



Public Administration and Constitutional Affairs Committee (PACAC)

Oral evidence: Annual scrutiny of the Parliamentary and Health Service Ombudsman, HC 696

Tuesday 12 January 2016

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Members present: Mr Bernard Jenkin (Chair); Ronnie Cowan; Oliver Dowden; Mrs Cheryl Gillan; Kate Hoey; Kelvin Hopkins; Mr David Jones; Gerald Jones; Tom Tugendhat; Mr Andrew Turner.

Questions 1-109

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

Q1 Chair: May I welcome the Parliamentary and Health Service Ombudsman and the chief executive, the Deputy Ombudsman, to this session? Could you identify yourselves for the record, please?

Oral evidence: Annual scrutiny of the Parliamentary and Health Service Ombudsman, HC

Dame Julie Mellor: I am Julie Mellor; I am the Chair and Ombudsman.

Mick Martin: I am Mick Martin. I am managing director and Deputy Ombudsman.

Chair: This is an annual review session following the publication of your annual accounts. We will try to ask short and crisp questions; if you can avoid giving very long and extemporising answers, we would be very grateful. I will pull you up if I think you are rambling. Thank you very much indeed.

Q2 Oliver Dowden: Dame Julie, the PHSO 2014-15 accounts were qualified due to serious failings, including a lack of management oversight. As the accounting officer, you are ultimately responsible for ensuring that the accounts are in order. Why was there insufficient management oversight in 2014-15?

Dame Julie Mellor: Can I just start by saying it should not have happened? I take very seriously our responsibilities for looking after £32 million of public funding, and, as the NAO has noted in its report to Parliament, I have put steps in place that will improve our financial management and accounting.

You asked why. On the overdraft, we were overdrawn by £275,000 on one day of the year, at the end of the financial year, because of inadequate cash planning and monitoring. The steps that I have taken are that we now have a monthly rolling cash flow, forecast and monitoring, and I have a monthly assurance meeting with the Executive, which now includes updating me on exactly what the cash flow forecast is for that month and to the end of the year. We are putting in place a set of financial management arrangements in terms of process maps, procedure guidance for staff, and the way in which we will audit whether they are being followed. We have put in some new software that will give better information to our finance team so that they have to spend less time on manual spreadsheets and more on what are the implications of the data. Finally, I have asked our executive director of finance, who is new to the organisation, who joined just as we were closing the accounts, what more we can learn from other Departments that have had their accounts qualified for similar reasons about failing to monitor their supply estimates.

Q3 Oliver Dowden: Specifically on this, there is a suggestion that the National Audit Office completion report was the stage at which this overspend was identified—the £275,000—rather than you yourselves internally recognising that. Is that correct and, if so, why is that the case? Why did it take the National Audit Office's completion report to identify this, rather than your own internal techniques?

Dame Julie Mellor: To be honest, I am not sure whether that is the case because it was an overdraft at the bank and we would have been notified of the overdraft. I think the other qualification—if you want me to talk about that one, I can pick it up, because it was in discussions with the NAO that we realised what we had not done in relation to our accommodation and leases—

Oliver Dowden: Yes, go on.

Dame Julie Mellor: On that one, the mistake we made was that we made a financial decision to sublet some of our accommodation, giving us a saving of £640,000 in the

financial year on which we are reporting, which is due as £1 million this year. The mistake we made is that we made that decision without considering the accounting implications. As a result of that, I have made sure that we have changed our finance code so that, when any business decision is made that has a financial implication, we look not just at the budget but at the cash implications—which, again, relates to the prior qualification—and also the accounting implications, so that any team that is making a financial decision would need to work with finance, and they are mandated to look at all three of those things. Similarly, there have been other Departments that have had accounts qualified in recent years for not taking account of the accounting implications. I want to make sure that we learn from them anything more that we can do to prevent that happening again.

Q4 Oliver Dowden: Just on this £275,000 though, your head of internal audit noted that the amber recommendation about cash flow forecasting was not “responded to by management sufficiently well to mitigate the identified risk of breaching the HM Treasury net cash requirement”. This cash limit was subsequently breached by £275,000. What did the internal auditors recommend?

Dame Julie Mellor: The kind of steps I have outlined that we have now taken. I commissioned them to do a review of why this had happened, so the steps that I have outlined are the ones that they recommended. I have to say that we were very clear that we needed to enhance the capability of the finance team and the staff who were around at the time so that these mistakes that were made are no longer with us. We have enhanced the capability and appointed at board level to make sure that we have that senior capability.

Q5 Kate Hoey: Given all that, did it ever occur to you that you might want to resign, given that you were ultimately responsible?

Dame Julie Mellor: No. My job as accounting officer is to make sure that the issues that are identified are addressed and prevented from happening again. The NAO has noted what I have put in place, and I look forward to its audits confirming that it cannot happen again.

Q6 Kate Hoey: Do you think that, if you had been in the private sector, you would still be in the job?

Dame Julie Mellor: Yes. I think, as an accounting officer, you cannot manage the money yourself, so I am not the person who is going to be monitoring the bank cash flow. I need to make sure that there are the appropriate arrangements in place. As I have said, one of the things that I have made sure of, as accounting officer, is that the assurance meetings that I have monthly with the executive now include more financial information than they did in the past.

Q7 Chair: In terms of the deficit that you carry forward, that is not a deficit that has been funded out of the Government’s grant. Therefore, is that a deficit you have to take into the current financial year and fund from the resources that are allocated to you for the current year, and therefore you are £275,000 short in the current year as a result of that deficit?

Dame Julie Mellor: The overdraft was not us overspending our budget. One of the things the NAO was very clear about is that our accounts were a true and fair reflection of our financial position. What happened is that, because of the inadequate cash planning, we had not drawn down all the budget that we had available from the Treasury, so it has made good that money.

Q8 Chair: So that money is now missing from your current financial plans.

Dame Julie Mellor: No, it has made good the money.

Chair: Because you did not draw it down before the end of the financial year, you lost that money and, therefore, the overdraft you have carried into the new financial year leaves you with less money for the current financial year.

Dame Julie Mellor: No, my understanding is it has made good that £275,000.

Q9 Chair: So you have had a discussion with the Treasury and sorted it out.

Dame Julie Mellor: Because it was in our budget, we just had not called it down.

Q10 Mr David Jones: To take that point further, you have mentioned that you have now put in place monthly cash flow forecasts, but this was flagged up to you earlier, wasn't it—the absence of cash flow forecasts was a matter of concern that had been raised with you previously? Why was that ignored? An organisation of your size surely should be doing that as a matter of course.

Dame Julie Mellor: As accounting officer, I rely in part on my audit committee to make sure that we have the appropriate financial management arrangements in place and they will be monitoring the implementation of the steps that I have asked to be taken. I think one of their reflections is that they accepted assurance from senior finance staff and they need to do more deep dives to make sure about the operation of these new financial management arrangements that we are putting in place.

Q11 Mr David Jones: What assurances were they from senior staff?

Dame Julie Mellor: Assurances about the monitoring of our budget and our cash.

Q12 Mr David Jones: But should that not have been something that you would personally check on, if you are receiving assurances? Is that not something that you should concern yourself sufficiently about to check on?

Dame Julie Mellor: To be very candid, the information that came to the audit committee and the board—about both cash and budget—was flawed. That is why I say that the audit committee had had information that would suggest that we were living within our cash, but we were not, because the cash flow monitoring was inadequate, and that is why we needed to put in place the much more robust financial management arrangements.

Q13 Mr David Jones: When you say “it was flawed”, do you mean that there was deliberate misrepresentation or that there was negligence?

Dame Julie Mellor: No. I mean the financial monitoring was inadequate.

Q14 Mr David Jones: So there was incompetence there?

Dame Julie Mellor: It was inadequate. You have used a term for it; I would just say it was very clearly inadequate.

Q15 Mr David Jones: It looks very much as if there was incompetence or deliberate misrepresentation. Since you have said that it was not misrepresentation, one can only assume it must be incompetence. Do you agree?

Dame Julie Mellor: I agree the arrangements were inadequate. That is why I have made sure that we have enhanced the capability of the finance team, and we are putting in robust arrangements so that that can never happen again.

Q16 Mr David Jones: You have touched on the subletting arrangements relating to Millbank Tower. However, as a consequence of that subletting over the five years to 2018-19, you will be paying £2.3 million more for that accommodation than you will be receiving in rent. That is right, isn't it?

Dame Julie Mellor: Yes, because the difference in the prevailing market rates meant that that was the case.

Q17 Mr David Jones: What advice did you take about the prevailing market rates? For example, did you go to see the district auditor or—

Dame Julie Mellor: We worked with the Government's property unit, which was clear that the market rate had changed, and with them we worked out that the best thing for us to do was to sublet. We did consider all the options. We knew that we needed less accommodation—we knew that in terms of best practice of square metres per person, in terms of the meeting rooms and room size we had, in terms of reducing headcount in London and in terms of increased flexible working meaning that our accommodation needs had reduced. We needed to think long term about what was the right thing to do. The lease on the building that we are in is not going to be open to us in 2019, because they are going to convert it into a residential property, and—

Q18 Mr David Jones: How long is your lease? How long a lease do you have?

Dame Julie Mellor: It is until 2019.

Mr David Jones: Yes. When did it start?

Dame Julie Mellor: Oh, that is a good question. Before I arrived, so I am not quite sure.

Q19 Mr David Jones: So presumably PHSO, at the time of taking the lease, would have received similar advice as to market values?

Dame Julie Mellor: In terms of the rate that we took it on at?

Mr David Jones: Yes.

Dame Julie Mellor: I would imagine that was the case. We did not want to tie ourselves into other London leases, because of the proposals for reforming the ombudsman services, and so, needing to be able to work with Government and others on the accommodation needs longer term, it was judged that the best option was to recoup what we could through subletting, saving, as I say, £640,000 last year, and £1 million this year.

