own employees to tell our own employees how our changes need to be made. I do not want to mislead the Committee by saying that we think we are at the end of this stage. We are at the early stages of modernising our service. We need to carry on doing that work with our employees. When Dame Julie earlier on was talking about our service charter work, a very important part of that is making sure that we involve and engage our employees as we are making those changes.

Q65 Chair: What can we expect in future employment? When is your next people survey being conducted?

Mick Martin: Historically, we have done them every two years, which would mean that the next one is due in the next financial year. We are going to be moving to doing those every year.

Chair: When is your next one?

Mick Martin: Next year, 2015-16.

Q66 Chair: When will it actually be conducted?

Mick Martin: Next year.

Chair: Which month?

Mick Martin: It is scheduled for July, but I want to move to it being annual and therefore setting a time when most of our employees are here.

Q67 Chair: Would it not be a good idea to bring it forward?

Mick Martin: Possibly, although I need to set a new survey and make sure we are baselining the things that we are measuring, so that they measure the real things that are important to our employees.

Q68 Chair: Why does it need to be different from the Civil Service People Survey?

Mick Martin: It may not do, but it will need to differ from the survey we have had in the past, because we are going to be a very different organisation that hopefully has a very different culture and has a very different tone.

Q69 Chair: Will the new people survey provide comparable data, so that we can compare like with like and see a clear trend?

Mick Martin: Yes. It will be important that it allows a comparison.

Q70 Kelvin Hopkins: Last year we were lobbied directly by trade union representatives of your staff. There was clearly a degree of unhappiness amongst the staff. That hopefully is a thing of the past. Is that fair?

Mick Martin: We have worked really hard with the trade unions this year and had really excellent co-operation from them. An example of that is that we have had a four-year pay dispute around the pay progression. Happily, we have worked together this year to solve that. We have come up with a solution to the pay disparity and have now put in place a forward-looking pay progression, based on competence and performance again.

Chair: In closing, if there are no further questions from my colleagues, can I thank you for coming today? Can I ask that you pass back to all your employees how appreciative we are for the work they do on behalf of Parliament? They are Parliament's ombudsman

service, and we very much appreciate the work they do and the challenges that they face with downsizing, an increased workload and a big change programme. We are rooting for them, and we would like you to pass our thanks to them.

Dame Julie Mellor: Thank you. We will. They are probably watching you right now.

Chair: I hope some of them have gone home. Thank you very much indeed.