The accounting issue, which is different from the financial issue, is that at that point the lease became onerous, because we were moving out of the property but still had the liability. We should have reflected that in our accounts. What the accounting requirements are is that you cannot take account of the money that you are going to bring in through subletting, so the provision is a technical accounting requirement.

Q20 Chair: You have to crystallise the liability, but you cannot crystallise the income.

Dame Julie Mellor: The additional income, yes.

Q21 Mr David Jones: I take it that your lease does not have a break clause then.

Dame Julie Mellor: No, it does not.

Mr David Jones: No, you have checked that.

Dame Julie Mellor: We did consider that one.

Q22 Mr David Jones: You have mentioned the deficiencies in your financial team, you acknowledge that the cash and AME breaches were serious failings, and you said that they were partly due to high staff turnover within the finance team, resulting in vacancies. What exactly was the root cause of the problem with the finance team? Why was it behaving so poorly?

Dame Julie Mellor: We are a small organisation and, while I am very conscious of needing to look after all our public funds, we have a relatively small budget, so the size of the finance team that we need is quite small and it is very easy, therefore, for us to be destabilised by a couple of moves in the finance team, and a combination of planned moves and unplanned moves did exactly that. I have done a couple of things to make sure that we do not succumb to that destabilisation in future: one is that we plan to move our finance team to Manchester, where the labour market is more stable; and the other is about the codification of our financial requirements, so there are procedure notes and so on, and we are making sure that the current interim team is going to be there long enough to do not just what interims are often asked to do, which is just kind of carry on with the day-to-day management. They are embedding the new financial management and having it all written down so that the permanent staff will not have to do all that when they join us—they will be picking up proper processes. That should reduce the consequences of movement in staff if it happens again.

Q23 Mr David Jones: Is there any particular reason for the high turnover in staff in the finance team?

Dame Julie Mellor: No. As I said, we are a small organisation with a small team, and a couple of people make a big difference.

Q24 Mr David Jones: I think all the senior positions were vacant at one time during 2014-15. It must have been quite worrying for you to have so many senior positions unfilled.

Dame Julie Mellor: I do not think they were unfilled; I think some of them were filled with interim staff.

Mr David Jones: So unfilled with permanent staff.

Dame Julie Mellor: Yes.

Mr David Jones: That must have been worrying in itself for you.

Dame Julie Mellor: We have some excellent interim staff right now. I don't think it is them not being filled and there being interim staff. I think the issue was the inadequate procedures.

Q25 Tom Tugendhat: We are talking about staff, so I am going to carry on with that theme, if I may. According to your written evidence, staff costs for finance and governance went down by about half—51%. You have spoken about focusing on the front line, which I understand, but do you think that any of this focus has been removed from the financing and that that is anything to do with the situation you have found yourself in that we have just had described?

Dame Julie Mellor: No, I do not. I think it is exactly as I said. It was the lack of written-down procedures, guidance notes and so on that meant the work was inadequate. I think historically we had a team who kept too much in their heads, and one of the reasons why we decided last year, and it came into effect when our new executive director of finance joined us in April-May time was—oh, I have forgotten what I was saying now. Say the question again.

Tom Tugendhat: I was asking you why costs have been halved in governance and finance, and whether that has any connection. You are making a strong case that it is nothing to do with that, but you are also saying that staff did not have time to write things down and kept it in their heads, which suggests that it was undermanned.

Dame Julie Mellor: I did not say they did not have time to write it down; I said they didn't.

Q26 Tom Tugendhat: Why didn't they?

Dame Julie Mellor: The particular staff who were around at the beginning of my time have long gone, so they are not there for me to ask now. I have discovered that this was the case. But, no, the point I wanted to make is that, as part of our settlement in the comprehensive spending review to reduce our budget by 24%, we are clear—from benchmarking our staff against other similar organisations—that there is scope for further

reductions in budgets in our corporate services, so I do not think it is a matter of inadequate numbers of staff; it is the issues that I have already raised.

Q27 Tom Tugendhat: You have also already spoken about having interim staff and you speak very highly of your interim staff, which is certainly a welcome factor. How many are there?

Dame Julie Mellor: I do not have that number off the top of my head, I am afraid. I would have to supply it in writing.

Q28 Tom Tugendhat: Could you do that? How many vacancies still remain?

Dame Julie Mellor: We have some permanent staff and some interim staff in the finance team. As I said, we are planning to move the team to Manchester, so that will involve changes in the team overall if that goes ahead, but we will create, longer term, a more stable team.

Q29 Tom Tugendhat: What controls have you put in place now to ensure there is proper financial management? Because you have spoken a little bit about new software, you have spoken a little bit about moving to Manchester, but you have spoken particularly about process and both of those are, frankly, mechanical fixes. What are you doing in the structural fix?

Dame Julie Mellor: What do you mean by “structural”?

Tom Tugendhat: In the structure of how you run the money in your organisation, rather than a new finance programme.

Dame Julie Mellor: Oh, I see. The monthly rolling cash flow is probably what you mean by a structural change. It is a monthly forecast but rolling, so it covers the next 12 months, and you roll on and it is the next 12 months. It is looking at our forecast expenditure and our forecast cash in the bank. For example, at the assurance meetings that I have, I was told this month that we are forecast to have £382,500 in the bank at the end of January and £250,000 in the bank at the end of March. That is the actual concrete difference. That information is available to the senior team.

Q30 Tom Tugendhat: That means that your board now has a much clearer role and you would be confident that now it knows exactly what is going on, and you know exactly what is going on.

Dame Julie Mellor: Absolutely. It is mainly the audit committee that would consider that, and the audit committee would report to the board, which will be monitoring the implementation of the arrangements to make sure that is happening.

Q31 Tom Tugendhat: The audit committee is the one that you have appointed, so you are confident in it.

Dame Julie Mellor: Yes.

Tom Tugendhat: So if we meet again in a year, we will not be having this conversation.

Dame Julie Mellor: Indeed.

Q32 Oliver Dowden: Just on these questions of staff and accommodation, I was looking at the breakdown of your staff and accommodation between London and Manchester. You still have a very large proportion of your staff in London and you say the lease expires in 2019. Are you looking at further reallocation of staff and accommodation away from London to Manchester, which is the sort of overall trend with public sector bodies?

Dame Julie Mellor: That is a perfectly proper question, but there is an additional question, which means I cannot quite answer it, which is: will there be a new public ombudsman service by that time—

Oliver Dowden: Yes, indeed.

Dame Julie Mellor: And, therefore, what do we need if we are creating a new organisation that involves staff from the Local Government Ombudsman who are currently in Coventry, London and York? Then we need to look in the round at what the accommodation needs are and where we should be placing the staff for that new organisation.

Q33 Oliver Dowden: I suppose the question is: is there a particular need for so many of your staff in relation to your function, which will be incorporated into the new body, being based in London, or could you shift a lot more of them to Manchester?

Dame Julie Mellor: No, there is not a particular need for all the staff, and indeed, as more staff operate flexible working and so on, that frees up accommodation as well. But there will always be a need for a London base for a parliamentary institution working with the House of Commons and this Committee.

Q34 Mrs Gillan: Dame Julie, you said you wanted to deliver more impact for more people, and there is no doubt that over the past few years you have achieved faster case handling and a tenfold increase in the number of investigations, which is pretty impressive. However, I do note that on your very own service standards that you set yourself, you have failed to reach four of them—on only one service standard you achieved 100%. Mind you, on concluding 98% of assessments and investigations in 52 weeks, you were close at 97%, but the others fall far short. The one that was 100% completed was the 100% of inquiries in 48 hours. What was involved in meeting that service standard?

Dame Julie Mellor: This is the area that the managing director will cover, but I want to give a bit of context, if I may. We decided to open our doors to thousands more people for good reason. It is not without its challenges, as your question indicates, but it was the right thing to do. All our research told us that there were too many people whose complaints were not being taken seriously by public services, so we needed to make sure that people like the family who were told that they would need to go to court to find out what happened should not have to do that, and they should not have to come to us to get the service provider to provide that answer. It is about the family who were told that no one could work out why their baby had been left with brain damage when it was very obvious to our lay investigator as soon as they looked at the clinical records what had happened,

and why the baby had been left with clinical brain damage. So it was the right thing to do, but there are huge challenges in bringing justice for thousands more people than we did. In terms of the specifics, perhaps I could ask Mick to answer.

Mick Martin: To answer your question directly, the way in which we are delivering a different service to people who contact us is by shifting the basis of the contact from what has historically been a paper-based approach to much more communication on the telephone and now more online, so that allows us significantly to reduce the amount of time it takes us to do those initial responses. Those different channels of communication are now flowing through our other work and investigations, and in looking into cases on assessment.

Q35 Mrs Gillan: Do you have an automated response?

Mick Martin: We had before a front end to our telephone service that was an automated response, but we have taken that out because we believe that, because of the content people are often contacting us about, the very last thing that they want to hear first is an electronic response. We have placed more staff on the telephone line so that we can answer the telephone quickly, and then we are getting from that the person-to-person communication that we think is right at the heart of the service we provide.

Q36 Mrs Gillan: We get complaints on the Committee about the PHSO. As you can imagine, there is a steady stream of correspondence. I understand a lot of these are based on the length of time taken to decide whether to investigate, and then the length of time to appoint the investigator and the length of time of the investigation, despite the improved statistics that you can produce. What action are you taking to make sure that the service standards that you have set yourself are met in the future?

Mick Martin: I think the first thing to say is to reinforce the point that, in opening our doors to thousands more customers, we have prioritised taking those cases on and making sure that people get the responses that they need. That has had an impact on people waiting for us, because there is a gap between our decision to open our doors and our ability to fully handle that volume. Thanks to some terrific work from our staff, we are now handling all the demand for our service, but we have retained some of that work in place for us, which is why we have now taken steps to reduce waiting times. We are doing that in a number of ways. Most importantly, we have changed our ways of working so that we are doing much more work in communication with the people who are coming to us. We have done it in a way that allows us to be clear about the scope of our investigation, what information and evidence we need to get, how we draft our reports, how we engage with people at that stage, writing shorter reports and spending less time in getting ourselves to a conclusion. That has all reduced the amount of time it takes us to provide investigations and assessments, but it also means that, by placing additional resources into the organisation, we can also reduce waiting times and we have done that.

Q37 Mrs Gillan: I am still concerned about this, because we have received reports about your re-categorisation of existing complaints as a new case. If it has a new case number and it is restarting the assessment process—you have identified for us 1,068 cases that were linked

to previous complaints—could this in some cases be seen to be a practice that makes it look as though you are meeting your service standards more effectively than you are?

Mick Martin: I think the first thing to say is that we deal with about 28,000 cases a year and, in the vast majority of those cases, our role initially is to help the person who has come to us to be properly plugged into the complaints process, so it is very often the case that, while we log the case at the beginning, the right course of action is that we plug that person back into the local service provider. The 1,000 cases that you were referring to are mostly where people have gone back into that local complaints process, but then, at the end of that, needing to re-engage with us. If a material amount of time has passed, we have to deal with that case again, because our first job is to see whether the local organisation has provided them with a credible answer.

Q38 Mrs Gillan: Are there exceptions to that? What are the exceptions?

Mick Martin: There are exceptions to that. Sometimes, for example, when we are looking at a complaint, it turns out that not only is there one thing that we need to look into, but several things that we need to look into, particularly on more complicated cases, for example on avoidable death, where there may be several NHS organisations involved. We often find that we need to look into some other bodies than we originally envisaged, and of course we would then open a different case and a different complaint about that case.

Q39 Mrs Gillan: With the pattern of work coming into the ombudsman, are there any identifiable peaks and troughs? Is it seasonal in some way?

Dame Julie Mellor: We tend to have slightly less work in the summer and slightly less work at Christmas, but we have a pretty steady flow of cases into us. What we have really concentrated on is reducing the amount of time that it takes us to get from that point of first contact to the point where the investigation starts. We were running about 48 days from the moment of first contact to the moment of decision. That is now down to about 33 days right now. We were running at a place in our performance last year when it was taking on average 76 days or so before people were allocated an investigator. That is now down to 35, and in those 35 days we are getting the papers together, we are communicating with the family and we are communicating with the organisation to make everyone clear about what we are doing.

Q40 Mrs Gillan: Can I ask about the backlog as well, though, because in 2014-15 there was a backlog of 1,222 cases referred for assessment but not assessed, and there was also a further bottleneck at the time waiting to begin an investigation stage. Can you say what caused those delays?

Mick Martin: The first thing to say is that while we can talk about the numbers, we recognise very clearly that that is 1,000 people who, having already gone through a really difficult process of complaining to the NHS or a public body, are waiting for us and that is why it is so important. On the numbers, underneath every one is a person. The reason is directly linked to the fact that we opened our doors to thousands of people whose cases needed to be investigated and, in reorganising our service and in coming up with new

ways of working, there is a lag between us being able to handle all the cases and those cases coming in.

That is the genesis of the backlog. Our staff have worked incredibly hard on the backlog and they are responsible for removing most of it. We have added some additional resources in, which allow us to handle some more simple cases in different ways, and we are now in a situation where we do not have material waiting times for people to have assessment. We have about 35 days of preparation in between making the decision to investigate and then investigating. That is a pretty transformed situation in the last 12 months.

Q41 Mrs Gillan: That takes you back to your 2013-14 figures of 36 days of time waiting for an investigation to begin, but in 2012-13 and 2011-12, those were down to 16 and 12 days respectively. Do you think you will ever get to those levels?

Mick Martin: The first thing to say is that, of course, those comparisons are between about 350 cases a year that we were investigating and about 4,500 that we are investigating now.

Q42 Mrs Gillan: I appreciate that, but you have raised the level of expectation in your customer base. You have more people coming in, but you continue to disappoint them, certainly on the complaints that come into our Committee. I appreciate it is an improving situation but, to raise that level of expectation among people, a week is a long time when you are seeking justice for something that has gone drastically wrong.

Dame Julie Mellor: Perhaps, Mrs Gillan, I can go back to your original question about the service standards. The action that Mick has outlined, in terms of changing the core service so that we deal with cases more effectively, has resulted in halving the time both for investigation and from when people contact us to when we give them a final decision, of which the investigation is just one part. That is a kind of tick in that we have halved the time, but the action of having a temporary project team is specifically to eliminate the group of cases where people were waiting—as it says in our annual report—about 76 days. We expect to be dealing with cases coming in at the service target rate by March and so, over time, the need for the temporary project team will reduce. However, because we are trying to plan, we also want that temporary project team to be there to enable our staff to spend time embedding the new ways of working, and we are changing our casework management system imminently. We have it and we have been making it ready for us and piloting it, so we want our permanent staff to have the time to embed the use of that.

I would also say that I am not convinced about talking about these service standards because I think it is an internal thing. It is our estimate of the time. It is a target based on some assumptions about demand and how long things will take. When we have gone out and asked people what they want and expect from our service, people have said that they want to know what it will mean in their case. Knowing that we complete 98% in 52 weeks doesn't tell people what it is going to mean in their case, so what people need to know is that at intake, where we are saying, "You need to go and complain to the service provider," or, "Yes, we will take it in and look at whether we should investigate," it should take two days. At assessment, it should take 20 days, and it is the decision on whether to investigate. Then, on the investigation, one of the things people have said is they want us

to be more open about the whole thing. So, in our service model that we introduced in August, we are saying that we should share the investigation plan and, on the basis of the plan, let someone know how long we think it will take for their case, and then we will update them based on progress during the case and what we have found and, therefore, whether that timing might need to change.

Q43 Mrs Gillan: Is that happening now with new cases?

Dame Julie Mellor: That is what our service model requires people to do and that was introduced in August.

Q44 Mrs Gillan: How successful is that? Are you doing that in every case—telling people how long you think it will take?

Dame Julie Mellor: That is where our quality checks will tell us whether that is happening, and I think our quality checks on keeping people informed are showing that there is still room for improvement, but we are getting more consistent.

Q45 Mr Turner: In your recent report, you highlighted the need for better-trained staff to deal with NHS complaints. How much training did these staff require before starting work?

Dame Julie Mellor: Mick, would you like to talk about our induction and training?

Mick Martin: Yes. We have generated a foundation course that every employee who comes into our operation to do either assessment or investigations receives before they start. That is typically a two-week programme during which we explain both our core investigative methods, how we run and organise our cases, and also the sources of support, information and coaching that every individual gets.

The second important thing that we do is that we make sure that, once those new employees start work, they have very significant degrees of support from both their line manager and also from other investigators who are allocated to those new teams. Finally, and hopefully to give real confidence, every single decision that those employees make for a service user, and every decision on whether there is a case to answer or an issue that we need to address with the NHS or a public service, is always quality assured by a manager and it is always overseen and checked before it leaves.

Q46 Mr Turner: You have reduced the number of full-time equivalent staff at a time when the organisation was under pressure to deal with more cases more quickly. Now you have had to spend £1 million on taking on more temporary staff. Why isn't your workforce planning more effective?

Mick Martin: Our workforce planning is obviously driven by demand. We opened our doors to our customers. We had an estimate of how much work came in. In the first year of opening our doors, we handled over 2,000 cases; last year we handled over 4,000. What that means is that we recognised in the course of making those changes that, in order to give the best service to our customers, we needed to input some more resources so that we could reduce waiting times and remove any backlogs in our service. We think that was the right thing to do. We have done that by reallocating resources from elsewhere and

tightening the areas of the organisation that we need to so that we are putting the right amount of resource in the right places.

Q47 Mr Turner: What is the role of the board in overseeing workforce planning and the extent to which the organisation is meeting its service requirements?

Mick Martin: The board does a number of really key things. We have a clear and straightforward business plan, which is a statement of what we want to achieve as an organisation to get us towards our strategic objectives. We agree that very specifically with the board via a process of interaction every year. That has associated with it our budget and that is about where we are going to allocate our resources, and that is engaged with and scrutinised very clearly by the board. We then have a quarterly review process by which we go back through our plan and our progress, and we review against the plan with the board and identify where we are doing well and where we need to change and improve.

Q48 Chair: How concerned are you that the acceptance and uphold rates for the cases assessed by the team are so much lower than the overall rates?

Dame Julie Mellor: Sorry, I am not sure I understand the question.

Chair: The cases assessed by the temporary team—

Dame Julie Mellor: Oh, right.

Chair: Some 43% were accepted for investigation compared with an overall acceptance rate of 63%.

Mick Martin: The most important thing to say there is that we have a wide range of cases that we deal with, from those that are about avoidable death and serious harm in the NHS right through to important queries about things like dental charges. What we do when we have project teams, or indeed new investigative resource, is that we channel particular cases to them so that we make sure that they are handling only particular types of cases. We would then send more serious cases to more experienced investigators.

To give you an example of that, where we are investigating cases of serious harm and potential avoidable death, the uphold rate is about 50%. That is much lower than, for example, the uphold rate that we have with quite a lot of our complaints into Government Departments so, in channelling some complaints to some places, you would expect very different uphold rates, which are not easy to compare.

Q49 Chair: This Committee has produced a report, which the Government has accepted, about clinical incident investigation, and this subject is about the challenges you face in investigating clinical incidents. However, I think it is going to be some time before we have a mature clinical incident investigation capability in the health service that is going to be able to provide us with this kind of information. How satisfied are you that you can be capable of bridging this gap, because so many of the complaints about your service arise from what people feel are failed clinical incident investigations?

Dame Julie Mellor: First of all, I would say that I do not think IPSIS is going to solve all that, because the new clinical incident investigation body will not be dealing with complaints; it will be looking at what happened and why, and the safety issues. My understanding is that it will be dealing with a relatively small number of investigations each year. That is why, when we published our own review of the cases that come to us that are about allegations of avoidable harm, we have expressed real concern about the quality of the local investigations. That needs to improve, whatever the new national body is able to achieve. That is where we found that the quality of investigations is just much too low. We said in that review that 40% of the investigations were inadequate to establish whether something went wrong, let alone why. We said that in a fifth, evidence was missing; we said that in 73%, where we judged there was a failure, the local organisation had said there wasn't.

As Mick just indicated, our uphold rate on avoidable death cases is 50%, which is higher than any of the other issues we look at in the health service. There is clearly a real problem and this is where we can look at the stage where we look to resolve the complaint, but that is very often getting the local body to do the work that they should have done to give adequate explanations, as well as showing how they have learned, and demonstrating to the complainant how they have prevented that happening again. My one real plea to the whole of the NHS system and this Committee is that the way to improve the quality of those local investigations, and to have the confidence of people who are concerned that they or their loved ones have experienced avoidable harm, is to train and accredit local investigators.

Q50 Chair: Is there a case for putting the burden of proof on the health provider to prove that there has not been harm, if they cannot produce their own evidence of a proper investigation following the original complaint? If they have failed to do a proper investigation of their own, isn't the burden of proof on them to prove that they did not cause harm, rather than for you to try to prove that there was harm caused because, in the absence of their proper investigation, why should you protect them?

Dame Julie Mellor: We certainly do not, as the evidence I have just outlined indicates. We are making a lot of noise about that inadequacy and I am not sure I can comment on the—

Q51 Chair: In past cases, many people who have complained about your service feel that you have finished up defending the system or justifying what the system has already decided for itself, because that is the evidence you are presented with. Are you now creating a capability that is able to assess whether there has been a proper investigation, or you are in fact dealing with some kind of cover up?

Dame Julie Mellor: No, we have always been able to assess whether there has been an adequate investigation.

Chair: In all honesty, not in all cases, and we know the ones where you have had difficulties.

Dame Julie Mellor: All our quality checks indicate that that is happening. Certainly those statistics, which I have just outlined about that review, was because our staff were saying they were concerned about the quality of local investigations and that is why we reviewed cases that had come in. We could do that only because we had taken on more cases, because last year we did 400 cases about alleged avoidable death, whereas that was the total number of investigations we did two years ago, so our data shows that we are an organisation that is challenging NHS organisations.

To give you a concrete example, I was talking to a colleague yesterday who was saying that, wherever there is inconsistency in the evidence that is not congruent between what the complainant says and what the body says, we will look to triage that evidence. Recently, our director of investigations had a case where they felt the evidence was not congruent, so they went and looked in the cupboards of the trust, and their hunch was right and they found records that had not been supplied. We will always look to triage where there is that discrepancy between the parties. That could be interviewing; it could be going and visiting; it could be saying, “We know there are more records. We need those records”; or it could be threatening to use our powers to gather evidence.

Q52 Chair: But the point I am making is that when you have found that the trust or the health provider has not provided all the information to you that they should have done, isn’t the burden of proof then on them to prove that there was not harm caused to the patient, rather than for you to carry on the investigation and then find that there wasn’t harm caused to the patient? Haven’t they lost the argument the minute they are found to have concealed—

Dame Julie Mellor: Certainly they have. One aspect of what we do is that, if there is inadequate investigation, we would say that is maladministration, so there is already the need for a remedy and putting something right for the family concerned, because they have not done an investigation that has given the family the answers they needed.

Q53 Chair: I personally regard our recommendation for independent incident investigation as one of the most important things that the previous Committee did, and has ever done. How concerned are you—you could use this opportunity to place this on record—that the Government are not going to get this right?

Dame Julie Mellor: I think the short answer, I am afraid, Chair, is that I do not know, because I do not know the detail of what they are going to do.

Q54 Chair: Come on, you were on the expert advisory group—you have attended the expert advisory group.

Dame Julie Mellor: I have attended it to give evidence in terms of what we found in the cases that we have looked at.

Q55 Chair: Let me put it this way, then: how concerned would you be if this new body was unable to provide a safe space in which clinicians, health service managers, patients and their families could go and explain their concerns or talk freely without immediate fear of prosecution or accusations of wrongdoing? How concerned are you that that is not going to be included in the proposals?

Dame Julie Mellor: I would be concerned if there was not a safe space for people. One of the things that prevents complaints being resolved is people fearing being blamed, so I think it is that emphasis on, “Look, mistakes happen. We need to learn from it.” It does not have to be about blame. I think that is exactly the same as applies with the complaints that we look at, because what we are saying is if something did go wrong, what you need to address is the consequences for the person who has suffered as a result. That does not mean blaming someone; it means addressing the consequences.

Q56 Chair: Okay. How concerned would you be if this new body was domiciled with an existing regulator rather than set up as a truly independent accident investigation body?

Dame Julie Mellor: I completely understand why you are asking these questions, Chair, and I very much applaud the work that this Committee has done and the way in which you have continued to pursue it, but in a sense it is not our job to—

Q57 Chair: Except you carry the can if the clinical incidents are not properly investigated in the health service, which is why I am trying to recruit you to the cause.

Dame Julie Mellor: Yes, and we laid out to this Committee in our written evidence on your clinical incident inquiry the criteria that we thought any new body or any new arrangements around clinical incidents would have to meet. I think they still hold and I was very pleased to see them used in the Government response on *Learning not blaming*. I think we have done what it is appropriate for us to do in terms of saying, “These are some of the criteria that we think anybody should meet,” and I certainly think having safe space is part of that, but I think what we are saying from our evidence is that there is an even bigger issue, because, while the body should be fantastic, it can only do a certain number of investigations and the public—

Q58 Chair: That depends how it is resourced. It depends how much the Government are prepared to back it.

Dame Julie Mellor: Yes, but public confidence in the right evidence being gathered quickly enough to understand what happened will depend as much, if not more, on the quality of those local investigations. That is why I hope this Committee will follow up our recent report and also look at what is going to be done to improve things like that.

Chair: We will have you in front of us soon to talk about that report. Moving on, Mr Hopkins and Mr Cowan—who wants to go first?

Q59 Kelvin Hopkins: I have a question, if I may. One of the things that concerns me—it comes to Members of Parliament through their constituency casework rather than going to you—is that hospitals, in particular, tend to be very defensive and want to quieten down any complaints and so on—perhaps not as extreme as Mid Staffs, which was an appalling scandal. How do we change the culture of hospitals so they want to tell you openly, “We have made mistakes,” or, “We are putting things right”? How do we change the culture in the national health service so that, instead of having a pressure relationship where they only give information if they are pressed, they come forward and say, “This is what has happened and we want you to know about it”?

Dame Julie Mellor: I think it takes time, but what we have done to try to assist with that process is to work with the public to look at what is important to them when they have a complaint. We have written that up with Healthwatch England and the Local Government Ombudsman as something that is called *My expectations for raising concerns or complaints*. It has been adopted now. It has been agreed by the NHS, the Department and the regulators that that will be the gold standard for each board of every provider to look at how well they are dealing with complaints. We are developing with NHS England the measurement tools for different provider settings to enable each provider to do that, but also to enable NHS England to look across all providers and the public and say, “Is it improving?” So, that is the thing that we have done. I think culture takes a long time to change but, hopefully, the leadership of every provider will be focused on people’s experience of complaining and if it is defensive or not, and measuring it through *My expectations* can play a part.

Q60 Kelvin Hopkins: This is a political question you may not be able to answer, but how much do you think that financial pressures on the health service are so great that they feel pressured and threatened? If they were resourced to the level of, say, the Germans, the French and the Belgians, would the world be very different?

Dame Julie Mellor: We look at individual cases because our unique job—we are not a regulator—is to make a judgment in individual cases about whether someone has experienced injustice or hardship as a result of service failure. We cannot generalise. However, I think our staff and I are worried about whether we are beginning to see—perhaps not in the area that you are thinking of—that where people are looking, quite rightly, at how to save money, whether that is a focus on saving money or dealing with fraud to save money, that is at the exclusion of the policy objectives of whatever the policy or the service is, and this is more in the central Government part of our jurisdiction—the UK part. That is something we are keeping an eye on, so that we can give guidance back to public services about that need to make sure they are looking at the policy objectives of the service in the first place, as well as how they can reduce costs.

Q61 Kelvin Hopkins: I say this because I think on average continental health services spend 2% more of their GDP on health than we do, which is the equivalent of £35 million a year. I think we could make a real difference. Will you provide the Committee with more detailed results for the last measured year and publish these on your website—the number of people surveyed in each group for which satisfaction figures are given and so on? Will you be publishing these on your website?

Dame Julie Mellor: Mick may want to add to this, but I would just say two things. One is that we have used a very similar customer feedback survey for several years. That information is published annually and is on our website. We have gone out and consulted the public on what they want and expect from our service, and developed a service charter, and tomorrow is a very important day because it is the closure of the consultation on the service charter. Once that is finalised, we will need to change the way in which we gather feedback from our customers to make sure we are gathering feedback on the issues that they have told us are important to them and are reflected in our service charter.

Q62 Chair: But, just to be clear, you should publish everything.

Dame Julie Mellor: Yes.

Chair: It is all very well giving us headlines, but there is no case for keeping secret the detail of these surveys, is there?

Dame Julie Mellor: I agree. They are on our website. We publish them.

Chair: So all the detail is on the website.

Dame Julie Mellor: Yes.

Q63 Chair: I am confused about that, because my understanding is you report the headline results, but you do not report the detail.

Dame Julie Mellor: We publish a lot of detail. One of the things that has come out of how we help people be confident in the decision that we make is—

Q64 Chair: Mr Hopkins asked about figures for the number of people surveyed in each group and which satisfaction figures are given. Can you check that out?

Dame Julie Mellor: In terms of the number of people surveyed, the survey is about 2,000 people over the year and 900 of them—

Chair: Yes, but it is the segments of the survey—the categories.

Dame Julie Mellor: Yes, 900 of them are people whose cases we have investigated, so that is getting on for 25% of the cases that we have investigated, and 1,100 are people who have used the service either at that initial stage of getting advice on how to complain—

Chair: Anyway, you are going to put everything on the website.

Dame Julie Mellor: Yes.

Q65 Ronnie Cowan: In terms of how you handle complaints, I am looking at your website and I commend the fact that you now have the British sign language video link on there, which is something that lots of other organisations would do well to copy, but I am looking beyond that and thinking about that how you handle complaints. We know that any organisation that provides a service will receive complaints. Monitoring the complaints and encouraging an honest dialogue with the party that is complaining would seem to be mutually beneficial, but we are getting reports that say that a complaint has been made, and for the case reviews and complaints with the PHSO service, they deal with the same member of staff who dealt with the original case. That cannot be feasible.

Dame Julie Mellor: No. Mick, if you can explain our process.

Mick Martin: That is not the case.

Ronnie Cowan: It is not the case.

Mick Martin: No, it is not the case. We have set up and are running a dedicated customer care team for every person who has experienced our service, whether or not it is just a first

contact, or we have assessed their case or investigated. That is a different set of people than the people who handled the cases. It is their job to continue to listen to what those service users are saying. Out of that conversation sometimes comes the need for us to do some more work, and sometimes comes the need for us to review those cases, and we do that. When we do that, it is a different person and sometimes an external person who reviews and looks into those cases again, so we do invest lots of effort into listening, but I think we do more than that. We meet families and people who have complained—personally I do—and when you go and talk to them, and you sometimes go to their homes, you hear very clearly what it is they want to say.

Q66 Ronnie Cowan: But you are talking about a set of people. If I come to you with a complaint, is there a team behind you—a number of people who look at my complaint?

Mick Martin: Yes.

Q67 Ronnie Cowan: So these people work as a team?

Mick Martin: Yes. If you are complaining about the service you have received from us, we have a customer care team. That team is in place solely to make sure that we are keeping that conversation going and that we are checking that there is nothing that we still need to do or that we have wrong.

Q68 Ronnie Cowan: What happens with the resolution of that if they come back to you and say, “I am not happy with how you handled my original complaint”? Nobody in that team would then be involved in the second team that was set up to look at my complaint; there is no cross-fertilisation there?

Mick Martin: There is an escalation process that exists within the customer care team, but we have lots of teams, to be clear. We have the people who are handling our service for you, whether or not they are an investigator or a customer service person helping you to be plugged back into the NHS or Government Departments, and they are very different teams within our organisation. What that means is that we will listen to your needs from different perspectives—the perspective of someone providing the service, and also someone listening to how you are experiencing what we are doing for you.

Dame Julie Mellor: Just to be clear, it is our job to make final decisions and if there is a good reason for reviewing, we will do so. In fact, the criteria for deciding whether we will review a decision were developed with previous members of the old Public Administration Select Committee. As Mick has indicated, we are the only public ombudsman service that has a separate team—rather than in the line—that does that activity: a mix of internal and external reviews. We are the only public ombudsman service that has that.

However, I think again, as part of our wider listening and what people want and expect from our service, it is clear that sometimes people do not understand our decisions and even whether we have upheld their case or not, and what happens as a result of our decision. Rather than waiting to try to explain at the review stage or the customer care team explaining, part of our learning from our reviews and from this listening is what more can we do during the process of investigation to share the evidence and emerging

views, and to make clear when we are giving a draft report. The point of a draft report is to make sure that there are no omissions and no inaccuracies, and that there isn't evidence that we have failed to take account of that is relevant to the decision. We want to move that dialogue with the customer upstream, as it were.

Q69 Ronnie Cowan: I hear what you are saying and it all looks very good on paper, but we are getting complaints from people who are saying that is not the case.

Dame Julie Mellor: One of the real challenges for you and for us, and for all ombudsman services—public and private sector—is that the outcome of a case, whether you uphold it or not, profoundly affects your view of whether the investigation has been impartial to the extent that, on impartiality, if we uphold a case, 82% think we are impartial; if we do not uphold a case, 18% think we are impartial.

Q70 Ronnie Cowan: To take that to its logical conclusion then, you referred to the previous Committee—the Public Administration Select Committee. In its scrutiny session in 2014, that Committee asked whether you would consider implementing wider access to external case reviews, but you have not done this. Would you consider doing this?

Mick Martin: We do carry out external reviews. We have access to independent people who do not work for us, and who are expert and experienced in investigations. We send a selection of our reviews to them—about 25% of all the reviews that we do. We have done 43 of those this year. On five of those occasions, the external reviewers found that we needed to do some more work. Three out of the five were about us being much clearer about the basis on which we made our decision, not changing our decision itself, which fuels us listening to our customers when they are saying not only that they need us to do our investigative work openly and well, but that we sometimes need to explain it more fully in terms of how we produce and engage on our reports.

Q71 Ronnie Cowan: Would the person who had made the original complaint have access to that external review?

Mick Martin: Yes, we share reviews, internal and external, with the person whose case we are reviewing.

Dame Julie Mellor: I completely understand your question, but I do think the thing that will make people more confident in our service is, yes, having that available, but doing the upstream work to make sure that people have a better understanding while we are doing that process of investigation. I have to say that I do think this is one of the challenges for you in judging our performance. I did want to share, if I may, Chair, that, in addition to the figures I gave about impartiality, in terms of the satisfaction of our service overall, some 88% say that they are satisfied where we uphold, and the figure is as high as 49% saying they are satisfied when we do not uphold. I am proud to say that that is the highest of any ombudsman service that records such information. The only other one that has anything like that is the Financial Ombudsman Service and, obviously, it is not dealing with people's health and wellbeing and a family member dying. While we are absolutely trying to improve, as you can hear, I think our performance, when judged against other organisations, is within normal and actually better.

Q72 Kate Hoey: On the draft report that you talk about, that gets sent to the complainant. Do you then listen to them? Do you change it? Do you go ahead and publish it with lots of inaccuracies in it, if the inaccuracies are what the person thinks are inaccuracies? How do you decide? Do you meet the person, sit down and go through it with them?

Mick Martin: On many of the most serious cases, that is precisely what we do. When we have finished our investigative work and we draft a report, we share that with both the person who made the complaint—

Q73 Kate Hoey: Sorry to interrupt. What do you mean by “the most serious cases”? Surely everyone feels their case is important and serious.

Mick Martin: Of course you are right but, in dealing with 4,500 cases a year of all sorts of different sizes and complexities, we do not have the resources to talk to every single person who complains through our draft report. Some of those draft reports are very simple and straightforward, but on cases where, for example, there are several NHS bodies involved in very interconnected ways in which care has been provided that we have needed to unravel, it is important that we share that in writing and sit down with the family, but also make sure that we do the other side of our job as an impartial and independent organisation, which is to give the organisation the opportunity to respond fully to that complaint. We do both those things.

We then have a further period of time in which we consider all that feedback and whether our report or our findings need to change or our findings need to change. We sometimes think that we may need to get some more evidence or some more expert advice. We do that sometimes, too, trying to balance not elongating the case too much. It is after we have done all that that we produce our final report, but in doing so we explain which of that additional input we have taken and which we have not, and why.

Q74 Chair: On this question of managing your complaints, we know that you have a handicap in that you have a very old-fashioned governance structure in which you do not have a non-executive chairman and a board that would—and should in the future—oversee an independent complaints process. Some of it comes to us and some of it goes through you, but it is a mess, frankly. We also know that you deal with your complaints as best you can under the circumstances, but inevitably people are going to feel that the way you handle them is inherently conflicted because you are adjudicating on your own complaints. You are trying to address that, but legally that is the structure you have. How do you think we can carry on managing this situation? What do you think you have learned in your period as Ombudsman, which is now a number of years? What do you think the top three lessons are about better handling of your own complaints until we get this new governance structure for you?

Dame Julie Mellor: I think it is probably all in our service charter because we have gone out for nine months and—

Chair: Just tell us what the three lessons are.

Dame Julie Mellor: I would say that there are four things that people tell us have most impact upon their confidence.

Chair: Yes, but I am not asking what people tell you; I am asking you what you feel you have learned.

Dame Julie Mellor: Well, it is the same. The four things are that people understand our role, what to expect, and what we can and cannot achieve. The second is that the investigation process is transparent, fair and impartial in the way evidence is gathered from both parties, and then independent and objective in the way the evidence is evaluated. The third is how we treat people when they bring a complaint to us—so, keeping them informed. For example, if people feel that they are driving the complaint, because we have not kept them informed, they are much less likely to be confident in the outcome. So, it is keeping them informed and being faster. While we are rated top for the professional and courteous nature of our staff compared with other ombudsman services, we need to be more empathetic in how we think of things from their perspective, such as by not calling someone at work when it is a case of someone dying, and asking them when it would be convenient. Those are the three things that I think, and that the public have told us, are most important to their confidence in our decision making.

Then the fourth is showing that you are delivering that, which is laying out the commitments and having those as our quality standards, measuring that against customer feedback, performance information such as timeliness and our own quality checks, and including information from the reviews that we do and from complaints about us. That gives us the information that we will share with you and the public on our website on how well we are doing on those four things.

Q75 Chair: That brings us to the question of the change programme. What you describe in your answer sound and feel more like changes to process rather than changes in what one might call culture, but perhaps we had better describe it as attitude and behaviour of staff. In our clinical incidents investigation report that was produced just before the election, we were quite critical of your capacity and capability to deal with the quantity and nature of the complaints that you have to deal with, particularly from the NHS. We said that we expect PHSO to make its internal change programme its main effort. Would you say that you have done that?

Dame Julie Mellor: Yes, I would. Chair, may I comment on your first point about culture and then I will comment on the change programme? In terms of culture, I think a common definition is “the way we do things around here”. It is the summation of everything. It is the summation of the training that staff receive, their working practices and the guidelines that they are asked to follow, which is where the four things I have outlined come in. It is the technology support that is available to people to do the job efficiently and quickly, and so on. I think all the things that we are developing and improving have an impact upon culture over time.

In terms of your question about the change programme, two years ago we set out on an ambitious five-year programme to modernise our service. We were clear on the four things that we wanted to achieve and they are in our strategy. It is about making it easier for people to find us, doing more cases and providing an excellent service, using the insight from the higher volume complaints to make sure that people’s aspiration that their complaint makes a difference is honoured by us and that you can follow that through, and

that that applies to complaint handling as well as service, and it is about us being an efficient and effective organisation.

Our change programme is to deliver those four things, and we have been very clear that we were doing it in three stages. The first is the one that has just been completed in the annual report that you are looking at today, which was to meet demand so that, when people were not being taken seriously, anyone who comes to us with a case to answer gets an investigation and a decision from us. The second, which we are right in the middle of, is some of what you have just been asking about. That is about the quality of the service, how we treat people, and how we make sure that we are independent and impartial, and the third is preparing for any reform to the legislation and the creation of a new service. Our whole set of activity, from our strategy through to our business plans through to what then gets delivered in each year, is our change programme.

Q76 Chair: Again, the three things you have just mentioned are all about activity and process. They are not directly addressing culture, and they are not directly addressing the behaviour and attitude of staff. How much easier would it be if the behaviour and attitude of your staff was exactly right? Wouldn't all these other things flow from that change in culture, which so many people outside your organisation do not feel they see?

Dame Julie Mellor: I will ask Mick to come in, but staff do what their leaders ask them to do. I have said this to the Committee before. What we are saying is that there are changes in expectation and our service charter describes those expectations. That is then what we expect our staff to do, but you cannot expect staff to come up with that if it is not what they have been asked to do in the past. That is why it has been so important to listen, to develop the service charter and to introduce the service model, as we did in August, which now makes it very clear to staff—they find it very supportive—what is expected of them. It reduces uncertainty. They are clearer, and they are therefore better equipped to deliver. Mick, did you want to say something?

Mick Martin: No.

Q77 Chair: Why do you think your staff engagement survey suggests that your staff are not as well engaged with the leadership of PHSO as other parts of the public sector, and below the average for the civil service, for example? Why do you think that is the case?

Mick Martin: Could I just pop very briefly back to your previous point, Chair?

Chair: I would like you to answer that one if you would.

Mick Martin: Okay. I think we have really engaged staff—

Q78 Chair: The figures do not suggest it. You give us figures all the time about how you are responding to this, that and the other. Here is a figure that you cannot game and we attach great importance to it. Why is it unsatisfactory?

Mick Martin: The reason I was saying that I think our employees are engaged is because they are the people who have been delivering the results that we have been talking about

all morning. They are the people who have delivered 10 times more investigations. They are the people who are maintaining really high levels of satisfaction.

Q79 Chair: If your staff engagement is below par, it is because your staff do not feel as well understood by the leadership. They do not feel the leadership perhaps fully understands the challenges they face, and they do not have as much confidence as they should in what you are trying to do in the organisation. Why do you think that is the case?

Mick Martin: I think we have a lot more to do to engage with our employees, but it is important that I take the opportunity to champion their engagement with the organisation, but also, Chair, I was troubled by the notion that we have staff with issues around care and behaviour. I work with our employees every day about some of the most difficult cases we could get our heads around. They are incredibly caring in the work that they do. Their behaviour is absolutely focused on coming up with a fair and impartial outcome.

In terms of our engagement with them, we have had to recognise that in opening our doors, we have placed huge strain on our employees. We also have to recognise that, in engaging with lots of feedback and lots of criticism about our service, our staff take that very, very personally. They care very much about what that is.

Q80 Chair: I am sure you are right, and I would like to take this opportunity to pay tribute to your staff because I think they work under incredible pressures. Our own staff in the Committee get a taste of that, in terms of some of the distress that is explained to us, and we do understand that your staff can find themselves working in very, very stressful and distressing situations. My criticism is not of them. If there is a lack of engagement in your survey, it is a criticism of you. I do not want to make this personal, but it is about them not feeling understood by you. If you do not understand them, how can you expect them to feel supported in the role that you ask them to take?

Dame Julie Mellor: Mick, I know you want to come back in but, as the chair of the organisation, we have looked as a board at the results of the last staff survey. Obviously, the fact that the engagement and morale are not where we want them to be is of significant concern to the board. It has improved slightly since the last survey, but we do need to build on that slight improvement.

One of the main things is that the staff survey took place just before we introduced the service model, when I think there was a lot of uncertainty. As Mick has said, staff were delivering the increase in the number of investigations, but they had concerns about working practices and that was some of the stuff that came through in the staff survey. The fact that we have now got our service model with the guidance that goes with it, so that people can be more confident that they are meeting what is expected of them, will be a big help.

You are absolutely right that we need to engage with people more, and one of the strong results of the staff survey was that 85% of our staff care about the future of PHSO. When we introduced conversations with staff about our comprehensive spending review decision to reduce our budget by 24%, we took note of their concern about not being involved and we did it differently. I think the spirit with which informally they have come back to us

and said, “We have noticed you are doing it differently,” is incredible given how much we have been asking them to do. We can build on that positive interest in the future of the organisation to involve them much more in determining how we deliver what has come out of the service charter, for example.

Q81 Chair: Whatever you are changing in your organisation in structural or process terms, you are not changing very much unless you are changing the culture. Would you agree with that?

Dame Julie Mellor: I think we are probably at risk of having an academic debate about what “culture” means, because I think culture is all of that.

Q82 Chair: Okay, but when we asked for you to make your change programme your main effort, we had in mind the culture and behaviour of the organisation. We asked you to set out your proposals on the form it will take from now on, and what it is intended to achieve and by when. We do not feel we have seen those proposals.

Dame Julie Mellor: Partly because you said that, we did start to put something together that was called a modernisation programme, but the more we completed it, the more we realised it is our business plan. Our business plans are published on our website. In our annual report we made very clear the things that we intended to achieve and did achieve last year, the things specifically to shift the culture around giving people better technological support, the service model and so on.

Q83 Chair: Yes, but giving people better technological support does not change the culture of an organisation; it just gives them better technological support. Where is the programme where you are talking to your staff about what values the organisation has, how those values are reflected in the way you treat each other, and the openness, honesty and frankness with which you deal with the problems that emerge? Everything we have learned about customer-facing organisations is that customers will only feel as well looked after as the staff feel looked after by the management. Where is the document that goes into all this, which asks what kind of day do staff have: what feels like a good day for a member of staff in relationships with their colleagues? What feels like a bad day? How do we make sure that staff have more good days in the office and fewer bad days? That is about how people interact with each other and trust each other. Where is that document?

Dame Julie Mellor: I think what I am hearing is that what you meant by “change programme” was how we work with our staff to effect change. With that level of activity, on everything that we do underneath each part of the business plan, there will be work streams, of which this is one part. That will come to the board. For different projects it comes to the board; for different areas of work it comes to the board.

Q84 Chair: Can we have the other half of the equation? Can you produce this? This is us holding you to account. We want to know how you are going to improve your engagement, how you are going to talk to your staff differently and how you are going to listen to them differently. That 88% support for the mission of the organisation is a huge untapped resource.

Dame Julie Mellor: Absolutely.

Chair: How are you going to harness that energy? We want to know that.

Dame Julie Mellor: Absolutely we can do that. As a result of the staff survey results last summer, we have had a set of activities across the organisation of volunteers working on the four areas, which we have agreed with staff that we want to focus on, that I think you are talking about. The result of that activity is coming to the board and I would be delighted to share that with you.

Q85 Chair: Forgive me for pressing you, but when do you think we could expect to see that?

Dame Julie Mellor: It is coming to our board meeting at the end of January, so you can have it in February.

Chair: Very good, thank you very much.

Q86 Mrs Gillan: When I was a Secretary of State, I had to look at the staff survey in my Department, but I asked the question: what do I have to do to modify my own personal behaviour and my leadership? When you come back to us, could you let us know how you, as the senior management, have modified your own personal behaviour and how you try to take forward the remedying of the situation? If you cannot tell us now, it is something you need to think about and perhaps incorporate in whatever you provide.

Dame Julie Mellor: In fact, leadership and visible leadership is one of the areas of work that we have agreed with staff is included.

Chair: I do emphasise that I think this is very difficult for you, because you personify the role of Ombudsman and you try to invite a board to support you, but you do not have as much support as you should, if we had a proper governance structure. I think it does leave you exposed and I think people feel that.

Q87 Kelvin Hopkins: A major change has taken place already, in that you have shifted from mostly documentary relations with your complainants to telephone and online. That makes an enormous difference to how you relate to people.

Dame Julie Mellor: Yes, absolutely.

Kelvin Hopkins: I know from personal experience that tone on the telephone makes an enormous difference if you sound caring, kindly and reasonable. If you become agitated, because sometimes these people are very distressed and they do not understand the role of the Ombudsman, a tension develops in the discussion and then it starts to go wrong. Has this change made your relations with some complainants much more difficult—the fact that it is done by telephone now rather than by correspondence?

Mick Martin: It is a big change for some of our employees to do much more of their communication person to person and less in writing. As you have identified, some of the content that they are talking about are some of the most serious things that happen in people's lives. One of the bits of learning for me is that we have to be much more sensitive and supportive of that. What looks like a very simple management change from

communicating via writing into communicating person to person places a kind of strain on support for us to help people, because those conversations are difficult and they are talking about difficult things. It is learning for me, certainly, that we need to give more support for those sorts of things and recognising that, when we are making those changes, it has a big impact on the people doing the work.

There is one other thing that I want to mention. It is clear to us that the heart of what we need to do is about supporting the employees in what they are doing every day, and that the key to that is the relationship they have with their own line manager and the support they get every day. That relationship is very good within our organisation. It is full of trust. It is full of support. We have to give that more help. What we are doing at the moment is that we are taking every single one of our managers through a management development programme. We are working out how we can help them with the job of helping us to manage change and performance, because we think that is a very tangible thing that is going to change the relationships and the culture on the ground.

Dame Julie Mellor: Sorry, could I ask say that I think this discussion is absolutely the right one, in the sense that, as I said, we have embarked on an ambitious change programme. The annual report that you have in front of you is about reaching the end of stage 1. What we are talking about now is what we are right in the middle of. We are not saying we have arrived at the end. This next stage we said would take two years, so it is 2015-16 and 2016-17. We know that we cannot deliver everything overnight. We have a programme to do it. It is this middle stage of our strategy that is exactly tackling these issues about how people can be confident in our service, how we ask our staff to work differently and how we support them in doing that.

Q88 Chair: What we asked for at the end of the last Parliament was a document about your change programme that we could scrutinise. We do not feel we have had that. It needs to address the sorts of issues we have been discussing.

Dame Julie Mellor: I think there was a misunderstanding about what you meant by change programme.

Chair: That is a very interesting revelation because I think that in itself indicates—in response to Cheryl’s question—that the change programme applies to the leadership as much as to the organisation as a whole.

Dame Julie Mellor: Absolutely.

Chair: It is not something the leadership does to the organisation; it is something the whole organisation—leadership and organisation—has to go through as an experience.

Q89 Kelvin Hopkins: May I ask a supplementary, Chair? Dealing with things on the telephone, the first point you made was the understanding of the role of the Ombudsman and what powers it has. Many ordinary citizens do not have an understanding of that. I am frequently described as “the Government”, as if I can order doctors to do things. I say, “First of all, I am a Back-Bench Opposition MP, which means I am not the Government, and also I cannot order GPs, hospitals or whatever to do things.” On the telephone, it is harder to

establish that understanding at the beginning, but you can in correspondence. You can have a paragraph that sets out the role of the Ombudsman and its limitations, and so on. Isn't that a problem? You said your first priority was to make sure that people understand the role of the Ombudsman and what expectation they might have.

Dame Julie Mellor: I think most of the things that we want to achieve you need to tackle in several different ways, so I would agree completely. Talking to people on the phone is part of it because out of the dialogue you can increase understanding, but it is also what is available on our website. It is also what people say on the phone when people first ring up and bring a complaint. We explain that what we do is to make a final decision when a complaint has not been resolved locally and so support people to make their complaint locally. I agree with you that it takes a range of measures.

However, one of Mick's innovations was to introduce the customer care team that we talked about in response to your questions, Mr Cowan. I would be delighted if you would accept our invitation to come and meet our customer care team, because they are dealing with people at the point where they have concerns or questions, or do not understand or are angry about our decisions. They are absolutely fantastic. I sat with them listening to calls recently and their skill in being understanding and dealing with people who are very upset and angry and, therefore, very rude and threatening, is absolutely outstanding.

Chair: That word "empathetic" or "empathy" that you used earlier is such an important part of that understanding, and if you are inculcating that into your staff, that would be a very good thing. A lot of people who deal with the Ombudsman and who deal with us do not feel they get that empathy, and I am sure you are aware of that.

Q90 Mrs Gillan: When we were looking at the figures in your report, there is one area where there is a huge uplift—your expenditure on external affairs and strategy staff, where the budget has gone up by 24%. We have heard about how you are struggling in other areas. Could you tell us why this budget has increased in this way?

Dame Julie Mellor: Yes. It relates back to strategy. If you look at the spread of our resources across corporate services, external affairs, strategy and insight and our operations, I think from memory it is about 10% is the external affairs side.

Mrs Gillan: You go up from £1.5 million to £1.8 million.

Dame Julie Mellor: Right. £1.5 million to £1.8 million?

Mrs Cheryl Gillan: Yes, approximately, so £1.861 million is your external affairs and strategy for 2014-15, and it was £1.512 million in 2013-14.

Dame Julie Mellor: There are a couple of things I would say about that expenditure. If we go back to what we are trying to achieve, our research showed that people were not being taken seriously locally and some people are put off complaining. In fact, we published research between Christmas and new year on older people's fear of complaining because they think it might affect their care and treatment in the health service, for example. We know, however, that people's confidence to complain is significantly lifted if they know they can come to an ombudsman service. I am sure all of you will have had—I know I

have had—conversations over Christmas with families where people are saying, “I don’t think it is right, but my parent will not let me make a complaint because they fear what will happen.” One of the things that we have done is to publicise—this is part of what that team will do—the cases that we uphold, and particularly getting that covered in local newspapers. It is an opportunity for people to understand that there is an ombudsman service to come to, so that is one example of the work.

Q91 Mrs Gillan: Is that a good use of your resources? Surely the NHS should be doing that.

Dame Julie Mellor: If the public are more confident about complaining locally when they know there is an ombudsman service, they need to know there is an ombudsman service. Part of what that team does is to raise awareness of our existence by giving examples of how we work.

Another part of it, which is pretty much an operational part of the team, is that our work on big and repeated mistakes is part of that area. The work where we work with operations, but we are looking at what the lessons are, is work on sepsis, on midwifery, on end-of-life care—we are about to do something on unsafe discharge—and on clinical incident reviews. A lot of that activity is in that function as well as in operations, so it is core to delivering our business.

Q92 Mrs Gillan: You are convinced that this area of spend is justified, as opposed to putting more resources into building case capacity?

Dame Julie Mellor: It is about a balance and part of what we are looking at following the comprehensive spending review.

Mrs Gillan: It is a tenth of your budget, though.

Dame Julie Mellor: Yes. In saying that we will reduce our budget by 24%, we will be looking at all the functions, including that.

Q93 Mrs Gillan: That is what I am coming on to. How on earth are you going to manage a 24% reduction, which you have agreed to, when you have rising demand and, on your own admission, areas in which you are struggling, not least in financial management, communications, internal communications and managing a change programme? Can you realistically save that 24% without damaging the whole service?

Dame Julie Mellor: That was the judgment of the executive team’s proposals to the board and the board’s conclusions. Part of what we did was to look in the round, comparing ourselves to other organisations and looking at what progress we had already made in terms of delivering value for money. We took on an organisation that was spending £34 million and giving 400 final decisions a year, which we did not think was value for money or what the public wanted—they wanted more. We are now at a place where we are meeting demand by increasing the numbers of investigations. If you take cost per investigation as a crude measure of value for money in terms of the efficiency of an organisation, we went from costing £88,000 per case to now costing £6,800 per case. Where we were a significant outlier in terms of cost per case among public ombudsman

services, we are now in the middle. Yes, we do think we can bring that down further and the 24% reductions will mean that will come down to about £5,000 a case.

Chair: That does lead us on to the next question.

Q94 Mrs Gillan: I was just going to say: where are the cuts going to fall?

Mick Martin: Can I just add to that?

Chair: Hang on, let us answer that question. Where are the cuts going to fall?

Mick Martin: There are four key areas where we think that we can make savings. The first one is that, having now come up with the new service models and new ways of working, there is further operational productivity savings that we can make as that flows through. Secondly, we do not use technology well enough as an organisation. We think there are some benefits there that we can have from our new casework management system and a different approach to how we use our website and digital services. We think there is further opportunity safely to reduce our corporate costs over the course of our plan. Finally, as we discussed earlier on, we spend too much money for the size of our organisation on accommodation and we need to reduce that.

What I was going to say, in the context of all that, is that we are going to make those savings of 24% safely over four years, rather than rush into big savings upfront. We are going to do it calmly and sensibly with a plan. That means that as we see the opportunity for cost reduction we take it, but we do that safely so that we carry on providing a good service to our customers.

Q95 Mrs Gillan: I am trying to navigate your report to find the page because you have significantly reduced consultancy costs, for example, if I remember from looking at your accounts, but have you concealed those consultancy costs in another budget, such as the external affairs and strategy budget?

Mick Martin: No, we have not.

Mrs Gillan: Just checking.

Mick Martin: We have made some straightforward choices. The most straightforward choice this year is to divert as many funds as we need to into our operation so that we reduce waiting times and increase service to customers. We have done that; we are clear about it.

Q96 Mrs Gillan: Are you anticipating any redundancies, because I was looking at your final package as well, which has gone down?

Mick Martin: As the organisation starts delivering productivity savings, once we start reducing the size of our corporate overhead, there will be the need to have less staff. Obviously, one of the things we have to do in a very different way, which I think we were talking about before, is to engage with our employees in that conversation and work through with them how we go from the organisation size that we have today to a different

organisation size in the future. Yes, I do envisage that we will need to have less staff. How we go about doing that and the pace we do it is something that we need to work through very clearly with them.

Q97 Chair: Before we leave this 10% on strategy and external affairs, can I suggest that you give us a breakdown of that? What you have told us is that quite a lot of that money is being spent on the kind of generic investigations, reports and recommendations that we would regard as the meat and drink of your operational business. Can I suggest that you give us a split? I think if you are giving the impression that you are spending 10% of your budget on people thinking in the clouds and communicating externally, that does feel unbalanced and presentationally it does not look good.

Dame Julie Mellor: The reason why the budget has increased over time was a conscious thing to do with delivering our strategy. The two things we said we wanted to achieve, having got the higher volume, is doing more to honour people's aspirations that the learning from their cases will impact upon public services. The insight from the cases is part of what that external affairs team do. It includes the research function and, therefore, the knowledge management and analysis of cases that enables us to bring the thematic reports to you, which enables us to feed back to services. It includes the team who have worked on my expectations, which is what does good complaint handling look and feel like from the public's perspective, and then working with NHS organisations to get that taken on board by the sector.

Q98 Chair: We need to think and talk a bit more about that because I think it is a very interesting area, but I wonder whether, in fact, you are taking responsibility for something that is outside. How much of how the Government or the health service respond to your recommendations is your responsibility? Handling the complaints properly might be the primary task.

Dame Julie Mellor: I agree, which is why, for example, having developed our expectations, and having got agreement that it is adopted by everyone, it is theirs now. NHS England has said it owns my expectations.

Chair: Okay. Ronnie Cowan, let us move on to value for money, which we are slightly on already.

Q99 Ronnie Cowan: Have you done any analysis of the value for money of your organisation, or have you compared it with the productivity and efficiency of other comparable organisations?

Dame Julie Mellor: Can I start by confirming what I said, which is that we have moved from an organisation that I do not think was providing value for money and was by far the most expensive of all the public ombudsman services, to one that is in the middle of the pack by reducing the cost per investigation, which is a crude comparative measure of effectiveness, from £88,000 to £6,800, and we plan to bring it down to £5,000. There is more we can do because value for money is not just about efficiency, but about economy in terms of the value of the inputs. It is effectiveness in terms of the impact of our work. In fact, we have engaged with our internal auditors to ask them to help us to summarise the

performance information and review our arrangements for assessing and improving value for money.

There are other areas where we already feel we have improved value for money. One is in terms of effectiveness, which is the work that we were just talking about, to make sure that we leverage the learning from complaints and provide that insight to those who can do something about it and provide it to you, so that you can hold people to account for doing something about it. There is a measure of value for money that comes from that effectiveness. We—

Chair: We can have another question if you run out of words.

Dame Julie Mellor: That is fine. Yes, we have done lots on value for money.

Q100 Ronnie Cowan: Do you believe you are less effective than other ombudsmen?

Dame Julie Mellor: In terms of?

Ronnie Cowan: Value for money.

Dame Julie Mellor: As I said, in terms of the crude measure of cost per case, we are in the middle of the pack and we think we can bring it down further.

Q101 Ronnie Cowan: I am looking at the figures and I am comparing it to the Scottish Ombudsman, which is the one I know best. These are rough calculations. We are looking at Scotland as being roughly 10% of the UK, and going through all the figures, for the total cost basis, which Scotland has 10% of, it is £3.5 million compared to £37 million, and the net operational cost is £36.8 million compared to £3.3 million, so you have 10% all the way down, including the number of staff employed. When it comes to cases handled and cases resolved, you cannot possibly say that PHSO is doing 10 times the work of the Scottish Ombudsman. It is closer to three or four times as much; the case work actually being resolved does not stack up to the amount of money and the amount of staff put into the organisation.

Dame Julie Mellor: As I said, the cost per case is a crude measure. One of the things about the effectiveness and the impact that we have is that the population of England, for the NHS part of our work, is about 84% of the population of the United Kingdom as a whole. Where we make a recommendation that is followed up by services, it has a huge impact upon a very large population. That is exactly why it is an appropriate measure of value for money.

Q102 Ronnie Cowan: If it was a closer number, I could go with that argument, but if we look at investigations completed, it is 4,159 compared with 944. That is just over four times as many with 10 times the amount of money and 10 times the amount of staff.

Mick Martin: Can I come in? We work very closely with the other public sector ombudsmen, and one thing that is clear is that we need to calibrate our counting mechanisms. What, for example, is an assessment? A case and an investigation in different countries is different. For example, Scotland concentrates much more on decision statements, whereas we concentrate much more on providing an investigative report.

While I understand the point you are making around different numbers, those numbers do not necessarily equate to the same things, because at the moment the work of the different ombudsmen is done in very different ways. Therefore, as Dame Julie was saying, it is the outcome, the learning and the improvement that we think is the way to go in terms of measuring the value of our service.

Ronnie Cowan: Based on what you have said there, can we be provided with the calculations you use to explain your value for money? Also, when you use the phrase “calibrate an accounting mechanism”—

Mick Martin: Counting.

Ronnie Cowan: —would that be cooking the books?

Mick Martin: What we count as an investigation, what we count as an assessment and what we count as a customer services case is not necessarily comparative to what another ombudsman service would count them as being.

Q103 Chair: Why don’t you think the National Audit Office understands that point because these are the NAO’s figures?

Dame Julie Mellor: The NAO did some work on the cost per person coming to the organisation and we are all pretty much of a muchness at around £1,000 a case. There was one recently that looked at both us and the Local Government Ombudsman. That is a slightly different calculation. I also think one of the things that the NAO talks about—

Chair: Sorry, forgive me; I have made a mistake. They are not the NAO’s figures. They are our own figures.

Dame Julie Mellor: Okay, right.

Chair: You are explaining something we need to understand, my apologies. I still think that the disparity is of interest and that it would be useful for you to set out in writing the difference in caseload. It is a nice anecdotal explanation, but it would be quite interesting to quantify it.

Dame Julie Mellor: I do not want us to promise to do that, because one of the things I have been trying to do in my four years in this role is to reach the point where we have that kind of information. I do not think we have fully comparable information, which is why I have made very clear that the figure I gave is a crude figure. As Mick said, people account for things differently. Lots of people have tried. The Law Commission and others have tried, but we are not there yet. What I am pleased to say is that the Ombudsman Association now has set up a project to do more benchmarking, both about quality and other things, so that will move forward, but I do not think we can provide it now. What we have provided, Chair, in our annual report, right at the end, in the section on an effective and efficient organisation, is our performance against our strategic performance indicators, which are a measure in value-for-money terms of effectiveness. That is in there. We do report on it.

Chair: Mr Cowan, anything else?

Ronnie Cowan: No, I am fine.

Q104 Chair: Thank you very much. We are nearly there. The last point I want to raise is about own-initiative investigations. You kind of do own-initiative investigations, but on the back of evidence you receive from complaints. The Government have indicated to us that they do not want to give the new service being conceived in the draft legislation own-initiative powers, as you have asked for and as we have recommended. What substantive difference does it make if we do not have those powers in the Bill?

Dame Julie Mellor: To clarify, the reports that we do are thematic reports; they are not own-initiative reports. Own-initiative is the ability to initiate an investigation without a complaint in order to gain justice, because that is our job—to gain justice for individuals who experience service failure. What all ombudsman services say is that we should have unfettered discretion to take whatever action we think is necessary to identify hardship and service failure and to provide justice. That is what is different. This is for the most marginalised people in society who are most vulnerable and least likely to make it to our door on their own, and the only way that we can make sure that we would get justice for those people who are not going to make a complaint is to be able to trigger an investigation when there is some evidence of a problem.

Q105 Chair: What evidence would you use?

Dame Julie Mellor: For example, looking at others around the world, a charity brought to the attention of the Australian ombudsman the treatment of asylum seekers in detention in Australia, so the evidence from the charity was used to consider whether it should trigger an investigation to provide justice for those people. Parliament could bring some of the concerns that you receive from your constituents to our attention. For example, one that we discussed when I first started was the inadequacy of the access to work tests that DWP were doing at the time. That was one of the things that members of PASC said was a huge proportion of your work in your constituencies, and that could be something that you would ask us to consider and we would decide whether to launch an investigation to get justice: was there service failure and do we need to get justice for people? An example of the European ombudsman recently was there was some *prima facie* evidence of late payment of invoices by the European Commission, so it did an investigation into late payment of invoices and the impact that was having on businesses across the whole of the European Union. Those would be the examples of the kinds of things that could be picked up. We were talking over Christmas about the number of older people who aren't complain because they think it will affect their treatment, but if there is some evidence that they are being disadvantaged and they are suffering as a result, it is about being able to help.

Q106 Chair: It would be unlikely that you would not have a single complaint about something that you wanted to do an own-initiative investigation into.

Dame Julie Mellor: From people in care?

Q107 Chair: Okay. I imagine the Government are concerned that you already have a huge amount on your plate and there is going to be a legislative reform that will also absorb quite a lot of extra resource for a period. Do you have the money to spend on this additional activity?

Dame Julie Mellor: The evidence from across the world is investigations triggered by an organisation—

Chair: The answer is “No”, isn’t it? You do not have the money?

Dame Julie Mellor: No, the evidence across the world is that those investigations that are triggered without complaint are between 1% and 3% of the investigations conducted, but the impact they can have, and, therefore, the value for money, is huge, because it can affect thousands.

Q108 Chair: Right. That is a good answer. I like that one. What about the argument that you are just empire building and becoming a more meddlesome and interfering body which, of course, Governments do not like?

Dame Julie Mellor: We want to do our job. Our job is to get justice for people who have been failed by public services, and to give them a voice that means they can get things changed and put right. This is one of the mechanisms that ombudsman services across the world say is necessary to do that job.

Q109 Chair: How acceptable do you think it would be for the legislation to contain provision for own-initiative powers, but that that would not be introduced immediately, as so often happens?

Dame Julie Mellor: What is the point then?

Chair: Well, it means it is on the statute book in the primary legislation, but it requires regulations. You get started on all your other stuff, with the change in the whole service and everything, and then introduce the own-initiative powers at a later date.

Dame Julie Mellor: I think there is enough experience within the UK that we can go straight to having those powers. Northern Ireland and Wales are currently putting through legislation that will give ombudsman services in those nations the power to do investigations without a complaint.

Chair: Not in Scotland?

Dame Julie Mellor: No, not at the moment. It is Wales and Northern Ireland. Robert Gordon, in his review for Government to consider your predecessor committee’s recommendations for change, felt, from looking at what Northern Ireland and Wales were doing and looking across the globe, that there were checks and balances that could be introduced to overcome people’s concerns and he articulates those in his report. I think there is plenty available that would enable the Government to include this in the draft legislation. It would be a huge shame for the most vulnerable people if it was excluded. I hope this Committee will feel able to continue to champion that recommendation as your predecessor Committee did and, if necessary, remind Government that it said, in accepting

that it would look at your recommendations, that it would be led by Parliament, because the ombudsman service is a parliamentary institution, not a Government one.

Kelvin Hopkins: Can I make the point that meddling and making life difficult for the Government is not necessarily a bad thing?

Chair: I am glad you picked that up.

Kelvin Hopkins: Also, you are our Ombudsman, not the Government's Ombudsman.

Chair: Well, if there are no further questions, with the permission of the Committee we may decide to write to the Government with some of those thoughts to make our views clear. Agreed? Agreed. Thank you very much for coming before us today.